INVITED REVIEW

Assisted reproductive technology - IVF treatment in Ireland: A study of couples with successful outcomes

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Abstract

This article describes the experiences of twelve Irish couples who had successful IVF treatment in Ireland. Irish Medical guidelines specify that IVF may only be used when no other treatment is likely to be effective. This article is based on data drawn from a longitudinal research study by Cotter (2009) which tells the stories of 34 couples who sought fertility treatment. Initially, the women assumed that they would become pregnant when they stopped using contraception. As a couple, it was the ‘right time’ for them to have a child - they were ready, socially and financially. For several months they were patient, hoping it would happen naturally. With envy and some despair they watched as their friends had babies. Infertility came as a shock to most of them. They were reluctant to talk about it to anyone, and over time their anxieties were accompanied by feelings of regret, stigma and social exclusion. They finally sought medical treatment. The latter involved a series of diagnostic treatments, which eventually culminated in IVF which offered them a final chance of having a ‘child of their own’. While IVF can be clinically assessed in terms of cycle success rates, their stories showed treatment as a series of discoveries, as an extensive range of diagnostic tests and procedures helped to reveal to them where their problems might lie.

They described their treatments as a series of sequential ‘hurdles’ that they had to overcome, which further strengthened their resolve to try IVF. Much more knowledgeable at that stage, they embraced IVF as a final challenge with single minded dedication while drawing on all their psychological and biological resources to promote a successful outcome.

Of the 34 couples who took part in the study, twelve got pregnant. Unfortunately, two children died shortly after birth but eighteen babies survived (see Table I). The findings suggest that health policy should raise awareness of infertility, and advise women to become aware of it – just as in the past, when health policy addressed contraception. Increased public knowledge would reduce the stigma attached to the inability to have a baby. In the Irish case, infertility diagnosis should be reviewed with a view to giving eligible couples earlier access to IVF.

Keywords: Social concerns, fertility treatment, reproductive choice

Introduction

Currently, there is no legislation specifically regulating assisted reproductive technology (ART) in the Republic of Ireland. The ethical guidelines provided by the Irish Medical Council in relation to IVF, state that “IVF should only be used after thorough investigation has shown that no other treatment is likely to be effective” (Walsh et al., 2011). A number of private clinics provide IVF treatment in Ireland, but little research has been conducted on women’s experiences of treatment.

Objectives of the study

The Commission on Assisted Reproduction in Ireland estimated that one in six Irish couples has problems conceiving a child (CAHR, 2005). This study, “A child of our own”, funded by the Health Research Board, explored the impact of infertility on their lives: their access to infertility treatment, their persistence through treatment and the outcomes of treatment.

Infertility

Franklin’s study describes women’s experiences of IVF as based on ‘cycles of hope’, and ‘cycles of coping with failure’ (Franklin, 1997:184). This study locates these cycles within a socio-medical context in which patients first undergo a series of less invasive treatments. If the first does not work, then a second treatment is tried, each treatment sequentially embodied in a context of menstrual cycles. As time passes on, women still long to conceive, hoping each month that the last treatment will
be a success. When none of these treatments work, they are offered IVF. Women eagerly want to move on to IVF as they feel time is no longer on their side.

Research design and methodology
This article is based on a longitudinal qualitative study of couples undergoing infertility treatment in Ireland. All couples who attended a leading fertility clinic over a year were invited to participate. There were 40 couples who responded positively, and 34 who were considering IVF were recruited. Each couple was interviewed four times over a field work time of 27 months.

Each couple was interviewed together. The rationale for this was that their infertility was experienced and treated as a couple’s issue despite women’s bodies being seen as more reproductive than men’s (Hargreaves, 2006). Each of the four interviews was conducted at sequential stages of treatment at their homes. The first interview took place shortly after they registered at the clinic. It gave them an opportunity to speak about their lives up to then, their attempts to get pregnant and the realisation that they may have a fertility problem. The second interview took place after they had an IVF treatment cycle and during the time they were waiting to see if it would result in a pregnancy. The third interview took place 3 months later when they were either pregnant or undergoing another IVF treatment. The fourth and final interview was conducted at least a year later. There was an inevitable attrition rate, 34 couples were initially interviewed, and 30 of these did the second interview, 29 couples attended the third one while 26 completed all four interviews, giving a total number of 119 qualitative in-depth interviews. Three couples did not proceed with any treatment after the first interview while a fourth couple got pregnant before treatment. All names are pseudonyms.

Research findings
Ten of the 34 couples had a successful outcome, with at least one take home baby. Two other couples became pregnant and gave birth but their babies did not survive long after birth.

Assumed parenthood and stigma of infertility
During the first interview, couples revealed the way in which they had mapped out their lives. They had used contraception conscientiously, some ruefully reflecting on having had an occasional ‘scare’, consistent with a strong desire not to get pregnant before marriage. Their ideal timing of a planned pregnancy varied from after the honeymoon to when they had finally acquired a ‘family home’ with children in mind.

They had all assumed they would become parents.

“Before we got married we were this type of couple that …..we discussed all these different things that are likely to come up in our lives, and religion and whatever….. So before we even got married we decided we all agreed that we wanted four children and we had their names picked out...”. (Sinead Young)

But as time passed and pregnancy did not occur, they became depressed and desperate.

As Sinead Young said “she was desperate to join the club of women who had given birth, who become ‘experts’ on motherhood and whose lives had become centred on babies and buggies”. She now felt excluded from her one time peers.

Lay experts in fertility treatment
As couples went through a series of diagnostic tests and learned about conception and possible causes of their infertility, they became lay experts. All were initially prescribed clomiphene (Clomid) to stimulate ovulation, as the first treatment. The diagnostic post-coital test usually came next, followed by a laparoscopy, to check for any abnormalities. The pain and discomfort varied between women and few seemed to be adequately informed about its effects in advance. In some cases this was accompanied by a HSG (‘lap and dye’) which runs a dye through the uterus and fallopian tubes to confirm their patency.

Though uncomfortable, laparoscopies revealed the need for tubal surgery and ovarian drilling for two of the women, and endometriosis was removed using laser therapy during the procedure in another two cases. So it was a form of treatment in their cases.

However, three other women claimed the discomfort of the laparoscopy was not matched by an informative outcome as ‘sole male infertility’ was subsequently diagnosed in their cases. They referred to it as ‘a non-essential operation’ which had a small risk to their lives. As noted by Earle and Letherby (2007:247), those who seek such medical assistance often feel a distinct lack of control throughout the treatment process. All of these tests took time and couples became increasingly impatient to have a full diagnosis feeling that they were in a race against time.

Waiting time

“it’s the time period that gets to you more than anything else, they can take pints of blood and test it and do what they like but it’s just the waiting game because it’s like ‘oh and you have to come back next month or two months’ or whatever and you’re just hanging around in between tests waiting, that’s very stressful” (Sinead Young)

A ‘time anxiety’ was especially acute for patients for whom all these tests were only preliminary ones to their goal of IVF. Yet these ‘urgent and impatient’ patients had to fit into hospital lists, appointment times, results, and
the scheduling and rescheduling of tests. Frankenberg (1992) argued that the medical world can be described as a waiting culture, in part defined by the power asymmetry between patients and their doctors, in which the severity of the treatment is often reflected in the length of time patients have to wait for it.

“I will do anything”

Despite these complaints, women expressed a very high willingness to endure whatever was necessary to have a baby, as Liz said “you don’t really complain too much because you want to do anything to have a child so you don’t really think of yourself that much, do you know what I’m trying to say, you just go along with it. If they say ‘Stand on your head’ you just do that, like you know and that’s it.” (Liz Black)

Intra-uterine insemination (IUI) (ranging from one to five times) was then attempted by nine couples, sometimes at the request of couples themselves, but for others (consistent with the Medical Council’s guidelines) after the performance of one more less invasive or more natural procedure before finally attempting IVF.

The women’s voices revealed their vulnerability together with a form of ‘desperateness’ (Franklin, 1997:202). IVF was “their last chance saloon” beyond which there were no other options. Couples believed that they would not be allowed more than three unsuccessful fresh cycles.

Other couples referred to IVF as quite natural (at that stage), they thought of it as their “just needing a bit of help” (Tom Brady). All of the couples were paying for their treatment privately. They were highly motivated and were goal driven. Their belief in the technology did not diminish their emphasis on self-efficacy. They were also determined to give the processes their “best chance”, embarking on IVF in a ‘professional’ manner.

As the Bradys, pregnant with twins at interview 3, reported “we had done an awful lot of research beforehand and we had done our own thing in terms of changing our diet and you know going off alcohol and doing acupuncture and things like that and that made us feel a little bit more in control of what was happening whereas I think if you were just to launch into just the IVF on its own, it’s totally out of your hands,……like there’s nothing we could know to make more follicles grow or respond better or worse to treatment. There’s nothing you can do and that is one part of it that’s very hard is the fact that it’s not in your control”. (Joan Brady. interview 3)

The diagnostic and early pre-IVF non-invasive treatments took time and couples found them emotionally trying and difficult. When all other treatment failed, IVF was their ‘only chance’. They deserved IVF treatment not only in the eyes of the medical practitioners but in the eyes of the patients themselves (especially among those who might have had moral reservations about it). IVF treatment itself then required patients to become self-reliant active players, as the following accounts reveal.

The initial preparation for IVF requires that the woman takes a nasal spray every six hours, even during the night, for “down regulation”. The ‘six week’ procedure time became a crucial phase in the couple’s life. It was disruptive physically and mentally.

The spray was followed by a series of abdominal injections which stimulate the ovaries to produce multiple eggs. Throsby (2002) describes both the nasal spray and injection phases of IVF treatment as constituting ‘the gendered burden of work that is rendered invisible by the dominant representations of treatment as performed by doctors on passive patients’. The majority of the women were able to self-inject, some husbands administered the injection as either the woman could not bear doing it to herself or to make the husband more involved in the treatment; it was, as Schmidt (1997) said, a ‘couple project’.

However, some men like Peter Daly acknowledged the greater burden it placed on women:

“I was just so proud of you because it’s like”wow going through this “and it’s so easy being the man as there isn’t anything to do like you just have to, and I’ve seen you do all the stuff you know”.

Women had to attend the clinic to ensure that the follicles were being developed but had to avoid over-stimulation which could be life threatening. Clinic attendance was often scheduled before their working day, which was a source of stress for those who were keeping their treatment a secret. The anxiety now became - would they produce enough eggs? Would it all work out?

Egg retrieval

When a woman’s eggs were considered ready for in vitro fertilisation, they were removed from her ovaries while she was sedated but not anaesthetised. Nine women were conscious during the procedure and six women found it painful.

“I could feel them plucking each one away, so that was awful”. (Nicola Campbell)

During the harvesting of follicles, the medical gaze is firmly fixed on the woman’s ovaries. The procedure could take up to forty five minutes, during which time the man is expected to produce a semen sample, which is mixed with the eggs in a laboratory, in the hope of fertilisation.

“They collected fourteen and I think eleven were fertilised or something like that. I remember it was very high and we were thinking ‘god that’s loads’, this is going to be great… and I think the next day there were only two. (Marie Walker)

For couples undergoing treatment, embryo creation and transfer is the penultimate milestone. IVF can be experienced as an obstacle course (Franklin, 1997) or as hurdles (Monach, 1993), meaning that “each stage of treatment can be experienced as a success or failure in the pregnancy trail” (Parry, 2006).
Embryo transfer, conception and waiting for fertilisation

The embryo transfer experience was not per se painful but the process was undignified as Leah Murphy remarked, as “the embryologist stood down there between my legs which were up in the air I felt exposed”. During this phase, women felt treated like passive receptive objects. While they were in a theatre, they were not anaesthetised, but the moment of conception in vitro or in utero had no romantic ambience.

When the embryo were transferred, women began another waiting period – the sixteen day wait before doing a pregnancy test was often found to be the longest waiting time of all. Women were especially anxious not to disturb the implantation process through over-excretion. Now the medication regime was only a twice daily vaginal gel. Amy Green found that the gel “seemed to come out fairly soon afterwards...so I had a spare one and I gave myself a bit extra but then you kind of wake up in the night thinking maybe I shouldn’t have done that...maybe I put in too much”. She was so anxious to do everything perfectly. A negative outcome might not be blamed on a failure of medical science but on their actions, as Joan Brady expressed it: “It kind of feels like I have a responsibility now...you kind of are worried about everything”.

All women described being conscious of pregnancy or period signs. Women feared the arrival of a period. The longer this was delayed the more they turned to waiting for day sixteen and the long awaited pregnancy test.

It was a very intense time as Sinead Young describes it “every morning you wake up thinking please let me not have a bleed...please, please and every time you feel a little cramp or something you think ‘Oh no this is my period starting’ and you’re just a basket case you know”.

Kate Kenny analysed changes she felt in her breasts, i.e. thinking “God my boobs are sore’ now is that a period or is that because I’m pregnant?”

Conflicting emotions such as hope, fear and lack of control produce emotional turmoil. During this time, couples were determined not to be too excited so that their disappointment would not be so great, but they were still trying to maintain a positive attitude as they believed this could affect the outcome. They did everything correctly so that a negative treatment outcome could not be attributed to personal irresponsibility.

Getting pregnant

Those who became pregnant could not believe their luck, as Joan Brady elaborated.

“I had bought a Clear Blue digital thinking OK that will really tell us either way and we did it and I couldn’t look at it and he was in the bathroom and the next thing I heard this “oh my God” and I ran in and he was getting excited and I was kind of Oh...Oh right, Ok it can’t be happening, you know we can’t be this lucky, it can’t, OK, may be HCG is still in my system because even though I’d been on the internet trawling….To see how long the HCG should take to come out of your system”.

Liz Black said “I didn’t wait until Monday. I did the test before then... didn’t I (to her husband)? And it was positive (laughs!). Simon added ‘She rang me’... and she continues “But I rang him at work like. “I’m Pregnant”, I did it again Saturday, Sunday and Monday and I was definitely pregnant ... “she spent a fortune on tests”...yes 40 or 50 Euros on tests” (Simon Black).

The first column in Table I shows that five of the couples were diagnosed with male factor infertility, three had female-related factors while one couple had a

<table>
<thead>
<tr>
<th>Male Name</th>
<th>Treatment history</th>
<th>Age Mother</th>
<th>Age Father</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Green</td>
<td>1 ICSI cycle</td>
<td>39</td>
<td>39</td>
<td>I child (interview cycle)</td>
</tr>
<tr>
<td>Male Brady</td>
<td>1 ICSI</td>
<td>32</td>
<td>31</td>
<td>Twins (interview cycle)</td>
</tr>
<tr>
<td>Male Kenny</td>
<td>2 fresh cycles</td>
<td>32</td>
<td>31</td>
<td>Twins (interview cycle)</td>
</tr>
<tr>
<td>Male Kenny</td>
<td>2 fresh cycles; plus one frozen</td>
<td>39</td>
<td>35</td>
<td>Twin pregnancy</td>
</tr>
<tr>
<td>Female Young</td>
<td>One ectopic pregnancy; one miscarriage; I fresh cycle plus frozen cycle</td>
<td>35</td>
<td>33</td>
<td>Twins – success from frozen cycle (complicated pregnancies and 4 years of investigation)</td>
</tr>
<tr>
<td>Female Black</td>
<td>2 miscarriages; 2 fresh cycles; I frozen</td>
<td>38</td>
<td>34</td>
<td>2 children (one from second fresh cycle and one from frozen cycle)</td>
</tr>
<tr>
<td>Female Murphy</td>
<td>Multiple miscarriages; 2 Ectopic pregnancies 2 fresh cycles; 2 frozen cycles</td>
<td>36</td>
<td>36</td>
<td>I twin pregnancy (one surviving child); Second child from second fresh cycle</td>
</tr>
<tr>
<td>Female Kelly</td>
<td>3 fresh cycles; I frozen</td>
<td>32</td>
<td>30</td>
<td>I child from a second fresh cycle (in a different clinic)</td>
</tr>
<tr>
<td>Male Campbells</td>
<td>3 fresh cycles</td>
<td>41</td>
<td>37</td>
<td>One baby who died shortly after birth</td>
</tr>
<tr>
<td>Male Walkers</td>
<td>Two ICSI cycles</td>
<td>31</td>
<td>30</td>
<td>One child with first attempt; baby from second cycle died shortly after birth</td>
</tr>
</tbody>
</table>

Table I. Female or male factor infertility, treatment history, age at interview and outcomes of treatment.
Combination of both factors. In the case of three couples, no specific factors were identified. The couples ranged from age 30 to 41 (columns 4 and 5).

The third column shows that only the Greens and the Bradys got pregnant after just one treatment cycle with ICSI. The reproductive treatment history of the other mothers reveal a number of cycle failures prior to successful outcomes. There was a high number of twins because in Ireland, at least two embryos, if available, are always inserted into the womb. All of the couples at treatment time were in their thirties.

Some pregnancies were difficult. Four women experienced bleeding during pregnancies but these were explained as extra sacs that bled away. In the case of the Clarkes, this was first interpreted as a miscarriage, but a later scan showed that all was well. Nicola Cox was worried about a bladder infection and miscarriage. Liz Black developed a very large cyst on her ovary and received steroid injections in case of an early delivery. She had the baby via caesarean section. Sinead Young felt uncomfortable as there was too much amniotic fluid present. Jenny Kelly had a low lying placenta and was hospitalised numerous times due to dizziness. Despite their experiences, they all said it was a “precious time”.

As Kate Kenny added: “It has been just an amazing road. And even I think in the pregnancy as well, it made you appreciate it so much and enjoy it. I never complained on it, no matter what was wrong with me. I was so delighted. I was delighted to have all those symptoms... I was delighted to be waking in the night time and feel the kicking... and I'd say to Ray...’feel it’, constantly putting the bump against his back and that sort of way. It was lovely”.

This quote sums up the delight of pregnancy after a long journey, which for these couples was worthwhile.

Discussion

The narratives give the embodied experiences to women and an insight into the extent of which such pregnancies were wanted. The popular quantitative measure of ‘cycle outcome’ does not quite capture the role of assisted reproduction as part of a reproductive health treatment in which infertility can become like a chronic illness. These findings show that infertility treatment is best understood as a biomedical practice seen in a framework of access to IVF treatment, which requires money, considerable patient effort, persistence and time. It shows the empowered position of clinicians in terms of couples’ access to IVF, which was given as a last resort only when other treatments failed. In Ireland, this was in keeping with the Medical Council’s regulations. Inevitably however, it meant that couples were patients for much longer and that their access to IVF was delayed.

Despite these constraints, the study demonstrates the willingness of couples who desired to have a child of their own, to undergo whatever treatment hurdles are required. It also reveals the need for greater public discussion and awareness of infertility as a health issue, to reduce the stigma attached to it and to offer couples effective treatment as soon as possible.

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