

How to choose an IVF clinic and understand success rates: Questions to ask when choosing an IVF clinic.

Fact Sheet

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The information contained here is aimed at helping people who may be seeking fertility treatment to understand aspects of fertility treatment that may be relevant to them and also to help them make decisions when choosing an IVF clinic.

Reliable sources of referrals to IVF clinics may come from your GP or your gynaecologist. These people will be able to assist you with knowing what is available. In addition, a list of clinics is available on the AccessAustralia website (access.org.au). It may be valuable for patients to compare the services of different clinics in their area before deciding what is best for their particular circumstances. Many factors will form part of a patient's decision-making – the final decision will most likely be related to confidence in the treatment and care provided by the clinic but convenience and geography are also important. For important decisions many people often prepare a list of what their priorities are and then make decisions based on how well different options compare with their priorities.

This information aims to help by providing questions that may help you determine those priorities or help you with understanding some factors that may be important to consider. IVF clinics are very open to answering the questions of patients and will be very willing to help you with information.

Clinic accreditation

IVF clinics are licensed by RTAC (Reproductive Technology Accreditation Committee). This is an independent body which is responsible for ensuring certain minimum standards are met by all IVF clinics in Australia. The commit-

tee was first formed in 1987 and since then their guidelines have been revised in 1992, 1997, 2002, 2009 and 2014. This Code of Practice governs treatment of patients with controlled ovulation stimulation, artificial insemination, IVF and related techniques and all procedures involving donated gametes or embryos.

The committee is composed of the following members:

- Chairperson - Appointed by the Fertility Society of Australia (FSA)
- A Deputy Chair - Appointed by Fertility Society of Australia (FSA)

- A representative of the Scientists in Reproductive Technology (SIRT) of the FSA

- A representative of The Australian and New Zealand Infertility Counsellors Association (ANZICA)

- A representative of Fertility Nurses of Australasia (FNA) of the FSA 1

- A representative of AccessAustralia (National Consumer Support Group) More information about RTAC and its role can be accessed from the website of the Fertility Society of Australia (www.fertilitysociety.com.au).

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Questions to ask IVF clinics

The following list of questions is not exhaustive but represents a good cross-section of topic areas.

When was the clinic last licensed by RTAC and have there been any major changes in staff, treatments offered or protocols since licensing? Does the clinic have full or provisional accreditation?

Licensed clinics are listed on the Fertility Society of Australia website.

What tests can be carried out by the clinic?

For most couples there are standard minimum tests which must be performed to establish potential causes for infertility. This will usually include analysis of the man's semen, the condition of woman's womb, fallopian tubes and possibly cervical mucus. Treatment will largely be dictated by the results of these tests. It may be useful to know where these tests are done, what is involved from the patient's perspective and what other specialist tests may be required in specific circumstances.

What treatments are offered at the clinic?

The cause of the infertility will dictate what treatment may be required. Some possible treatment options are the following:

••• Donor insemination (DI) – donor insemination involves the collection of sperm from a donor who has been screened for various health problems; his sperm is frozen for six months at which time he is rescreened for health problems. The safe sperm is then thawed and placed in the woman's vagina, cervix or into the womb itself at the time of ovulation. This

treatment option is used by couples with male factor infertility, where the intended father has a genetic condition he does not wish to pass on to children. It can also be used by single women and by lesbian couples.

••• AI (artificial insemination) – the male partner's sperm is transferred to the woman, as above. This process is often tried before proceeding to more complex treatments. (See also intrauterine insemination below.)

••• Ovulation induction – this is a treatment where the woman's ovaries are stimulated to produce just one egg and intercourse is timed with ovulation. This technique was originally developed for women with ovulation difficulties.

••• Intrauterine insemination – following stimulation of the ovaries to produce one or two eggs, specially prepared sperm is placed into the uterus at the time of ovulation.

••• IVF – in vitro fertilisation where eggs are collected from the woman and fertilised in the laboratory for transfer back to the woman once healthy embryos have been identified. This technique was originally developed for couples where the woman no longer had intact fallopian tubes.

••• GIFT – this involves the introduction of collected eggs and sperm into the fallopian tube and is a technique not used frequently these days but may satisfy religious or cultural needs of the patient when IVF is the treatment that is required.

••• ICSI (intracytoplasmic sperm injection) – this is the same as IVF however fertilisation is by one sperm being literally injected into the egg. This treatment was developed for severe male factor infertility but may also be used after an IVF cycle has shown that there is a fertilisation

problem as well.

••• IVF using donated gametes (eggs or sperm) or embryos – this is the same as IVF however the source of the gametes is from an altruistic donor. Some clinics have special policies on known donation. RTAC defines specific counselling requirements for all donor procedures. It may be useful to ask about these. This treatment option is usually reserved for very special circumstances where other treatment options have failed.

••• IVF surrogacy – this involves an IVF cycle where fertilised eggs from the intended parents are transferred to another woman (a surrogate) who carries the pregnancy for the commissioning couple. This is a treatment for those couples where the woman no longer has a womb. Check the regulations in your state as surrogacy is not permitted in every state of Australia. Some clinics have special policies on known surrogacy and there are specific counselling requirements. It may be useful to ask about these.

If you have not already attended a clinic you may not know what treatment you are likely to have. The above list will at least give you an idea of the breadth of services available. You may also like to ask just how many procedures are done by the specific clinic each year. This gives you an idea of the clinic's focus. Some clinics are more willing to try less invasive procedures such as ovulation induction under particular circumstances rather than others. You may also like to ask if the clinic has a specialist area of fertility treatment.

Who donates sperm, eggs or embryos?

In the special circumstances where donation of gametes or embryos needs to be considered, it is important to understand where the gametes and embryos have been sourced and what checks have been taken to ensure the health of the intended

mother and the well-being of the children resulting from such arrangements. Some clinics may have a policy of known donation and there are specific counselling requirements so it would be important to ask about these. Some clinics may require that you find your own donor or the clinic may have access to donors or donor material. You may also like to have an understanding of what the criteria are for selecting a donor. RTAC defines procedures for donor services – ask the clinic about these. If the clinic recruits its own donors, it would be useful to ask about the process of how a donor is selected by you.

What information does the clinic provide for each procedure?

Informed consent is an important tenet of medical care. Patients are within their rights to ask about how treatment information will be provided to them. It may be important to know who explains each individual treatment and test and also ask if there is clear written documentation for future reference.

Does the clinic offer storage facilities for frozen sperm and embryos?

After an IVF cycle there will often be spare embryos available, i.e. embryos that have not been transferred in the current cycles. These embryos offer another attempt, or attempts, to achieve a pregnancy should the first attempt be unsuccessful, or to attempt a subsequent pregnancy. Most clinics store these embryos for patients in a frozen state until they are next required. It is important to know that storage facilities are available and the ongoing costs for this storage. You may want to ask about there being any time limits on the storage of embryos and what are the choices for embryos or gametes no longer required for the patient's own treatment?

What counselling is available?

Infertility is a major life crisis and for

some, the treatment can be an “emotional roller-coaster”. Even people who normally have particularly challenging lives may be surprised by the impact that infertility and its treatment have on wellbeing. Under these circumstances, good friends, supportive family and the services of a counsellor may be required. In fact one of the criteria which must be met by all clinics is the provision of counselling services. It is therefore important that patients know that one counselling consult is covered by Medicare (by the so-called global fee) and to find out what the cost is (if any) of subsequent counselling sessions.

Other questions which may be important to patients in relation to counselling:

- Can I see a counsellor before starting treatment?
- Can I see the counsellor in the clinic, rather than going to another place?
- What counselling is available for donors and recipients?
- What counselling is available for surrogates and the intended parents?

Does the clinic have a patient support group?

Some clinics have a support group which allows opportunities for people to talk and share experiences whilst on treatment. Ask the clinic for details. Some clinics cover membership costs for their patient group or membership to AccessAustralia. If there is no support group available consider contacting AccessAustralia Infertility Network. You may be interested in joining one of their options groups. Contact details are at the end of this information.

Are there any restrictions on who may access treatment?

Anti-discrimination legislation prevents

clinics from restricting who may be treated. Increasing age of the woman will limit the chance of success and a clinic may, in the interests of the woman, try to dissuade her from undergoing rigorous medical interventions when there is little chance of success.

What is the clinic's success rate?

At the heart of a patient's question about a clinic's success rates, is the need to know whether they can be assured of the best chance of success. Some of the more popular means of measuring success rates are live birth rate or positive clinical pregnancy (positive fetal heart showing on ultrasound) per treatment cycles commenced, per egg collected, per implantation rate or per embryo transfer. Considerable debate exists on what is the most reliable measure. The following may explain what each of these terms mean and gives some indication of their respective limitations.

Live birth data – this relates to the number of live births, multiple births being classed as a single live birth. This measure is most close to the intention of the infertile couple, however collection of data is often slow – at least until all the live births have occurred and been followed up and recorded. Live birth figures are a reflection of a number of factors, including the following: the number of eggs recovered, fertilisation rates, the quality of embryos and embryo transfer technique.

Clinical pregnancy – this relates to an ultrasound test usually at about 7 weeks into the pregnancy when a fetal heart is seen. This is a more rigorous test than that of biochemical pregnancy (the first blood test which shows a positive pregnancy test) and has the one advantage in that it provides more recent data from the clinic than live birth data. However this data does not show how many of these clinical pregnancies result in a live birth.

Pregnancies/live births per treatment cycles commenced – this relates to the number of cycles where hormonal stimu-

lation of the ovaries has been initiated irrespective of whether any of the cycles were cancelled prior to egg pickup.

Pregnancies/live births per egg collection – this relates to the number of cycles where the woman has proceeded as far as egg collection and would include also all those patients for whom eggs were retrieved but did not result in embryos for transfer.

Pregnancies/live births per embryo transfer – this relates to the number of cycles where the woman has proceeded as far as embryo transfer and would not include those couples for whom the cycle was cancelled, who did not make it to egg pickup, who were overstimulated* or who did not produce embryos. This data would also include frozen embryo transfers. (*Overstimulation, or ovarian hyperstimulation syndrome – OHSS – can result, in severe cases, in cancellation of a cycle. In other cases all embryos resulting from the cycle are frozen, to be transferred at a later date when the hyperstimulation has resolved.)

Pregnancies/live births per implantation rate – refers to the rate per embryo transferred. There is now greater emphasis on transferring a single embryo and reducing the risk of multiple births.

Cumulative pregnancy rates – some clinics may have data on their cumulative pregnancy rate, which is either pregnancy or live birth per x number of attempts at IVF and includes data from both fresh and frozen cycles.

It is important to realise that as we move down the above list the apparent success rate increases. Armed with this information it becomes important to ask clinics about the specific per cent figure they are reporting. National average data is also published annually through the National Perinatal Epidemiology and Statistics Unit (NPESU) of the University of New South Wales and freely available the under the Surveillance Reports menu at www.npesu.unsw.edu.au. Reports from 1992 can be found at the ANZARD link at the base of that page. These figures are

another useful comparator.

There are no IVF Clinic ‘League Tables’ for patients to see where a particular clinic’s performance sits compared to other clinics. Given there are many factors that influence a person’s choice of IVF clinic, and their individual success, it is best to take the time to prepare the questions important to you, discuss them with the clinics you are considering and research supporting information like that available on Access Australia and other independent sites.

Success rates should be discussed with your IVF specialist and remember, when making a decision about which IVF clinic to choose take into account the other items which are highlighted in this information.

Other questions which may be useful to ask are:

••• What is the success rate for my particular age group? The age of the woman is a known predictor of the chance of achieving a pregnancy. Patients will find it useful to know what the likely outcome is for their age bracket.

••• What is the success rate for my/our particular infertility?

••• What is the chance of multiple birth and what is the average number of embryos transferred? Note success rates could be higher for clinics which are transferring higher numbers of embryos, but the multiple pregnancy rate will probably be higher also. Some clinics may have specific policies on how many embryos should be transferred so ask them about their policy. The RTAC Code of Practice indicates that no more than two embryos should be transferred unless in exceptional circumstances, and there is a recommendation that no more than one embryo is transferred on the first treatment cycle

when the egg has been obtained from a woman under 35.

••• How many cycles are conducted per year by the clinic? For smaller clinics the results can get skewed because of the lack of something called statistical power. This means that their results may look “good” one year and then the following year they may look “bad” but in reality the results cannot be compared. A clinic may have 200 cycles one year and 200 the next; in the first year there were 55 live births and in the second there were 60. The percentages would be 27.5% and 30% respectively. The percentage difference may look quite different but in reality we are only talking about the difference of five live births out of 200. Be mindful of statistics when considering success rates and talk to your IVF specialist as they will be able to point these apparent discrepancies out to you.

••• What is the success rate achieved for a so-called “gold standard” prognosis group? This “good prognosis” group may be considered to be where the woman is under 35 years of age and has undergone three or fewer cycles. Pregnancy rates vary tremendously depending on the type of treatment and the age and cause of infertility in the people being treated; the success rates achieved by a clinic for the “good prognosis” group reflect the quality of the clinic, not the variety of patients.

Is there a waiting list for treatment?

Some IVF programs may have a waiting list. If so, patients should ask how long the waiting list is. Some patients in remote country areas may have access to metropolitan-based clinics that come to a nearby town only three or four times a year. Patients in these circumstances should ask about the availability of these satellite clinics.

The other circumstance which may “stall” treatment is clinic advice or

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recommendations on how soon to recommence treatment after a treatment cycle that has not resulted in a pregnancy. Ask the clinics about this as well.

How many times will I have to visit the clinic?

Depending on the treatment required this will vary. For an IVF cycle for example, you will likely need to come to the clinic for blood tests, ultrasound scans, egg pick-up and embryo transfer. Clinics vary in what type of treatment protocol they follow, so the number of these visits will vary also. There is only one egg pick-up and one embryo transfer – providing patients respond to the stimulation treatment and reach this stage – but patients may like to know how many times they will need to have blood taken and ultrasound scans done. These will all be occasions when the woman could be late for work, for example. Patients may choose to give their own injections on an IVF cycle or may want to know what arrangements the clinic can make to have the injections done for them. It is important to note that the Medicare global fee for IVF treatment does not cover the cost of your GP giving you the injections.

What is the cost of the treatment and what is included in this charge?

If patients know what treatment they will require then, the questions to ask would be the following:

- What will my costs be after Medicare rebate? What will this price cover me for?
- What will the costs be with/without private health insurance?
- Does the charge include tests, drugs, treatment, anaesthetist, counselling, surgery, follow-up consultations, embryo freezing, and storage?
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••• How much do frozen embryo cycles cost?

••• What possible additional costs might arise?

••• How and when are payments required?

••• What are the costs if a treatment cycle is cancelled?

If patients do not know what their treatment will be then, perhaps more general questions about the cost of an IVF cycle might give you some indication of the cost and whether the budget will stretch!

What will happen if I get pregnant?

Once a pregnancy has been confirmed by ultrasound your pregnancy should proceed just as any other. Your care may be referred to your GP or obstetrician; or perhaps your IVF specialist is also your obstetrician. Ask the clinic what happens after a positive pregnancy test. The clinic itself may not be actively involved in your care once a pregnancy has been confirmed however they will be keen to know of your progress and of the outcome of your pregnancy. They are required to pass on the results of the pregnancy to the National Perinatal Epidemiology and Statistics Unit. Your identity is not released to the NPESU.

What will happen if I don't get pregnant?

For some, the first time they will know they are not pregnant is when their period arrives, for others it will be the result of a blood test, usually about two weeks or so after embryo transfer. The news of a negative pregnancy test or the arrival of a period can be a particularly emotional time for most couples. Even just waiting two weeks so that a blood test may be taken can be quite harrowing. Often the initial news is conveyed by the nurse coordinator but it may be useful to know

what expectations you can have as far as the following:

- Who will make contact with me?
- What is the availability of support, counselling or assistance with further treatment options and decision-making?

Will I need genetic screening?

There are only a handful of circumstances which are known at this time where part of the management of infertility would require genetic screening. Older women may choose to have genetic testing for such things as Down syndrome, however this would normally be something you would talk to your obstetrician about.

Some clinics have established a procedure called preimplantation genetic diagnosis (PGD) which is important for assisting couples who carry the genes for some specific genetic abnormalities. If you are considering accessing IVF treatment for the purpose of screening your embryos, it is important to find out if the clinic offers the testing and if they do, how many procedures are undertaken annually. The larger the number of procedures and successful outcomes are significant pointers that the program is a good one. Also determine whether the clinic has handled cases of the same genetic condition as the one you are enquiring about. To date there are far fewer PGD procedures compared to that of IVF procedures so it is difficult to compare programs.

Other general questions you may consider are:

- Is a genetic counsellor or geneticist available?
- What are the costs associated with PGD and what do these cover?
- How much is covered by Medicare and private health insurance?
Other general questions you may consider are:
- Can I have the choice of either a male or female doctor?
- How long has the clinic been established?
- Does my doctor(s) have CREI qualifications? (CREI qualifications are a specific subspecialty for doctors treating infertile couples.)
- Where are the egg pickup and embryo transfer procedures undertaken?
- Will my own doctor do the procedures I am required to have as part of my treatment? If not what are the skills / experience of the other doctors?
- Can I have a natural cycle (no drugs) if I wish?
- Does the clinic have an expert in male fertility?
- What are the arrangements for semen collection?
- What do I do if I need to contact medical assistance after hours?
- Is the laboratory accredited by ISO quality systems?
- Does the clinic have any arrangements for financial hardship?
- What is the privacy policy of the clinic?
- Does the clinic have its own website or can they recommend one?
- Does the clinic offer any lifestyle management programs for patients e.g. stress management, nutrition etc?