

“Now we feel like we did everything we could”: A qualitative study into the experiences of Dutch patients who travelled to Belgium for infertility treatment

W. VAN HOOF, P. DE SUTTER, G. PENNING

Bioethics Institute Ghent, Philosophy and Moral Science.

Correspondence at: wannes.vanhoof@ugent.be

Abstract

Many Dutch infertility patients go to Belgium for treatment every year. This is the first qualitative interview study looking into the experiences and perspectives of Dutch patients who travel to Belgium for infertility treatment. We recruited 16 heterosexual couples and one single woman to ensure maximal diversity in age, distance to the clinic, type of treatment and number of previously failed cycles. The interview data was analysed using inductive thematic analysis. The central theme in the data was that going to Belgium was the next step. The Dutch patients believed that the quality of care was very high in Belgium and that in taking this step, they did everything they could to achieve a pregnancy.

Key words: Clinic cooperation, cross-border reproductive care, infertility, patient-centeredness, quality of care.

Introduction

Cross-border reproductive care (CBRC) is a fast-growing phenomenon at the intersection of medicine, law, business and travel (Gurtin and Inhorn, 2011). CBRC is the concept used primarily to describe the travel of infertility patients from one jurisdiction to another in order to access treatments. In Europe, free movement laws and portable health insurance facilitate crossing borders in search for infertility treatment. In 2010, it was estimated that 11000-14000 infertility patients cross borders in Europa annually (Shenfield et al., 2010). This number is likely to be higher now. Patients are crossing borders in Europe in response to a patchwork of local laws and regulations on assisted reproduction and differences in waiting times and quality of care.

Many Dutch infertility patients go to Belgium for treatment every year. For Dutch patients, Belgium is a neighbouring country where some highly reputable IVF centres are located and where they can speak their own language. CBRC between the Netherlands and Belgium is also facilitated by

portable health insurance coverage for patients: treatments in Belgium are reimbursed under the same conditions as treatments in the Netherlands for Dutch patients. 1.763 Dutch patients visited a Belgian clinic for fertility treatment between 2005 and 2007, and their number continued to grow every year (Pennings et al., 2009). Most of the Dutch patients in that study travelled to Belgium for intracytoplasmic sperm injection (ICSI) (38% with ejaculated sperm, 15% with non-ejaculated sperm), for sperm donation (16%) or for IVF (14%). There is anecdotal evidence that some Dutch patients travelled to Belgium for egg donation, but Spain was by far the most popular destination for this treatment (van der Meer-Noort, 2011). The largest quantitative study on CBRC in Europe found that 53% of Dutch cross-border patients travelled for better quality, 32,2% for legal reasons, 25,5% because of previous failure and 7,4% because of access difficulty (Shenfield et al., 2010).

Most Dutch patients travel abroad either for better quality or because of previous failure (Pennings et al., 2009; Shenfield et al., 2010). However, from a purely medical point of view there

seems to be only little difference in expertise since the empirical data show that the success rate of treatment in Belgium and the Netherlands is similar (Ferraretti et al., 2013). Therefore, further research is required into what Dutch cross-border patients mean when they refer to 'quality of care' and 'previous failure' as primary motivation to travel to Belgium.

CBRC from the Netherlands to Belgium for legal reasons is peculiar in the sense that there are only minor differences in legislation. There is an identifiable gamete donation system in the Netherlands versus an anonymous system in Belgium, but it is not clear to what extent Dutch patients who travel to Belgium prefer anonymous gamete donation. Additionally, testicular sperm extraction (TESE) is considered to be an experimental treatment in the Netherlands and is currently only performed in two clinics where waiting lists are long, whereas it is routinely performed in Belgium. This explains the flow of Dutch patients travelling for ICSI with non-ejaculated sperm. The legal age limit for access to IVF in the Netherlands is 45, but most clinics set the age limit at 43 or lower depending on the woman's ovarian reserve. The women who reach the age limit in their clinic in the Netherlands can continue treatment in Belgium where women can start treatment both legally and in practice until they are 45 years old.

This is the first qualitative interview study looking into the experiences and perspectives of Dutch patients who travel to Belgium for infertility treatment. One qualitative study was conducted recently on the discourses about IVF treatment in Belgium on Dutch internet forums (Van Hoof et al., 2013). The insights from this study were used when the interview guide for the current study was drafted. The general message on the forums was that quality of care is higher in Belgium. According to the information posted on forums, the main difference between IVF treatment in Belgium and the Netherlands was the central position of the patient: in Belgium, more tests and treatments were possible and patients were seen as persons rather than numbers.

In this article, we will build on the Belgian and European quantitative surveys to explore the motivations of different categories of Dutch patients to go to Belgium for infertility treatment. Based on data from semi-structured interviews, we will present a thematic analysis of the push and pull factors for these cross-border patients and how the conceptualization of Belgium as the next step in the treatment process transforms the experience of cross-border infertility patients.

Methods

Between June 2012 and March 2013, 15 Dutch heterosexual couples, one woman whose partner could not accompany her during the visit to the clinic and one single woman were recruited from a large Belgian fertility clinic. The ethics committee of this clinic approved the study and all participants provided informed consent in writing. The couples were interviewed together and the partners were encouraged to probe and challenge each other's responses, especially towards the end of the interview when their opinions and perspectives were being questioned. In all, we interviewed 32 Dutch infertility patients.

The participants were purposefully sampled based on the available data about Dutch infertility patients travelling to Belgium. Previous research revealed the relevant categories of patients (De Sutter, 2003; 2011; Pennings et al., 2009; Shenfield et al., 2010). Most Dutch patients travelled to Belgium for IVF or ICSI treatment. These were mainly patients with a complicated history of infertility treatment who had exhausted their maximum of three reimbursed cycles in the Netherlands and a large group of patients who were 'diagnosed' with unexplained infertility and who wanted more answers or to continue treatment. Dutch patients in need of TESE travelled to Belgium because it was only available in some clinics in the Netherlands. Women over 40 with a reduced chance of success travelled to Belgium because they were denied treatment in Dutch clinics. Another group of Dutch patients travelled to Belgium simply because the Belgian clinic was the closest in the area. Some Dutch patients travelled to Belgium for treatments with donor sperm to avoid long waiting lists or the Dutch open identity donation system.

For every category of patients, we aimed to recruit participants with different profiles based on age, number of previous treatments (in Belgium or the Netherlands) and distance from the clinic. We recruited four couples for whom the Belgian clinic was the closest IVF clinic. They had started treatment (intrauterine insemination) in a small Dutch clinic that referred patients to Belgium when they needed IVF or ICSI. We recruited two couples in which the woman was 43 years old, which meant that they were no longer eligible for treatment in most Dutch IVF clinics due to age limits. We recruited eight couples who had started IVF or ICSI treatment in the Netherlands, but made a decision to go to Belgium hoping to be more successful there. Five of them had exhausted their maximum of three reimbursed cycles in the Netherlands, two of them were specifically disappointed with their 'diagnosis'

of unexplained infertility and four of them had bad results after ICSI treatment in the Netherlands (these are overlapping categories). They all went to Belgium because they believed that the quality of care was higher there. We also recruited two couples and one single woman who went to Belgium for artificial insemination with donor sperm.

The semi-structured interviews were conducted after the insemination or embryo transfer took place. These were short procedures that could be the endpoint of treatment in the clinic if a pregnancy was achieved. The interviews took place at the fertility clinic, but it was repeatedly made clear, both in the informed consent form and through oral communication that the interviewer did not work at the clinic. The interviews and data analysis were conducted in Dutch, the excerpts were translated as literally as possible. During data analysis pseudonyms were created to ensure the anonymity of the participants.

The interview guide was developed by the first and third author and amended after consulting with the staff of the clinic. The semi-structured interviews started with very open questions about the participants' reasons to go to Belgium. Next, participants were encouraged to adapt a standard timeline (considering going abroad – making the choice – travelling – treatment – after treatment) to their own story using post-its. This timeline remained on the table during the interview to encourage participants to talk about previous experiences as well as more current ones. Subsequently, the interview focussed on the participants' experiences and the practical issues they faced. After this, the participants were confronted with four fictitious declarations of other infertility patients who had gone to Belgium for treatment. This way we questioned their opinions and perspectives. Finally, we asked about the future child and any support from home, and about gamete donation if relevant.

The interviews were transcribed verbatim and analysed with Nvivo by the first author using inductive thematic analysis (Braun and Clarke, 2006). Initial codes were gradually combined to form initial themes inductively to ensure that relevant data that was not a subject of direct questions from the interview guide would get proper attention. The emerging themes were continuously reviewed to see if they worked in relation to the codes and other themes, gradually developing a thematic map of the data. Because the participants had very different medical backgrounds and reasons for going to Belgium, the thematic map was reviewed for differences and similarities between the categories of patients. The thematic analysis

was subsequently discussed until consensus was reached between all authors.

Results

We identified five main themes in the data. 'Treatment in the Netherlands', 'information', 'treatment in Belgium', 'Belgium as the next step' and 'donor sperm'. Almost all the participants underwent some form of infertility treatment in the Netherlands and all participants talked about why they chose not to start or continue treatment in the Netherlands. Once the participants decided to cross borders for treatment, they needed information to guide their decision making process. We focused on their sources of information and on their own intentions to share their experiences with others. Next, the participants' experiences during treatment in Belgium are described and specific attention is given to their experiences during cycle monitoring in a local clinic. Finally, the focus was on how the belief that treatment in Belgium was the next or final step in the treatment process transformed the experiences of many Dutch cross-border patients. The most important theme in the data was that going to Belgium was the next step. The Dutch patients believed that the quality of care was very high in Belgium and that in taking this step, they had done everything they could to achieve a pregnancy. This conviction had an effect on the way they thought about their previous treatments and on how they experienced their current treatment. The experiences and perspectives with regard to treatment in the Netherlands can be seen as push factors and the idea of higher quality of care in Belgium as a pull factor in the cross-border flow from the Netherlands to Belgium.

The experiences of the Dutch patients who travelled to Belgium for treatments with donor sperm partially coincided with the other categories of patients with regard to dealing with practical issues and gathering information, but the need for donor sperm and the choice to use anonymous donor sperm were specific aspects of their stories. After the thematic analysis of the common experiences and perspectives, this specific issue will be addressed.

Participants

Data was gathered about 16 couples and one single woman. The average age of the women was 32 (range 27-43). The average travelling time for the participants to the clinic was 2 hours (range 1-4 hours). Six couples already had a child; in two cases the baby was present during the interview.

One woman had conceived a child without assisted reproduction, but since had her fallopian tubes removed. One child was conceived after IVF treatment in the Netherlands and four children were conceived after ICSI treatment in Belgium.

In total, the participants experienced 17 inseminations with donor sperm, 7 IVF cycles and 18 ICSI cycles in Belgium and 24 inseminations with the partner's sperm, 19 IVF cycles and 17 ICSI cycles in the Netherlands. For all treatments, there were participants who went to Belgium for the first time as well as seasoned patients with complicated histories who had undergone several treatments.

Treatment in the Netherlands

The central theme when the participants discussed treatment in the Netherlands was that their treatment was based on rules and protocols that were followed blindly. They compared the care they received to assembly line treatment. Examples included: 'the physicians had no time for questions or niceties', 'they did not even recognize you when you came in for your seventh treatment cycle', 'they always seemed to be in a hurry', ... Several participants used the phrase 'we were treated like a number rather than a person'. Luc and Cynthia had three failed ICSI cycles in the Netherlands before they travelled to Belgium. They explained what happened when they had a second miscarriage during their treatment in the Netherlands:

LUC: Let me give you an example. At a certain point during our treatment in the Netherlands she was pregnant and we went to the clinic three times a week for eight weeks straight. Then afterwards there was an evaluation scheduled and we arrive at the gynaecologist's and he asks 'It went wrong, right?' While we practically lived there for eight weeks!

[...]

CYNTHIA: As a patient you recognize this immediately, you know. Did the physician take a minute to read your file or not? That's the difference when you're not a number. You know you're only one of many, but still, it already is an emotional process.

According to the participants, the consequence of protocol-oriented treatment was that patients who differed from standard cases did not get the specific tests and treatment they needed. In some cases, the standard treatment had no chance of success, which meant that patients had gone through the disappointment of a failed treatment cycle and lost one of the three cycles that are reimbursed by the Dutch health care system. Several participants voiced frustrations over this. Willem and Erika, for

example, had three failed IVF cycles in the Netherlands:

WILLEM: Exactly. In our case we could have had five more treatment cycles in the Netherlands and there would have never been a pregnancy.

ERIKA: Never.

WILLEM: Because her system blocks it.

ERIKA: Yeah, after our tests here they said 'you had 0% chance of success in the Netherlands'. That hurts, you know.

Almost all participants who travelled to Belgium because there were no more treatment options in the Netherlands for them complained about how their story in the Netherlands ended. After failed treatment cycles (often the three treatment cycles that are reimbursed in the Netherlands), they were told that they had had bad luck, or that 'nature did not want to cooperate'. They felt like they were not informed about what caused their treatment to fail. They felt like they were given up on even though they were ready to continue treatment. Some participants said they had a hard time accepting that someone else had decided for them that their treatment process would end there. With regard to the age limit, Chloe and Sam were refused another treatment cycle (even though they still had one reimbursed cycle left) because she only produced three eggs after her last stimulation and she was 43.

SAM: You only need one and then you see there is one less than the rule requires, you see, it's just thinking in terms of rules.

CHLOE: Yes, Sam said to me one time 'they are playing God' and I think that's a nice way to put it. That's the way it is. They make this decision even though when David [their first child] was born there were also three eggs.

The participants believed that the reason why care in the Netherlands was often protocol oriented rather than patient-centred was the way the Dutch health care system was structured. Since the privatization of health insurance, medical care was said to be a budget calculation: 'you have this problem, so you need this treatment at that price'. The participants claimed that infertility could be too complex to fit the neat compartments of health insurers. They also felt that cost benefit analyses of extensive testing prior to treatment did not take into account the burden of failed treatment cycles.

BEN: It's simple, no?! Just test us and you can prevent a lot of issues. Even if the results are negative.

VANESSA: At least then you know.

Information

Almost all participants relied on the internet for information about clinics and treatment options abroad. The internet forums of the Dutch patient organization Freya were mentioned explicitly by several patients. Except for the patients who were referred by their Dutch clinic to Belgium because it was the closest IVF clinic, only one couple received useful information from a Dutch physician about treatment options and clinic choice in Belgium. Several patients mentioned talking to their physician about wanting to go abroad, but they all got a similar response: 'ultimately it is up to you, but they cannot do more for you than we can'. Two couples contacted their health insurer for information about success rates and quality of care in different Belgian clinics, but they learned nothing new. Of the eleven couples who did not have a physician as their primary source of information, six reported they had friends or family who also went to Belgium for infertility treatment or came into contact with other cross-border patients through someone in their social life. These first-hand accounts of treatment in Belgium were seen as very important sources of information.

All participants would recommend travelling to Belgium if someone they knew would be in a similar situation. However, for most patients their commitment to information sharing stopped there because reproduction was a private matter and infertility treatment was a burdensome process they were happy to leave behind. Some participants were already posting their experiences on internet forums or were planning to in order to provide helpful information for future patients. Especially with regard to making practical arrangements with health insurers to secure reimbursement some participants believed they could share valuable insights as many of them had encountered difficulties in that area themselves.

Treatment in Belgium

The core concept describing the experience of the patients during treatment in Belgium was trust. This was largely due to the perception that Belgian clinics were centres of excellence with regard to assisted reproduction. During the first consultation, where previous failures were evaluated and future options were discussed, the feeling of trust was confirmed. The reason why they believed that they were in good hands was the perception that there were more treatment options in Belgium (i.e. assisted hatching, day 5 embryo transfer, different drug treatments, ...), that more tests (extensive

blood tests, better ultrasounds) were done, that there was more experience and technical expertise, that physicians took patient input seriously and that physicians made decisions about a specific treatment plan together with the patient.

CHARLES: After our third treatment cycle in the Netherlands they told us 'sorry, that's it for you' and then you arrive here and through thorough testing they find out why exactly it didn't work and if that's something they can treat, then you feel recognized as a patient, like they take you seriously.

All participants explicitly mentioned in some way that they felt good in the clinic. Most of the participants even referred to this when they were asked if they wanted to add something to the interview at the end. This positive feeling was often not described in more specific terms, but several patients referred to it as patient friendliness or good customer care. The majority of the women in the study explicitly mentioned that the pick-up was less painful in the Belgian clinic. More importantly, physicians were said to be empathic, communicate openly and were willing to make time for questions and niceties. Several participants mentioned that in Belgium midwives were more qualified, which meant that they could answer most questions directly. This was especially appreciated because midwives were more easily accessible than physicians and also available by phone when questions arose after a visit to the clinic. In general, the discourse was that everyone at the clinic was willing to go the extra mile for patients during the burdensome process of cross-border infertility treatment.

VERA: It is a time in your life when you are working intensely towards this goal and well yes, it's just nice here, you feel like everyone at the clinic is here for you.

Most participants opted to do cycle monitoring (ultrasounds and blood tests) in the Netherlands to diminish the need to travel. Because of the conviction that quality of care was higher in Belgium, some patients (one couple and the single woman) preferred to do everything in Belgium, even though this required they drive two to four hours for a five-minute ultrasound. For the patients who were referred from the small local clinic to Belgium, clinic cooperation went very smoothly. The other participants had very mixed experiences in that regard. Once they found a clinic or a physician who was willing to cooperate with a foreign clinic, most patients said it all went well. However, some indicated they received spiteful and unfriendly comments about going elsewhere for treatment. Four participants were told in the clinic where they

were previously treated that they were not willing to perform tests for a treatment cycle in another clinic and one couple that was never treated in the Netherlands had to contact three clinics to find one willing to help them. Sam and Chloe conceived a child following treatment in a Dutch clinic and had four IVF treatment cycles there.

CHLOE: It's just that in the Netherlands it is hard to find a clinic to do the ultrasounds. I have called different places for hours until I found a place. Clinics don't want to do that in the Netherlands.

INTERVIEWER: And why?

SAM: Because they are not actually treating you? I don't know why, but it's a little short-sighted.

CHLOE: Not even in the clinic where we've been known for five years, they were not willing.

SAM: It's not the money. We would pay just like that, but still they were unwilling.

[...]

SAM: For me, personally, what really hurt was that they were not willing to do the ultrasound. Five minutes and still refuse, that's just...

CHLOE: Yeah, policy...

Belgium as the next step

The participants saw going to Belgium as the next step in their treatment process. For some it was the logical next step, for example for the patients for whom the Belgian clinic was the closest or the two couples who went to Belgium for TESE and decided to stay in the same clinic for inseminations with donor sperm. Most participants saw Belgium as the ultimate or final step in the treatment process. In general, the conceptualization of Belgium as the next step transformed the experiences of the cross-border patients.

STEFANIE: 'Go to Belgium, you will succeed there', my mother always said. [...] That's the idea, you know, if you go there it has to work. That definitely carries you away.

Cross-border patients potentially face many practical issues, for example making arrangements with health insurers, travelling, having to stay overnight to be on time for an appointment in the morning, taking leave from work and investing time and money. However, because going to Belgium was seen as the next step, these practical issues were seen as part of the deal. It is striking how little talk there was about the financial cost of cross-border treatment during the interviews. Other than what was and was not reimbursed, some people mentioned they were happy they could afford to go to Belgium, but most participants did not talk about costs. The couples who had exhausted their reimbursed

treatment cycles talked very little or not at all about the financial burden. The treatment abroad was deemed to be worth all the trouble and the cost.

None of the participants expressed any regrets about their decision, except some regret about not having taken it sooner. Most participants felt like they were taking charge of their own treatment process by going to Belgium. They faced a problem in the Netherlands (a waiting list, perceived incompetence, failed artificial inseminations) and now they were actively working their way around it. Conceptualizing going to Belgium as the next step meant that it was a positive choice, which implied that one was partly responsible for all the consequences of this choice. Tim and Elize, for example, decided to travel to Belgium after their first failed ICSI cycle in the Netherlands and they accepted the fact that they had to travel almost three hours one way as part of that decision:

TIM: Yes, but I also have to say that we actively went looking for a solution to our problem because if you look for a certain recognition of your preferences and well there is a chance of disappointment that it is not available to you nearby, but I think it is an attitude. I think we are very active and keep on looking for solutions.

ELIZE: Of course we would have preferred this kind of clinic to be only half an hour away. Of course this is inconvenient, but it's just the way things are right now. You could ponder over that but it wouldn't change anything.

There was a psychological factor to the idea of Belgium as the ultimate step. It could become easier to stop treatment and to accept that their child wish would go unfulfilled when patients felt they did everything they could. This implied that even if the treatment failed, it was still worth taking this step.

LINDA: Yes, but we had two failed cycles in the Netherlands and then maybe there are more opportunities here and in any case we tried.

KEES: Maybe techniques are a bit further developed here with things they may not yet be allowed to do in the Netherlands.

LINDA: Now we feel like we did everything we could. That's how I feel.

Donor sperm

The participants using donor sperm had all contemplated the difference between identifiable donation and anonymous donation, but the importance they attributed to the fact that Belgium has an anonymous donation policy varied. The two couples in the study wanted to make use of an anonymous donor because they feared third party interference with their family when the child would

go looking for the genetic father. The single mother would have preferred an identifiable donor, but she wanted a way around the long waiting list in the Netherlands because she was already 39 years old. None of the participants believed that their choice for anonymous or identifiable donation would have a big effect on the wellbeing of the future child. All participants using donor sperm were telling the same story to their friends and family that they were planning to tell the future child. The single woman and one couple were planning to tell the child about its donor origin and were open about their situation. Fiona and Ronald were not planning to tell the child and told everyone the TESE operation was successful and that they were going to Belgium for ICSI treatments.

Discussion

This article is based on a small sample, but data analysis showed that there is a common narrative among patients with very different backgrounds. The timing (after an embryo transfer or insemination, but before the result of the treatment was known) and location (in the Belgian clinic) of the interviews may have had an influence on the results, but we tried to be reflexive about this during the interviews and the data analysis. Nevertheless, we do not know if the treatments were successful and whether or not the participants continued treatment after the interview. For example, Franklin (1997) indicated that infertility patients may be inclined to continue searching for something new to try instead of finding closure at some point during their treatment process. We interviewed couples together, which affects the data in a variety of ways (Taylor and de Vocht, 2011). Critics of joint couple interviews assume that individual interviews bring the researcher closer to the unencumbered voice of the participant. However, joint couple interviews can provide a common reflective space and may result different types of interaction that contribute to the richness of the data (Bjornholt and Farstad, 2012). We preferred joint couple interviews because they were more practical in our research setting and because infertility affects a couple rather than an individual.

The perception of Belgium as the next or ultimate step in the treatment process transformed the experiences of the participants. This idea reinforced bad experiences in the Netherlands and good experiences in Belgium. It served as a justification to invest time and money in cross-border treatment. This means that statements about treatment in the Netherlands and in Belgium should not be seen as necessarily corresponding to reality.

Throughout the data it was striking how often participants used phrasings (even though they were not used in the questions or the probes in the interview guide) similar to the discourses found on internet forums (Van Hoof et al., 2013). This could indicate that this is the best way to describe the experience. However, it is more probable that most participants formed a certain image of what treatment in Belgium would be like when they were gathering information on the forums and that this influenced the way they experienced their treatment.

At this point it is interesting to revisit the quantitative data on the motivations of Dutch infertility patients to travel abroad: 53% reported travelling for better quality, 32,2% for legal reasons, 25,5% because of previous failure and 7,4% because of access difficulty (Shenfield et al., 2010). This data can be combined with the knowledge of the different profiles of Dutch patients in Belgium and the qualitative data from this study (De Sutter, 2003; 2011; Pennings et al., 2009).

Those patients reporting to travel for better quality and previous failure travelled because of the perception that quality of care or that their chance of success was higher in Belgium. Van Empel et al. (2008) identified six dimensions of quality of care in assisted reproduction: safety, effectiveness, patient centeredness, timeliness, efficiency and equity of access. Even though effectiveness and safety may be similar in Belgium and the Netherlands, our participants indicated that there were big differences with regard to the other dimensions, especially efficiency and patient centeredness. This difference in quality of care may have been perceived because of the situation most of these patients were in. When patients travelled a long way and across borders to see a physician, they might get more attention and empathy, especially when they have a long history of failed treatments. Additionally, listening to their history, performing tests and searching for alternative treatment options may provide clarity and answers. The mere fact that a physician is willing to continue treatment when another has given up may also add to a perception of higher quality of care. In that sense, treatment in a Belgian clinic may inherently score higher on all factors of patient-centeredness (e.g. information, communication, competence, attitude, emotional support, ...) in the experience of Dutch patients (Dancet et al., 2011). Previous research has indicated that more patient-centred care alone can be a reason for patients to change clinics (van Empel et al., 2011).

Those patients reporting to travel for legal reasons or because of access difficulty travelled because they felt that they had to go abroad to fulfil their

child wish. Because there are few policy differences between Belgium and the Netherlands, it is surprising that almost 40% of the patients reported this as their reason to cross borders. Presumably these are the patients travelling because of age limits or to avoid waiting lists for a TESE operation or sperm donation. Based on the strong conviction of some of the participants in this study that the Dutch health care system is purely protocol oriented, a possible explanation for this high number may be that patients who travel for assisted hatching or because they suspect immunological or thyroid related problems might report that they travel for legal reasons.

During the long and burdensome process of cross-border reproductive treatment, clinic cooperation is a big help for patients. The European Society for Human Reproduction and Embryology (ESHRE) confirmed the importance of clinic cooperation in its good practice guide for CBRC (Shenfield et al., 2011). However, several participants reported that it was difficult to find a Dutch clinic or physician who was willing to help them and were often treated unfriendly during ultrasounds and blood tests. This is in line with the finding from a small qualitative study on the attitude of Dutch gynaecologists towards CBRC: some are not willing to do cycle monitoring for patients who are treated in Belgium (Van 't Hooft et al., 2012). It is unknown why certain clinics refuse to perform a blood test or an ultrasound for a treatment that will be paid for by health insurance. Refusing to cooperate is at the cost of patient wellbeing and should be ethically justified.

After the change in the Dutch law in favour of identifiable donation, more patients travelled to Belgium to have access to anonymous donor sperm (Ombelet et al., 2007; Pennings et al., 2009). This is true for both couples in this study. Previous research indicated that even though identifiable donation was widely supported among people who needed donor gametes in the Netherlands, some people still strongly preferred anonymous donation (Brewaeyts et al., 2005). Going to Belgium could offer those people who prefer anonymous donation a way out of the Dutch system. For some patients, however, donor anonymity may be an undesired part of the package in Belgium. The waiting list may be a more important reason to travel abroad than the conviction that using anonymous donor sperm to create a family is better. This was true for the single woman in this study and the same has been suggested in a qualitative study of UK patients (Culley et al., 2011).

Conclusion

Dutch infertility patients who travel to Belgium for treatment travel primarily because of the perception that quality of care is higher in Belgium. Because of this perception, treatment in Belgium is seen as the ultimate step in the treatment process. This conceptualization in turn transforms the experience of the treatment to confirm the higher quality of care. The main difference in quality of care may be that some Belgian clinics approach infertility treatment in a more patient centred way compared to the Dutch system, which the participants described as mainly protocol oriented.

References

- Bjornholt M, Farstad GR. 'Am I rambling?' on the advantages of interviewing couples together. *Qual Res.* 2014;14:3-19.
- Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol.* 2006;3:77-101.
- Brewaeyts A, de Bruyn JK, Louwe LA et al. Anonymous or identity-registered sperm donors? A study of Dutch recipients' choices. *Hum Reprod.* 2005;20:820-4.
- Culley L, Hudson N, Rapport F et al. Crossing borders for fertility treatment: motivations, destinations and outcomes of UK fertility travellers. *Hum Reprod.* 2011;26:2373-81.
- Dancet EAF, van Empel IWH, Rober P et al. Patient-centred infertility care: a qualitative study to listen to the patients' voice. *Hum Reprod.* 2011;26:827-33.
- De Sutter P, Van der Elst J, Dhont M. Resultaten van in-vitrofertilisatie bij Nederlandse subfertiele paren uitgeweken naar Gent, 1993-2002: geen patiëntengroep met verminderde prognose. *Ned Tijdschr Geneesk.* 2003;147:1741-6.
- De Sutter P. Considerations for clinics and practitioners treating foreign patients with assisted reproductive technology: lessons from experiences at Ghent University Hospital, Belgium. *Reprod Biomed Online.* 2011;23:652-6.
- Ferraretti AP, Goossens V, Kupka M et al. Assisted reproductive technology in Europe, 2009: results generated from European registers by ESHRE. *Hum Reprod.* 2013;28:2318-31.
- Franklin S. Embodied progress: a cultural account of assisted conception. London: Routledge, 1997.
- Gurtin ZB, Inhorn MC. Introduction: travelling for conception and the global assisted reproduction market. *Reprod Biomed Online.* 2011;23:535-7.
- Ombelet W, Lannoo L, Nijs M. Infertiliteitstoerisme bij KID. In: Slager, E. (ed), *Reproductieve geneeskunde, gynaecologie en obstetrie anno 2007*. Haarlem: DCHG medische uitgeverij, pp. 59-63.
- Pennings G, Autin C, Decler W et al. Cross-border reproductive care in Belgium. *Hum Reprod.* 2009; 24:3108-18.
- Shenfield F, de Mouzon J, Pennings G et al. Cross border reproductive care in six European countries. *Hum Reprod.* 2010; 25:1361-8.
- Shenfield F, Pennings G, De Mouzon J et al. ESHRE's good practice guide for cross-border reproductive care for centers and practitioners. *Hum Reprod.* 2011; 26:1625-7.
- Taylor B, de Vocht H. Interviewing Separately or as Couples? Considerations of Authenticity of Method. *Qual Health Res.* 2011;21:1576-87.
- van der Meer-Noort I, Kremer JAM, Alberda AT et al. Cross border reproductive care; gebruik van eicel-donatie in het

- buitenland door Nederlandse vrouwen. *Ned Tijdschr Obst Gyn.* 2011;124:98-103.
- van Empel IWH, Nelen WLDM, Hermens RP et al. Coming soon to your clinic: high quality ART. *Hum Reprod.* 2008;23:1242-5.
- van Empel IW, Dancet EA, Koolman XH et al. Physicians underestimate the importance of patient-centredness to patients: a discrete choice experiment in fertility care. *Hum Reprod.* 2011;26:584-93.
- Van Hoof W, Provoost V, Pennings G. Reflections of Dutch patients on IVF treatment in Belgium: a qualitative analysis of internet forums. *Hum Reprod.* 2013;28:1013-22.
- Van 't Hooft J, Maes JWM, Pennings G. Grensoverschrijdende fertiliteitszorg van Nederland naar België: een grens te ver? Kwalitatief onderzoek naar het perspectief van de gynaecoloog. *Ned Tijdschr Geneeskd.* 2012;68:974-8.