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LETTER TO THE EDITORS

To the Editors:

In Volume 7, Number 4, Paul A. L. Lancaster wrote an interesting article about assisted conception. He cited an article that a colleague and I published in 1989 (6) and stated that we do not consider in vitro fertilization (IVF) and related technologies legitimate methods of treating infertility.

This statement misrepresents our position. While my colleague and I have indeed criticized the manner in which these technologies are applied, in particular the uncontrolled proliferation of these technologies in some countries without their having first been subject to proper evaluation of their efficacy, risks, costs, and benefits, we did not say in the article, nor do we hold the opinion, that medically assisted conception has no legitimate role in the treatment of infertility. Rather, we believe it should have a much more limited role than at present, and its role should be defined more rationally within the context of all preventive, social, and medical options for the management of infertility in the community.

Lancaster goes on to suggest that the present clinical services in Australia are appropriate for the needs and that these data can be applied to project future expansion of services in other countries. The underlying assumption here is that services expand in a population until they reach a saturation point, whereupon one then infers that the need for service is met.

This assumption is erroneous. Overlooked is the fact that the "need" for services is often manufactured; the literature is replete with examples of unnecessary treatment and surgery, occasionally for conditions that are normal variations of human physiology.

Infertility, in this regard, has become a kind of new morbidity—a medical reconstruction of a social problem. Clinicians and popular sources continually cite inaccurate data on the prevalence of infertility, stating that one out of every six couples is infertile and that there is an "epidemic" of infertility (2;3). Yet, there is no epidemiological evidence to support these statements (4). For example, the 1988 U.S. National Survey of Family Growth (N = 8,450) found the prevalence of infertility (defined as failure to conceive after a year of unprotected intercourse) over all age groups to be about 8.5% (1 out of 12). However, only about 4% of the sample of married couples with a wife 15–44 years of age were childless and reported having a condition which impaired fecundity. Moreover, the proportion of the total sample who were childless, had impaired fecundity, and were 35 years of age or over was 1.4% (5). There was no evidence of increasing prevalence (5).

There is, on the other hand, a great deal of evidence that infertility is, in a large proportion of cases, a preventable condition (1). Thus, whenever we are faced with a situation where more effort and resources are applied toward the development and

expansion of expensive, not particularly effective, risky medical technologies rather than to services for prevention, we must consider this a failure of the health care system, not an indication of the acceptability of the technology.

P. A. St. Clair Stephenson
Centrum för Folkhälsoforskning
S-651 82 Karlstad, Sweden

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