Title: Australian women's use of complementary and alternative medicines (CAM) to enhance fertility: exploring the experiences of women and practitioners

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Author's response to reviews: see over
Iratxe Puebla  
Senior Editor,  
BMC-series journals  

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Dear Iratxe  

Re: MS: 6035653812982822  
‘Australian women’s use of complementary and alternative medicines (CAM) to enhance fertility: exploring the experiences of women and practitioners’.  

Thank you for the reviews of the above paper. The reviews were very helpful and we wish to thank the reviewers for their thoughtful and constructive comments which we feel have strengthened the paper. Please find below a detailed point by point response to each of the reviewers’ comments.  

Let us know if there are any further changes that should be addressed.  

Thankyou again for considering this paper,  

Yours sincerely  

Dr Jo-Anne Rayner
Reviewer One: Alison Heawood

1. Developing the data analysis beyond descriptive data and incorporation of both practitioners and women’s comments into themes.

We have reorganised the findings section of the paper. The findings now incorporate both women and practitioners’ comments under the three global themes: women’s strong desire for motherhood; women’s experiences of ART; and women’s experiences of CAM. The global themes are also further illustrated by the inclusion of the dominant basic codes, each illustrated with quotes from both women and practitioners. (page 12 onwards)

2. Little reflection and discussion within the paper about which themes are unique to women using CAM to assist fertility or are the themes that cross-cut CAM use for other health issues.

We have modified the background to include possible motivations for CAM use proposed for CAM use cited in the literature suggested by the reviewer and also reflected on reasons for CAM use in the discussion. The following paragraphs have been added/amended:

Background (page 4, para 3)

‘Reasons advanced to explain the increased use of CAM include: dissatisfaction with or poor outcomes associated with orthodox medicine [27, 28]; a need for more control in healthcare decisions [22, 29-34]; treatment of chronic illnesses [20, 29, 30, 32]; the perceived technological or impersonal nature of orthodox medicine versus the perceived naturalness of CAM [33, 35]; and the personalised nature of the interaction with CAM practitioners, coupled with the use of individually tailored interventions [33, 36, 37]. CAM are commonly used in conjunction with orthodox medical treatments, however information about CAM use is not provided to nor sought by doctors [10, 18, 23, 35].’

Discussion: (page 22, para 2, line 3).

‘Five women reported negative experiences of ART associated with short consultation times; a limited knowledge of CAM modalities among some orthodox medical specialists; and the mechanistic and disempowering affect of ART procedures. These reasons are consistent with the literature on CAM use especially in relations to dissatisfaction with or unsuccessful use of orthodox medicine [27, 28]; the need for more control in decisions [22, 29-34]; the treatment of chronic conditions [20, 29, 30, 32]; the impersonal nature of orthodox medicine versus the naturalness of CAM [33, 35]; and the nature of the interactions with CAM practitioners [33, 36, 37]. Women in this study were also desperate to achieve parenthood, related to the use of CAM for fertility enhancement reported elsewhere [65].

The unsatisfactory didactic style of communication from medical practitioners (ART specialists and GPs) reported by women in this study supports other findings [35, 75]. Coulter and colleagues (1999) reported similar responses from focus group participants with chronic ailments, including infertility [75]. Participants valued a less paternalistic practitioner relationship, the provision of up-to-date information
including different treatment options, and individual involvement in treatment decisions [75]. Vickers and colleagues (2006) reported women’s past negative experiences with their GPs provoked their reluctance to disclosure CAM use [35].

The women participating in our study reported that they valued the information, support and sensitive communication provided by CAM practitioners, as well as the whole of person approach to fertility enhancement. The quality of the woman-practitioner relationship, especially communication style, and practitioners’ acknowledgement of women as individuals, were important to women’s overall experience of both ART and CAM. Sirois (2008) reports the motivation for CAM use in Canada has shifted away from ‘push’ factors such dissatisfaction with orthodox medicine to ‘pull’ factors including the holistic approach of CAM [31]. The women were satisfied with CAM and willing to pay out-of-pocket to access these services because practitioners provide them with some hope of achieving motherhood’.

3. Limitations.

We have included more reflection in the discussion on possible limitations other than sample size (page 24, para 1). ‘The limitations of this study include its small sample size, and the self-selected nature of the participants. It was based on the experiences of women who participated in three focus groups recruited from five CAM clinics that specialised in this area of care in Melbourne, Australia. Recruitment to focus groups is always difficult, even more so when the issue is of a sensitive nature [78]. CAM practices were chosen as the site for recruitment because the specific aim of the study was to understand why women use CAM to enhance fertility as little is known about this issue. Recruitment was undertaken over several months and despite a large number of women expressing interest in participation fewer women attended the focus groups than originally intended. Our intention has been to include women who were not using ART (women using CAM for preconception care or women only using CAM for fertility enhancement), however participation reflected what CAM practitioners reported - the majority of their fertility enhancement practice was with women also using ART. While we do not know what our findings may have been if the women participating were more diverse in their reasons for using CAM, the findings about motivations for CAM use reflect those reported in the literature on CAM use more generally, i.e. dissatisfaction with or poor outcomes associated with orthodox medicine [27, 28]; a need for more control [22, 29-34]; the impersonal nature of orthodox medicine [33, 35]; and the personalised nature of the interaction with CAM practitioners [33, 36, 37]’.


Additional references have been included on non disclosure (page 5, para 1, line 3). ‘CAM are commonly used in conjunction with orthodox medical treatments, however information about CAM use is generally not provided to nor sought by doctors [10, 18, 23, 35]’.

5. The demographic profile of Australian CAM users – similar or different to users elsewhere?
This has been amended and additional references included to show that the profile of CAM users in Australia is the same as elsewhere (page 4, para 2, line 12).

‘The Australian [18, 25] and international [13, 15, 22, 23, 26] literature shows CAM users are more likely to be women, who are well-educated, employed on higher-than-average incomes, with private health insurance’.

6. **Acknowledgement of different healthcare systems in other countries and funding of ART.**

The background has been amended to include details of funding arrangements of ART in different countries has been included in the background (page 5, para 4).

‘Like Australia, many other developed countries providing public funding for ART although this varies significantly [43]. However, many countries apply restrictions to publicly funded ART such as limiting the number of cycles, ineligibility for women over 40 years of age and waiting lists for treatment [41, 44]. In the United States the costs of infertility treatment are borne by the couple [45]. In 2005 Medicare Australia expenditure for ART services totalled $108.4 million, a 117% increase from 2003 [41].’

7. **Details of rationale for sampling.**

The rationale for sampling has been developed further in both the methods and the discussion.

Methods (page 9, para 1): ‘CAM practitioners and women using CAM to enhance their fertility were recruited from five CAM practices in metropolitan Melbourne that specialise in women’s health. The decision to recruit women from CAM practices rather than ART clinics was chosen as little is known about why women choose to use CAM for fertility enhancement or their experiences of CAM and we wanted to specifically recruit women seeking CAM treatments. Flyers with study information and contact details were left in the participating CAM practices over three months (October to December 2007). Interested practitioners and women were instructed to contact the research team directly if they wanted to participate, to separate the recruitment of participants from the practitioner/client relationship.

Discussion: (see Limitations above)

8. **Methodological issues related to focus groups.**

A sentence has been added to acknowledge the methodological issues related to focus groups (page 8, para 3, line 4).

‘We used focus groups to gain a preliminary understanding of the issues related to this little known area. Historically, focus groups have been used in reproductive health research especially among marginalised groups to ‘give a voice’ and empower participants [77]. Focus groups can stimulate discussion through group dynamics - the social interaction between and the relevance of the topic to the group members; however people may also feel uncomfortable about disclosing or discussing sensitive issues with strangers [78].’

9. **Methods: growing body of qualitative research on CAM use in general and for health issues.**
A sentence has been added to background, including references to acknowledge the growing body of qualitative literature on CAM use (page 7, para 3).

‘There is now an increasing body of qualitative research literature on CAM use [27, 28, 30, 35, 67] including women’s use of CAM for reproductive health [68] and experiences of infertility and ART [59, 69-71], however no qualitative research was found specifically relating to women’s use of CAM to enhance fertility. Among the studies reporting on CAM use to enhance fertility, the proportion of women or couples using CAM to enhance fertility or treat infertility varied considerably from 12% [61] to 91% [62]. This may be somewhat explained by the various definitions of CAM [61, 63-66] and small sample sizes of many studies [62, 65]. Most studies did not explore reasons for using CAM for fertility enhancement.’

10. Issues explored in focus groups the same for women and practitioners?

The sentence below has been changed to clarify the issue raised by the reviewer (page 10, para 3, line 3).

‘Focus group guides were developed specifically for the study. Issues explored with both practitioners and women related to women’s use of CAM to enhance fertility in conjunction with ART and to enhance fertility generally; their expectations of CAM and ART; and women’s satisfaction with both the modalities used and the practitioners they consulted. Practitioners were also asked about referral practices, the modalities they use and their views on why women consult them.’

11. The use of theory in analysing the data.

This was a descriptive study which aimed to provide some preliminary data for the development of further work in this area. The analysis section has been revised (as suggested by the reviewer) to clarify data analysis (page 11, para 1, line 5).

‘Thematic analysis was used as exploratory studies require inductive identification of themes from the transcripts. A thematic conceptual network was used to connect basic codes into organising categories and finally global themes with quotes from the focus groups [79]. Data analysis proceeded with reading and re-reading the transcripts to ensure the transcripts were fully explored and guarantee emergence of basic codes. Basic codes were interrogated to ensure they were fully defined and to elicit organisational categories. This included identification of the frequency, intensity and extensiveness of the codes across all three focus group transcripts [78]. Final analysis of all organisational categories elucidated three global themes to form the basis of the analytical argument [80].’

12. The use of a qualitative data management package.

We did not use a qualitative data management package. The analysis section has been revised to clarify data analysis (page 11). See above

The findings section has been revised to incorporate both women’s and practitioners’ comments under the global themes.

14. Clarification of research gaps.

The sentence has been revised to clarify the research gaps (page 24, para 2).

‘Further research is needed to explore the experiences of CAM use; the benefits or harms of combining ART and CAM to enhance fertility, as well as more qualitative work around women’s experiences of ART and CAM and why women choose or do not choose to use CAM for fertility enhancement.’

15. All minor revisions have been undertaken as outlined by the reviewer.

19 Methods: Where were the focus groups held?

A sentence has been added regarding the location of focus groups (page 10, para 3), line 3).

‘The focus groups were held in different locations: two at different CAM practices in metropolitan Melbourne and the third at Mother and Child Health Research, La Trobe University, also in metropolitan Melbourne.’

Reviewers Two: Fuschia M. Sirois

1. Update of introduction with more recent work on possible reasons for use of CAM and caution when using ‘theory’.

See Reviewer 1, point 2 above. We have updated the introduction to include references as suggested and have replaced the word ‘theory’ with reasons (page 4, para 3).

2. Demographic profile of Australian CAM users – similar or different to users elsewhere?

We have amended paragraph to show that the profile of CAM users in Australia is the same as elsewhere. See Reviewer 1 point 5, above.

3. The inclusion of more studies on the use of CAM to enhance fertility.

We have included more studies as suggested by the reviewer. Those studies which do not pertain to women’s experiences of CAM for fertility enhancement but focus on treatment outcomes have not been included. (page 7, para 3, line 4).

‘Among the studies reporting on CAM use to enhance fertility, the proportion of women or couples using CAM to enhance fertility or treat infertility varied considerably from 12% [61] to 91% [62]. This may be somewhat explained by the various definitions of CAM [61, 63-66] and small sample sizes of many studies [62, 65]. Most studies did not explore reasons for using CAM for fertility enhancement.’
4. Type of analysis used?

The analysis section has been revised (as suggested by the reviewer) to clarify data analysis (page 11, para 1). See Reviewer 1, point 11 above.

5. Conduct of focus groups

The methods section has been revised to make clear that the focus groups with women were conducted separately from practitioners (pages 8, para 2).

‘Three focus groups were conducted in Melbourne, Australia in 2007; two with women who used CAM to enhance their fertility and one with CAM practitioners.’

6. Presentation of findings.

The findings have been revised to include women’s and practitioners’ comments together in the three global themes, as outlined in point one of reviewer one above.

7. Limitations

The limitations section of the discussion has been revised as discussed in point three of reviewer one above.

8. Minor essential revisions – inclusion of a table highlighting main themes with exemplar statements for each.

We do not think it necessary to include a table highlighting the major themes that emerged from the focus groups according to the samples. We feel the findings are strong and easy for the reader to follow in the present format.