The Fertility Nurses Group has been very active during the spring and summer period. We've had an opportunity to respond to various documents from the Human Fertilisation and Embryology Authority (HFEA), including single embryo transfer, hybrids and the draft Human Tissue and Embryo Bill.

April 2007 saw many of our members attending RCN Congress at Harrogate. As a group we maintained a high profile by, for example, having a poster on display that illustrated the work undertaken by the Fertility Nurses Group.

We organised a fringe event that was presented by Allan Pacey from Sheffield, looking at issues around fertility as well as donor recruitment (see page three). Delegates at the fringe event included nurses specialising in general and mental health nursing who had an interest in fertility as well as our colleagues from the Gynaecology Forum. – this resulted in a lively discussion!

We also submitted a resolution for Congress to debate, entitled “Voice at the Top” (page two). This resolution urged nurses to push for strategic input to all bodies concerned with health regulation and policy development, and we are pleased to say that it got 100 per cent support from the voting members at Congress.

Other activities within the group continue. Jane Denton and Debbie Barber have kept on driving forward the online fertility course with Greenwich University (see page 12). Our international links are maintained with Akiko Mori travelling over from Tokyo to meet representatives from the RCN as well as fertility organisations.

We also had cause to celebrate during the summer months when Jane Denton, Director of the Multiple Birth Foundation, received a CBE in the Honours List. Well done, Jane!

Our next FNG Conference has been booked for Saturday, 3 February at RCN headquarters in London. Sessions will include human papillomavirus (HPV) vaccine, chlamydia screening, embryo selection and single embryo transfer. Have a look at our ad on page three and contact Pat Anslow, Conference Organiser, for the latest details – she's at pat.anslow@rcn.org.uk or telephone 029 2054 6492.

Finally, many thanks to all active forum and committee members who have been supporting the continual work of the Fertility Nurses Group.

See you in February!
CAROL WILSON, Chair of the Fertility Nurses Group and voting member at Congress 2007, made an impassioned speech in support of our resolution at Harrogate. Here’s what she said...

Voice at the top

“... that this meeting of RCN Congress urges RCN Council to lobby Government to ensure that nursing has strategic input to all bodies concerned with health regulations and policy development.”

With the current major reform in health and social care, never has it been more important for nurses to be involved at the highest levels in shaping the future.

Yet we still have to fight to ensure that nurses are included in key positions as a routine. One example is that since a nurse, Jane Denton, completed her term of appointment over two years ago as a member of the Human Fertilisation and Embryology Authority, another nurse has not been appointed despite the Fertility Nurses Group writing to the minister and raising the matter at every opportunity.

Most nurses in fertility units have a highly specialised role, often with senior management responsibilities, and are by far the majority profession in the multidisciplinary teams. In contrast, there are three doctors on the HFEA Board out of a total membership of 19 individuals. Not one doctor, not two doctors, but three doctors – and no nurses!

We heard in the debate earlier this week that the work on transition in children to adult services of the Children, Young People's and Maternity Service Framework is being led by doctors, even though nurses can and should be playing a more significant role in the process.

Despite a pledge by Patricia Hewitt that nurses would be represented at board level on primary care trusts, the RCN is investigating the reports that some PCTs have not yet appointed nursing directors. Why?

An article on professional leadership in 2005 highlighted the need for practice nurses to develop skills and pursue leadership opportunities. This will then ensure the involvement of practice
nurses in directing the future of the changing primary care workforce.

Not only do we need to have nurses in key positions on boards, we should also be contributing to public debates on all important issues such as assisted dying, the revisions to the Mental Health Act and prison services. Nurses are rarely interviewed on the Radio 4 Today programme or other serious and influential programmes on subjects other than pay and deficits. Where is our professional voice?

Not only must we fight for places at the top, we must also be able to deliver. We must make sure there are nurses in the right place with the right knowledge, skills and experience to influence and contribute at a strategic level.

The RCN has the necessary expertise and infrastructure to achieve this, but it must be put into action more effectively. The essential resource of access to professional expertise must be upheld and strengthened within the new professional membership structure.

The RCN has a unique role to play in developing and mobilising leadership capability and capacity. We need to support and enable nurses to effectively take on major strategic roles. We must ensure a reliable, strong and confident voice that speaks for nurses and for patients.

The nursing profession has to maintain and promote an active voice within health consultations and, ultimately, health policymaking to ensure that patient care is maintained at the highest quality level possible.

It is not just having nurses involved; it is also about being able to deliver. Therefore we must have an input into all bodies concerned with health regulation and policy development.

Speak for us all. Please support this resolution!

And so they did – delegates backed this resolution by a resounding 100 per cent.

RCN EVENTS

RCN Fertility Nurses Forum Conference & Exhibition

The Best Possible Start-making reproductive choices

Saturday 2 February 2008
Royal College of Nursing, 20 Cavendish Square
London W1G 0RN

The best possible start is aimed at all nurses and other healthcare professionals involved in fertility nursing and care. Discuss the diverse nature of current developments in fertility nursing and challenges you face day-to-day in your workplace. Learn about significant developments in this specialty and share your expertise with your peers.

Sessions will include:
- HPV Vaccination
  Dr Sarah Jarvis, Women’s Health Spokesperson, Royal College of General Practitioners
- Chlamydia screening – are we screening the right sex?
  Annie Sutthill, Lead Nurse (STI), Brook Milton Keynes
- Anti-mullerian hormone (AMH) or FSH – what is the best predictor of ovarian reserve?
  David Hodgson, Medical Director, London Fertility Centre
- Embryo selection: how do we select the ‘best’ embryos for ET?
  Daniel Bryson, Scientific Director, Dept of Reproductive Medicine, St Mary’s Hospital, Manchester / Dr Diane Critchlow, Clinical Scientist, Dept of Reproductive Medicine, St Mary’s Hospital, Manchester
- Elective Single Embryo Transfers – dilemmas for patients, practitioners and regulators
  Debbie Barber, Nurse Consultant, John Radcliffe Hospital, Oxford
- Opening the donor register
  Jennifer Hunt, Imperial College, London
- A personal experience
  Speaker to be confirmed

Continuing Professional Development
This event is RCN accredited

Further details
Conference: Pat Anslow: Telephone 029 2054 6492;
Email pat.anslow@rcn.org.uk
Exhibition & sponsorship: Telephone 0208 872 3110;
Email exhibitions@rcnorganising.co.uk
Bookings: Telephone 029 2054 6460;
Email rncdeventregistration@rcn.org.uk

www.rcn.org.uk/events

SING!

The Senior Infertility Nurse Group (SING) met at the Instituto Valenciano de Infertilidad (IVI) unit in Valencia for a tour of the facility and a presentation from one of the doctors regarding their egg donation programme. The autumn SING meeting took place on 4 October in Nottingham.
**Fertility**

The subject of “reproductive tourism”, a term suggested by Pennings (2004), is very topical. More and more couples are leaving behind the high prices, long waiting lists and legislation of the UK and heading to destinations worldwide where fertility treatment is an increasingly attractive option (McMillan and Hope, 2003; Sidebottom 2003 cited by Pennings, 2004).

People are travelling to countries all over the world for cheaper treatments such as in vitro fertilisation and intra cytoplasmic sperm injection, or to receive donor eggs and sperm.

There are many issues to be considered. Fertility is an emotive subject and this is only exacerbated by repeated failed treatment attempts or the frustration caused by expensive prices and long waiting lists. Patients therefore appear to be willing to accept the potential risks involved in undertaking fertility treatment abroad. It seems that the need for a baby is justification enough.

The Human Fertilisation and Embryology Authority in a statement released on 27 April 2006, urged patients “to consider the risks and implications of going abroad for treatment …”, but some of the risks are in fact the reasons why patients are choosing to travel abroad. It is important to consider the risks involved in undertaking fertility treatment abroad. It seems that the need for a baby is justification enough.

The Human Fertilisation and Embryology Authority in a statement released on 27 April 2006, urged patients “to consider the risks and implications of going abroad for treatment …”, but some of the risks are in fact the reasons why patients are choosing to travel abroad. Patients who travel abroad to escape the UK legislation on donor anonymity, for example, are only too glad that many countries do not have such legislation in place.

**Patients who travel abroad to escape the UK legislation on donor anonymity, for example, are only too glad that many countries do not have such legislation in place.**

In contrast, payment of donors abroad is common. The lure of financial gain attracts immigrants across borders to offer eggs to desperate foreigners. Itziar Alkort-Idiákez, a Spanish law professor, told the *Independent*: “The private Spanish clinics target students and ‘good donors’ among Eastern European immigrants who produce a large number of eggs.” In 2005, www.ivf.net quoted a BBC report stating that Romanian women could earn £150 per donation which was equivalent to the average monthly wage.

Some patients are travelling overseas for different reasons such as family balancing, pre-implantation genetic diagnosis or embryo adoption. Sex selection is only practised in the UK for medical reasons (HFEA, 2003a), but family balancing is offered in countries such as Malaysia for non-medical reasons.

Appropriate follow-up is vital for such women. A Romanian lawyer reports in the *Independent* how two young women gave eggs to a clinic in Bucharest which has an egg-sharing arrangement with a UK clinic. The clinic abandoned them when their egg donation resulted in health problems.

It should be noted here that many foreign clinics are reputable, but it is difficult for patients to make an informed choice.

Further, what is the cost to the UK when the patients return with multiple pregnancies – there is already a national shortage of special care baby beds. A 2006 report, *Counting the cots*, carried out in
London neonatal units, describes just how overstretched London units are.

This point is further illustrated by sensational headlines in the media and other sources such as www.ivf.net, a website catering for infertility professionals. “IVF twins for world’s oldest mother” and “World’s oldest mom bears twins at 67” are just a few examples. The mother in question was a 67 year old Spaniard who had IVF in America and then allegedly returned to a hospital in Barcelona which specialised in high risk births.

Undoubtedly stories such as these will divide international public opinion on the risks and benefits of seeking treatment abroad.

So whose baby is this?
There's also the question of which country's health care system takes responsibility for the patient. Our clinic has had experience of patients attending clinics abroad, but relying on us for follicle monitoring, providing drugs, blood tests and ensuring that results get to the appropriate clinic within a certain time frame.

Who should actually take responsibility for the patient when a problem arises? Inevitably a UK-based clinic will bear the brunt of a patient’s frustrations when things go wrong.

Multiple pregnancy is a serious risk to both mother and babies, but worryingly a risk which some would-be parents are willing to take or do not fully appreciate.

In the UK, centres are obliged to follow HFEA regulations. The HFEA Code of Practice (2003b) states: “Women under 40 at the time of transfer receive not more than either two eggs or embryos in any one cycle, regardless of procedure used.”

Further: “Women aged 40 or over at the time of transfer receive not more than either three eggs or embryos in any one cycle, regardless of the procedure used.”

In some countries, such as America, couples are offered the chance to have a higher number of embryos at transfer and then the option to have embryo reduction. Iberico et al (2000) state: “First-trimester transvaginal embryo reduction is an effective alternative for the management of multifetal pregnancy in assisted reproduction.”

Who is going to take responsibility for this procedure when treatment is procured abroad? Are the risks and costs of the procedure fully explained to the patient prior to making the decision to proceed with treatment?

And then there's the question of citizenship
Children resulting from donor treatment cycles in countries where there are no anonymity laws may investigate their right to citizenship. A Times report (August, 2005) claims that this is indeed a worry. Despite reproductive tourism being good for the Californian economy, some academics predict an “immigration headache for the US when the offspring of children conceived by foreigners with the eggs of American donors claim US citizenship.”

In addition, the anonymity laws may also mean that some couples have no access whatsoever to a genetic history for their child and this could have serious future implications.

Following on from this, there is also the question of who has legal responsibility for the child. Again, foreign laws may be unclear and less stringent. Olivia Montuschi of the Donor Conception Network suggests “the right of any offspring to know the donor’s identity tends to disappear when fertilised eggs are implanted overseas” (Independent, 2006).

There may also be serious implications when you consider that not all clinics worldwide follow blood borne virus screening or quarantine policies so some couples may be receiving unscreened donor gametes. Is it only a matter of time before a patient returns to the UK pregnant and then sero-converts? It was difficult to find accurate information or statistics to fully substantiate this which, I think, raises its own issue.

But how ‘informed’ is the choice?
On the surface it can seem easy for curious, childless couples to find information regarding seeking treatment abroad. While researching this subject I found lots of information, but much of it is media driven.

By putting “reproductive tourism” into a search engine, I was presented with numerous advertisements for foreign clinics and links to chat rooms about the subject. For someone without clinical knowledge, it must be difficult to assess which information is reliable and to identify any gaps. There appears to be an absence of peer reviewed clinical studies.

The scope for uptake of reproductive tourism looks huge, but for how long? The enthusiasm for foreign assisted conception may dwindle if and when something goes badly wrong.

Perhaps there should be an arrangement within the European Union that legislation would be mandatory for all member states. We can only hope that the EU Tissue Directive will contribute towards quality and standardisation (Department of Health, 2007). It would be unrealistic to expect this to extend worldwide, but it would be a reassuring prospect.

Or does the future of fertility treatment lie in High Street chains where couples can book an IVF package holiday, complete with extra leg room on the way there?

Full references on request to the Editor.
The single biggest risk from current IVF practice is multiple pregnancy.

The initial jubilation which follows the successful implantation of two or three embryos must be countered by the significant risks to both mother and foetus which are associated with multiple births. For twins there is a five fold increase in perinatal mortality and, for triplets, a ten fold increase when compared with singletons. The majority of the increased risk is because multiple births are more likely to be premature.

The latest figures (2003–2004) show that following IVF almost one in four births will be twins or triplets (23.7 per cent twins and 0.5 per cent triplets). Comparing this with the rates following natural conception for twins (one in 80) and triplets (less than one in 6,000) highlights the increased risk of multiple births following IVF.

Since 1985, the rise of triplet and higher order births has trebled in England and Wales with statistics from the HFEA showing a clear association with the increasing use of IVF, gamete intrafallopian transfer (GIFT) and associated procedures.

Twins are approximately 10 times more likely to be born prematurely (before 37 weeks gestation) than singleton pregnancies. This means that half of all twin pregnancies will be born before 37 weeks, with five-to-10 per cent born before 32 weeks gestation.

Many families describe their time on the neonatal unit as an emotional rollercoaster, with their babies taking “three steps forward and two back” ... Underlying this is the thought that their baby may not survive the journey.

Weighing the risks

With advances in medical care it is now possible for infants born as early as 17 weeks premature and weighing as little as 450g to survive. However, the risks associated with enabling the survival of these babies are significant and include cerebral palsy, learning difficulties, chronic lung disease, and visual and hearing problems.

Premature babies may spend several months on the neonatal unit, suffering setbacks such as infections, brain haemorrhages and bowel or heart problems which may require surgery.

This can be an extremely difficult time for the families of these babies, who may live many miles from the nearest tertiary neonatal intensive care unit. They may have to balance caring for other children and work-related issues with being at the bedside of their sick newborn.

Many families describe their time on the neonatal unit as an emotional rollercoaster, with their babies taking “three steps forward and two back” in their journey from being born prematurely to survival home. Underlying this is the thought that their baby may not survive the journey.

Babies born between 23 and 26 weeks gestation have a 50 per cent chance of survival and, of those who do survive, one in four will have moderate/severe disabilities at the age of six years.

The survival of these babies and likelihood that they remain free from disability increases with their gestational age at birth. For example, babies who are born at 23 weeks have a 10 per cent chance of survival with half having moderate or severe disabilities at the age of six years. At 28 weeks, 90 per cent of babies will survive, with only 10 per cent having moderate or severe disabilities at six.
Miracle babies?  

Recently there have been a number of high profile cases reported in the media about extremely premature infants who have survived to discharge home. In particular, one infant was reported to be less than 22 weeks gestation, weighing only 283 grams at birth.

The remarkable survival of this baby was broadcast around the world as a new landmark in the care of premature infants and, while the medical team caring for this baby were rightly applauded for their achievement, these case reports must be taken in context.

This story made worldwide news because it was extraordinary. In the UK, infants below 22 weeks are not routinely resuscitated and many would only be resuscitated below 23 weeks in extreme circumstances. It is unlikely that babies at this gestation will survive and if they do, it is highly likely that they will have life-affecting disabilities.

In addition, there are cost implications for infants being born prematurely. An intensive care cot costs around £1,300 a day to keep open with some infants requiring several months of this level of care. The cost implications continue beyond discharge from hospital with increased ongoing health care, social care and schooling costs for infants born prematurely.

It can therefore be seen that the impact of being born prematurely affects not only the individual baby, but also the family and the wider society in general.

Following assisted conception, singletons are twice as likely to be born prematurely than those conceived naturally. This does not appear to be the case for twins where there is no difference in pre-term birth rates between twins conceived via IVF versus those conceived naturally.

Interestingly, there is also some evidence that twins who are conceived through assisted conception may have an improved chance of survival when compared with twins who are conceived naturally. The reason for this is not fully understood, but is probably multifactorial. Among possible explanations:

- IVF twins are more likely to be dichorionic
- The successful implantation of two as opposed to one embryo may reflect an “implantation advantage” or a healthy intrauterine environment
- IVF twin pregnancies are more likely to be detected early and receive targeted antenatal care.

However, while an assisted twin pregnancy may be relatively advantaged in terms of survival compared with naturally conceived twins, this is poor consolation for the much greater risks of twin pregnancy overall. Virtually all perinatal and infant morbidity occurs more frequently in twins than in singletons.

Information regarding the long term follow-up of infants born following assisted conception is limited. Results from a Danish cohort of infants showed that twins born after assisted conception have a similar risk of neurological problems at seven years of age as naturally conceived twins and singletons born after assisted conception.

This suggests that there are no long term disadvantages in being born following an assisted twin pregnancy. However, results from epidemiological studies such as this must be interpreted with caution, given the possibility of reporting bias.

Virtually all perinatal and infant morbidity occurs more frequently in twins than in singletons.

Miracle babies?

So how many is enough?

The question regarding the number of embryos to transfer during assisted conception is not a simple one. Single embryo transfer results in fewer pregnancies and births than double embryo transfer, but it is also less likely to result in multiple births.

Multiple pregnancies are much more likely to be born prematurely than singletons and therefore are at increased risk. However, while pregnancy and live birth rates are routinely collected following assisted conception, there is limited information regarding the long term follow-up of these infants.

Until this information is obtained, preferably from randomised controlled trials of single versus double embryo transfer, parents are unable to be fully informed about the pros and cons of single versus double embryo transfer.

Suggested reading

Pandian, Z; Bhattacharya, S; Ozturk, O; Serour, GI and Templeton, A (2004) Number of embryos for transfer following in-vitro fertilisation or intra-cytoplasmic sperm injection, Cochrane Database of Systematic Reviews, Issue 4, Article No CD003416. DOI: 10.1002/14651858.CD003416.pub2.


Marlow, N; Wolke, D; Bracewell, MA and Samara, M (2005) EPICure Study Group, Neurologic and developmental disability at six years of age after extremely pre-term birth, N Engl J Med, 352 (i), pp.9–19.
DEBBIE JEFFERIES, Senior Fertility Nurse at Cardiff Assisted Reproduction Unit, tells us about an innovative, patient-focused approach.

OPEN EVENINGS FOR COUPLES: How we cut waiting lists and missed appointments!

In 2004 the Welsh Assembly Government (WAG) asked the Health Commission Wales (HCW), the body responsible for health provision, to form a working party to look at National Institute for health and Clinical Excellence (NICE) guidelines for fertility and how they might be applied. This resulted in the introduction of Wales-wide criteria for patients requiring IVF.

I was initially employed in 2004 to look at the long IVF waiting list with an eye to:
- applying new criteria set by the HCW
- promoting health, particularly advice on weight loss and smoking cessation
- improving patient satisfaction and education.

First we worked closely with the trust and HCW to validate the waiting list, writing to everybody on the list to see if they still wished to proceed with treatment.
- some 1,066 patients had been on the list for more than three years
- validation reduced this to 633

In January 2005 the HCW asked that new criteria be applied to patients now being placed on the waiting list. Those on the existing list were exempt, but were only offered one cycle of treatment. This would result in a more equitable system and remove the postcode lottery that had existed.

The new criteria, based on NICE guidelines, covered health and social aspects, asking that those having treatment should:
- be non smokers

The constraints were and still are that staff goodwill is needed to provide this out-of-hours service.

CHRISSE EFTEKHAR has examined current practice at the London Fertility Centre and sends this report.

Does your service measure up to best practice for clinics using donor gametes?

The National Gamete Donation Trust has a best practice policy which all clinics should try and follow. Our staff are made aware of the best practice for gamete donors and informed of protocols, but communication is vital in getting the right patients. I wanted to see if we really were following their best practice policy in our clinic and, if required, consider how improvements could be made.

These are my findings.

How do we recruit egg donors?
Advertising in women’s magazines, both weekly and monthly, is the most common method. Occasionally we advertise on public transport. We have
● have a BMI of 19–30
● have no children living in the household
● be no more than 38.5 years of age for the female partner and be treated before 40
● have had no more than three previous private treatments
● not be infertile as a result of sterilisation in either partner.

Priority was obviously given to addressing the pre-January 2005 waiting list. By treating these patients as quickly as possible, we would then be able to apply the new criteria and start offering an equitable service.

To facilitate this task we looked at introducing “evenings”.

From benchmarking with other units we could see that large numbers of patients could be given good quality information in the form of a presentation and slideshow.

Thus on Wednesday evenings, 16–17 couples were invited to the unit where they were given a presentation by the Director and Head of Embryology.

Here couples had the opportunity to ask questions in an open forum or on a one-to-one basis. They could also meet staff and be shown around the unit by the nurses.

A pack was given out containing relevant consents and information as well as health promotion advice regarding smoking cessation, weight loss, cervical screening and so on.

Better by half!
Couples were asked to contact the unit the following day to arrange a clinic appointment where consents could be signed and any outstanding investigations organised. Only those who wished to proceed did this and it resulted in a 50 per cent reduction in those not attending appointments (DNAs) and consequently reduced the length of the waiting list.

Our evenings have been very successful, greatly improving patients’ understanding of in vitro fertilisation (IVF) and intra cytoplasmic sperm injection (ICSI) as well as enabling patients on the original waiting list to be treated within a year. The constraints were and still are that staff goodwill is needed to provide this out-of-hours service.

As the waiting list is now a year long, we do not have to see the same numbers at these evenings. The new criteria are now in place and patients have time during this year to address issues such as weight loss and smoking cessation. The DNA rate remains low and we have also extended the service to those undertaking intrauterine insemination.

We have had very positive feedback from the patients and have acted upon any comments or suggestions received. Some of the positive comments include:

“Very helpful and reassuring.”
“Atmosphere very relaxed and informal, and I felt more at ease than I expected.”
“Other couples thought of questions we may not have thought of asking.”
“Really informative and put our minds at rest.”
“A handout which repeats the details of what we should do would be good…”

That last comment led us to devising a “What to do next” leaflet.

As a unit we entered the Welsh Innovations in Health Service Award and were lucky enough to be among 33 finalists attending the awards ceremony hosted by the Welsh Health Minister at the Millennium Centre. Unfortunately we did not win, but it was a great night and an honour to reach the final.

CONTINUED ON PAGE 10

a dedicated free phone line which they can call for information. The response is good, but there is a huge dropout once the potential donors find out what is involved.

Who enquires?
We hear from women from across the UK, with more response from women out of London. They are interested for altruistic reasons, often single mums and women who just want to help other women.

What do they get out of it?
Financially, very little. They are allowed to claim travel expenses on producing receipts. And they can claim loss of earning or childminding fees to a maximum £50 a day. This cannot exceed £250 in any treatment cycle.

What happens after they enquire?
We send out an information pack which contains a registration form. On receipt of the completed form, we check that the person will fit the criteria/protocol to be an egg donor. These are:

● aged 36 years or less
● a BMI within our limit
● no medical reason for not becoming a donor.

An appointment is then made for the potential egg donor. Half of them do not turn up for the appointment!

And for the other half: the clinic appointment
Before seeing the doctor for their appointment, potential donors will have an appointment with our Counsellor who follows a strict Anonymous Egg Donor Assessment Counselling Protocol.

If the Counsellor is happy with the assessment, the donor will see the doctor on the same day and arrangements will be made to do all blood screening and scanning. The
CONTINUED FROM PAGE NINE

doctor will write to the donor’s GP.
The screening bloods include HIV, HTLV 1 Hep B core, Hep B and C CMV, syphilis, blood group, antibody screen, FBC, toxoplasmosis, blood karyotype and CF 30 mutation screen, plus chlamydia and gonorrhoea urine.

A follow-up is arranged to discuss all the results. A suitable recipient is then found.

After being accepted as an egg donor ...

We keep in contact in case of any delays for either the donor or recipient. If we have not had any recent contact, we will write a letter as some donors change their minds. There is no pressure from the clinic – if there is no response, she will be removed from the egg donor list.

If she successfully become an egg donor?

After the egg collection the donor is called to check if she is well. Women are advised to come back after their period for a free scan and follow-up to make sure that there are no problems or complications. Counselling is also offered after treatment as a follow-up.

A thank-you card is sent within two weeks of the treatment being completed. Previously we would send flowers to the egg donor, but the HFEA was not happy with this practice and it was stopped.

Some egg donors want to know how things went with the recipient – others don’t. Some donors telephone years later to ask the outcome. They are usually delighted if the treatment was successful.

Donors are very happy that we check that they are well after the egg donation – they feel that someone is still caring for them. We have very positive feedback regarding this practice

How about sperm donor recruitment?

Again, we advertise in magazines and newspapers. On average if we get 50 men responding, only two will end up becoming sperm donors. Many men ask if they will get paid. When they discover that there is only minimal payment, some do not want to continue. Others dropout when they find out about the lack of anonymity.

What’s the next step?

If they are still interested, they will be sent an information pack. If they return the registration form, they will then be contacted and an appointment made for one hour. At that time they will fill in a medical questionnaire. A semen test is performed along with a screening urine test for gonorrhoea and chlamydia. If the semen test is of good enough quality, it is sent away to be tested for trichomonas and gonococcal microculture and sensitivity.

When we have the semen and urine tests back, the potential donor is brought in again for counselling. If the counsellor is happy with the assessment, screening bloods are completed on the same day.

Which tests?

Tests include HIV, HTLV 1 Hep B core, Hep B and C, CMV, syphilis, blood group, antibody screen, FBC blood, karyotype and CF 30 mutation screen and Y chromosome microdeletion.

When we get the results back and everything is clear, a semen freezing appointment is given. A total of six samples are frozen, one every week. We ask the man to abstain for three-to-five days prior to freezing the sample. For each sample frozen, he will get paid £20. For the counselling he gets £10. The payment must not go over £250 in total, including the cost of donors coming back for the freezing in six months.

Six months later?

After six months another blood test is done to check the screening is still clear. Donors can then claim £120. They can freeze another six samples and then take a month’s break until we have enough semen for freezing. Further counselling is offered and follow-up given as required.

A card is sent to thank the donor for his help.

As you see, we try to follow the National Gamete Trust’s Best Practice Policy, but we are always looking for ways to improve. We would greatly appreciate any ideas from other centres regarding their best practice for gamete donors.

Contact Chriss Eftekhar, Senior Nurse Manager, at London Fertility Centre, 112A, Harley Street, London W1G 7JH.

ERRATUM

In the article The Extended PLISSIT model for addressing sexuality by Bridget Taylor in the spring 2007 issue, it was stated that psychosexual therapists and relationship counsellors are available “for a donation” from the charitable organisation Relate. This is in fact not accurate as Relate do have fees. We apologise for this error.

WING launches new matching service

Following a successful pilot project, WING is offering a new matching service that links members with other members for peer support and friendship. Members are matched by shared experience of ill health or injury (e.g. linking all members with MS together) and contacts are made by telephone or email. WING provides advice, information and support to all RCN members affected by injury, ill health or disability – whether work related or not. For more information about the matching service or any of WING’s activities, please call 0845 408 4392 (10am– 12 noon weekdays) or email wing@rcn.org.uk
Together with the Senior Infertility Nurse Group (SING) and the British Infertility Counselling Association (BICA), and with sponsorship from Ferring, the new counselling course went ahead on 20–21 July with 12 delegates (11 nurses and one embryologist). Feedback from the delegates has been excellent, as you will see here as TRACEY LEWIS and VICTORIA KING from Midland Fertility Services share their experiences.

SPecIALIST COuNSEllING COURSE: How was it for us?

“The stresses of trying and failing to conceive for that long have significant effects in the individuals, relationships. Therefore, it is recommended that specialists in fertility know about and attend to the psychological component of their patients’ medical problem.”*

We were fortunate to be able to attend Counselling Skills for Specialist Nurses Working in a Fertility Setting – a course organised by SING in association with BICA.

The course was run over a two day period, conducted in workshop format by trained counsellors. Prior to arrival we felt a mixture of both anxiety and excitement – anxious about the potential unveiling of our own emotional baggage among strangers and excited about developing skills that we require and use daily in providing quality, holistic care.

We wanted to be punctual, but after a traumatic journey we ended up arriving fashionably late and embarrassed ...

We were immediately put at ease by course leaders Jenny Dunlop and Norma Wilson and welcomed into the group of 10 people to introduce ourselves. This provided the foundations for a relaxed and open learning environment. We were given the opportunity to set a contract for the two day workshop, including the aims and objectives we wished to achieve.

Even at this initial point people in the group seemed comfortable enough to disclose their needs in accordance with personal experience.

Jenny and Norma delivered ongoing 30-minute stints, alternating with presentation, visual aids, role play, non verbal communication and case discussions to maintain group interest and interaction. This was very effective and the group were enthusiastic to participate – it presented a dynamic way to explore counselling and subject content. It also facilitated exploration of the nurse and patient relationship.

The course content included the use of different skills in various scenarios to ask, “what is counselling?”. This incorporated breaking bad news, loss, mourning and the importance of self care.

The course was an invaluable experience, completely tailored to developing skills used throughout the fertility setting. It has contributed to the maintenance and development of high quality, patient care.

It was refreshing to work with other nurse specialists/embryologists to gain an insight into their experiences and how other clinics function.


Heidi Birch adds ...

This course was funded by an unrestricted educational grant from Ferring and we are grateful for their help. It’s been well received and as a result, SING will be organising another course in February (date and cost to be confirmed). Places will be limited to 24 delegates so if you are interested, email me at heidi.birch@midlandfertility.com right away. We will send information as soon as it becomes available.

Exciting changes to BFS summer colleges

The British Fertility Society’s summer college for 2008 will be in Liverpool with an exciting new format to attract more interest from nurses. Following the success of this year’s meeting at York, the format will include two main sessions every day that are relevant to nurses, including workshops and updates on clinical developments and embryology.

There are also two nurse prize sessions. A cash prize is awarded to a nurse for the best presentation skills on a given topic. There is also the chance to win a trip to Canada for the best submission by a nurse of a piece of audit, reflective practice, essay or research.

Details are on the BFS website: www.fertility.org.uk or you can contact Julie Hinks, Nurse Representative of the BFS meetings sub-committee. You can email Julie at julie.hinks@repronmed-bristol.co.uk

Now is the time to prepare your submission for Liverpool 2008.
The meeting in 2008 will be in Barcelona. The paramedical pre-Congress course had 42 participants. The afternoon session was shortened as the planned visit to the IVF unit was cancelled at short notice. The sessions organised during the main programme covered a variety of topics including basic embryology and the relative risk of drugs and ovarian cancer as well as a hotly debated ethics session. The meeting in 2008 will be in Barcelona.

Understanding Human Fertility

This course offering 15 credits at level 3 started in the first week of October, running for 11 weeks. The cost is £450. It is aimed at practitioners who provide direct services or assist as members of a multidisciplinary team with investigations, treatment or subsequent care for infertility. It will enhance the scope and practice of practitioners for the benefit of clients and provide the essential knowledge required to support couples undergoing fertility treatment.

Managing Infertility

This course also offers 15 credits at level 3 and will run from the week beginning 7 January 2008 for 11 weeks, with a break for Easter. The cost is £450. Designed for practitioners who have worked in fertility clinics for at least one year, the course is central to the role of providing care to infertile couples and gives the essential knowledge required to offer holistic care for clients and help them make informed choices.

Key benefits

- A rich online learning environment with tutor support and easy access to quality links will enhance the learning experience.
- The e-learning format facilitates worldwide access as well as embracing and valuing involvement and sharing of knowledge.

Counts towards degree

Individuals who successfully complete one or both of these courses can apply to have the credits counted towards a programme of study at any university or may wish to apply for a BSc Hons Professional Practice in Health and Social Care, Sexual Health at the University of Greenwich.

How to apply

For more information, contact Course Co-ordinator Ros Delaney on 020 8331 7594 or email: r.t.delaney@gre.ac.uk. To register your interest, contact Programme Leader Jayne Beeby on 020 8331 8090 or email: j.p.beeby@gre.ac.uk.

The Paramedical Group was started in 1987 and acts as a platform for nurses, laboratory assistants and junior embryologists (who have been in the field for less than two years) to present their work in a non-threatening environment. There are two prizes awarded each year at the annual meeting, one for nurses and one for laboratory personnel. Paramedics are a vital part in all successful IVF units and therefore should be represented at the meeting. Paramedical sessions during the conference are specifically targeted to meet the needs of the group. Yearly membership is only €30 and reduces the price of courses and meetings significantly. I hope to see you in Barcelona in 2008.

FNG Committee, works with Midland Fertility Services.
Email heidi.birch@midlandfertility.com