INTRODUCTION

Medical training focuses on treating a patient until the medical issue is resolved. Unfortunately, infertility treatment does not always resolve the medical issue in favor of a pregnancy. Consequently, medical professionals will encounter regularly the need to counsel a patient that their chances of success are so low that it is in their best interest to discontinue treatment. However, because there is no clear end-point for the cessation of unsuccessful fertility treatment, as there is always some probability of success inherent in further attempts, the physician may have difficulty in justifying his/her best advice to patients. Similarly, from the couple’s point of view, being able to walk away from treatment involves significant psychological tasks. For instance, the couple must accept that treatment has failed despite the odds, begin decision-making about the next steps and emotionally deal with such losses as wish-fulfillment, a potential genetic offspring, etc.

From an evidence-based perspective there is limited research carried out directly on this specific doctor-patient communication. Thus the following sections are based on both relevant clinical theories and indirect research. Physicians can best support couples in this ‘end of treatment’ consultation by being able to recognize the:

(1) Psychological factors that make this process difficult for couples;

(2) Risk factors that contribute to some patients suffering greater distress during this transition;

(3) Specific skills which can facilitate the consultation process for both physician and patient.
ASSISTED REPRODUCTION IN THE COMPLICATED PATIENT

THE EMOTIONAL CHALLENGES EVOKED BECAUSE OF THE ‘END OF TREATMENT’ CONSULTATION

A review of the literature reveals three main emotional challenges which make ending treatment difficult for couples: fear of not being able to cope; an inability to imagine a life without children; and concerns over survival of the partnership.

Fear of not being able to cope with ending treatment

The hope produced by being in treatment keeps at bay the full sorrow of never having your own children. When there is no further possibility of conceiving, these feelings surface completely and can feel like they are too much to bear. Daniluk\(^1\) proposed that one of the main factors preventing couples from ending treatment is the fear that such feelings will be overwhelming and impossible to cope with. For most couples, ending treatment is a process rather than an event, with the mental transition from ‘not yet pregnant’ to ‘not going to be pregnant’ being gradual.\(^2\) Although this process is distressing, it is manageable, because it gradually allows couples to adapt to the possibility of treatment failure. Thus, couples will move from being certain that they want further treatments, to being ambivalent about biopsychosocial and financial costs versus chances of success, to eventually being comfortable in their decision to end treatment. The acceptability of advice about ending treatment will therefore vary as a function of where couples find themselves in this transition process.

An inability to imagine a life without (one’s own) children

Many couples persist with treatment because they cannot imagine a satisfying and happy life without their own children. For these couples, being told that treatment is over is tantamount to having no future. During the transition from ‘not yet pregnant’ to ‘never going to be pregnant’, couples must construct a new future for themselves. However, parenting is such an important organizing principle for how people see their futures that this task can seem insurmountable. Add to this society’s emphasis on parenthood as the major developmental milestone in adulthood, and one can understand why the future looks so bleak to these couples.

Part of this pessimism is due to a lack of knowledge. Research shows that couples who remain child-free eventually fare well, in the sense that they can achieve a contented life, and they can interpret their infertility experience in terms of its positive impact on their life, for example on their commitment as a couple.\(^3,4\) Despite this positive growth, the sadness of
infertility is not entirely forgotten, and this traumatic life experience continues to have effects. For example, studies have shown that many years later women still report intrusive thoughts about their fertility, and still report fertility-problem stress.

Fear concerning survival of the marital relationship

For many couples, the basis for committing to a relationship is the eventuality of forming a family with children. The end of treatment may cause people to question the basis for their marriage. Furthermore, the diagnosed partner may have fears that their partner may not wish to continue in a childless relationship. Strauss and colleagues found that couples who felt their union would be threatened by a lack of children were the ones most likely to persist with treatment and/or be reluctant to end treatment. Thus, the recommendation to end treatment may trigger marital issues that have lain dormant, or threaten the viability of the marriage.

FACTORS THAT INFLUENCE PATIENTS’ REACTIONS TO THE ‘END OF TREATMENT’ CONSULTATION

How a person or couple reacts to advice about ending treatment will differ according to a variety of factors. Thus, couples will enter the ‘end of treatment’ consultation with different mental agendas, from being prepared to hear that it is time to give up to being completely unprepared. It is important to know in advance the factors that may influence how people will react to advice about ending treatment, as this will influence the physician’s expectations for the consultation.

Demographic factors

Gender is critical to decision-making about further treatments. Women are more likely to initiate treatment, want to try new treatments and want to continue with treatment compared with men, and men tend to be willing to end treatment sooner than their partners. This gender difference can produce significant conflict and disagreement between spouses about ending treatment and/or pursuing alternatives. Although age does not seem to be a predictor of treatment persistence, parity has been found to be a significant predictor of withdrawal. Couples who have children are more likely to accept the end of treatment. On the basis of these findings, one can expect that women, particularly childless women, will receive advice about ending treatment with more difficulty, and possibly more resistance, than her partner.
Emotional and relational factors

One of the most consistent findings in the infertility literature is that patients overestimate their chances of success. This 'optimistic bias' is well documented, and understood from a theoretical perspective as being an important factor in determining positive adjustment. Several studies have shown that optimism plays a part in the initiation of treatment and the maintenance of treatment efforts. Indeed, Callan and colleagues found that those who were willing to end treatment had become less optimistic that in vitro fertilization (IVF) would help them achieve their goal of parenthood. Based on these studies, we could predict that those who remain highly optimistic about IVF success will have a harder time accepting the end of treatment. Ironically, these same people will be more optimistic with regard to third-party alternatives such as egg donation and adoption.

As noted previously, couples who believe that their marriage needs children to survive will be more resistant to ending treatment. However, those who believe that treatment has had a negative impact on their marriage and their personal lives will be more open to ending treatment and less likely to seek treatment for a second child. In a longitudinal evaluation of adaptation to treatment termination, it was reported that 10% of couples ended treatment because of the strain that treatment was putting on their partnership. Similarly, people experiencing much psychological distress are more likely and/or willing to end treatment, as shown by high stress-related drop-out rates. These findings suggest that people who are at the 'end of their tether' or emotionally worn out by treatment may more easily accept recommendations to end treatment.

Cognitive factors

The way that people think about or evaluate their treatment experiences and alternatives to treatment will also determine how they will react to the 'end of treatment' consultation. People who feel that they have not done enough to become pregnant will have more difficulty ending treatment. A central issue in accepting advice about ending treatment is dealing with the possibility that more or other kinds of treatments could, in theory, lead to a pregnancy: 'What if this new treatment works? What if one more cycle works? What if we use a different stimulation protocol?' Couples are more likely to accept advice about ending treatment if they can achieve a sense of 'having done enough'.

People who are more open-minded about different ways to form a family will likely react more favorably to advice to end treatment, as the end of treatment will not automatically mean childlessness. A Dutch study
found that life-satisfaction scores among people at the end of treatment were higher than population norms, but only for long-term infertile couples who were also exploring alternative options to natural pregnancy.\textsuperscript{15} Similarly, choosing to adopt was the main factor accounting for lower emotional distress in those who had experienced treatment failure.\textsuperscript{16} Finally, it has been shown that divergence between partners on their willingness to pursue other parenting options is associated with a more difficult transition when treatment ends.\textsuperscript{4}

**SPECIFIC SKILLS WHICH CAN FACILITATE THE ‘END OF TREATMENT’ CONSULTATION PROCESS FOR BOTH PHYSICIAN AND PATIENT**

**Establishing aims of the consultation**

At the beginning of the consultation the physician should set the agenda for the meeting as well as explore what agenda or approach the patient brings. Stating what the physician wants to accomplish, for example review the patient’s treatment and discuss future treatments, prevents the patient from having concerns or anxiety about what to expect. Sometimes it is helpful to ask the patient directly if he or she has any expectations about what the physician might say. The second task is to inquire about the patient’s agenda. By asking for the patient’s agenda and expectations, the physician can ascertain the patient’s level of preparedness for hearing the recommendation to end treatment. It is essential to arrive at a ‘shared understanding’ of the problem at hand for the consultation to proceed successfully. Research has shown that patient-centered consultations which involve more open-ended questions, with greater scope for patients to raise their own concerns and express emotions, are preferred by patients in medical situations which are uncontrollable and unpredictable like the ‘end of treatment’ consultation.\textsuperscript{17}

**Setting the context for the recommendation to end treatment**

The physician can begin to review the patient’s medical history and treatment cycle as a foundation upon which to build his or her recommendation. If the patient is informed about the reasoning behind the recommendation and is reassured that the physician has fully evaluated the couple’s unique medical situation, then they may be more willing to accept the physician’s opinion. It is at this point that the physician should encourage patients to reflect on what they have done to achieve a pregnancy, so that
they too can feel they have ‘done enough’. Physicians can help patients come to this belief by asking them to reflect on whether they believe they have: received the best treatment; followed well the recommendations of their specialists during each treatment trial; and given each treatment option their best effort.

Ensuring supportive follow-up

The consultation should also include enough time for the patient to ask any questions and physicians should encourage patients to call or come back once the information is processed. Patients’ feelings of disappointment or of being overwhelmed should be normalized. It is critical that patients leave the consultation not feeling abandoned, and with the understanding that this is a process not an end-point. A recent study showed that insufficient information, poor comprehension of medical advice and lack of empathy expressed by medical staff were key contributing factors to patients evaluating fertility centers poorly.18

Stating the positive aspects

Depending on where the couple is in the transition process from ‘not yet pregnant’ to ‘not going to be pregnant’, pointing out some of the positive aspects of ending treatment may be appropriate at this time. Some of these might include:

(1) Relief about ending constant treatments;
(2) Climbing off the emotional roller coaster;
(3) Life no longer being ‘on hold’ or in limbo;
(4) Feeling more ‘in control’ than ‘out of control’;
(5) Privacy reintroduced into the relationship;
(6) End of financial considerations;
(7) Opportunity to explore other options for family building with better success rates;
(8) Opportunity to focus on other life pursuits.

Preparing the couple for the future beyond IVF

The physician should ask the couple whether they want to explore alternatives to IVF at this point, or come back at a later date. Their decision will
GIVING BAD NEWS

depend on where they are in the transition process and the many risk factors noted previously. Patients’ needs for this information can best be met at a time when they are ready to receive it. It might be outside the mandate of a medical person to counsel further those patients who will not be pursuing medical alternatives, because this mainly involves addressing psychological and emotional issues. In either case, the physician may want to end the consultation by referring the couple to a mental-health counselor or by recommending reading material on alternatives to parenthood, including living child-free. It is important not to overwhelm the patient with information, and to pay attention to how much the patient is actually taking in.

SUMMARY OF MANAGEMENT OPTIONS

In summary, it is possible to deliver the bad news of ending treatment in such a manner as to minimize stress and commence the process of healing and recovery for a couple. Overall, during the consultation, physicians should ensure that patients assimilate accurately the information conveyed and its ramification, without provoking denial or overwhelming emotional distress. In an empathetic manner, physicians should help patients to disclose their concerns about ending treatment, express their associated feelings and decide whether they want to review different options. The long-term benefits of such effective physician–patient communication are: better coping, improved patient self-management, better recovery, psychological adjustment and increased patient satisfaction.¹⁷

The guiding principles for the ‘end of treatment’ consultation should be:

1. Build a case based on their treatment history before presenting the recommendations and options.

2. Help couples to reflect on all they have done to achieve a pregnancy so that they can more easily accept the evidence provided and feel that they have done enough.

3. Allow patients to express concerns and feelings and listen with empathy, as the end of treatment will undoubtedly trigger such emotional responses.

4. Let the patient set the agenda once the advice is conveyed.

5. Reassure patients of continued attention and care.

6. Ensure that the patient has assimilated any hopeful news along with the bad news.
REFERENCES

9. Callan VJ, Kloske B, Kashima Y, Hennessey JF. Toward understanding women’s decisions to continue or stop in vitro fertilisation: the role of social, psychological and background factors J In Vitro Fert Embryo Transfer 1988; 5: 363–9