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Enhancing pregnant, donor oocyte recipient women's health in the infertility clinic and beyond: a phenomenological investigation of caring behaviour

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Abstract

Aim—To describe pregnant, donor oocyte recipient women's perceptions of the essence of caring behaviour among nurses and other healthcare providers who they encountered in the clinic environment.

Background—Despite the ever increasing use of donor oocytes to treat infertility worldwide, little is known about the caring behaviour of nurses and other health-care providers that support and enhance the health of pregnant, donor oocyte recipient women.

Design—Qualitative, descriptive interviews.

Method—A Husserlian phenomenological approach.

Results—Eight women participated in a larger phenomenological study that examined the lived experience of pregnant, donor oocyte recipient women. Five components of caring behaviour among nurses and other healthcare providers emerged from the in-depth interviews with the women and were: being available, providing communication, exhibiting compassion, demonstrating competency and promoting empowerment. Being available was described when the participants had ongoing access to or were humanly present with nurses. The ability of nurses to provide communication and education about complex information was perceived as supportive. Nurses exhibited compassion through words and behaviours that expressed empathy and a deep understanding of the women's experience. Competency was demonstrated when a healthy pregnancy was achieved and maintained and through behaviours where a high level of technical and ethical knowledge and skill was observed. Empowerment occurred when nurses encouraged the women to engage in aspects of decision making and when a sense of control over infertility treatment and obstetrical care was promoted.

Conclusions—For donor oocyte recipient women, caring behaviour in the clinic environment consists of five essential components. The findings support a link between empowerment and the concept of caring.

Relevance to clinical practice—The dense empirical description of the women's perceptions of caring behaviour are directly applicable to clinical practice, delineating areas for improvement and providing specific data driven interventions including the development of a 'hope box'.

Introduction

Since the epoch-making birth of Louise Brown, the first 'test-tube' baby in England in 1978, the global landscape in assisted reproductive technology (ART) has experienced tremendous growth with over one million children born worldwide as a direct result of ART (World Health Organization 2002). Oocyte donation, a specific ART treatment, has an unprecedented live birth rate per transfer of about 31–51% when fresh donor oocytes are used compared with other forms of ART, which are currently reporting a live birth rate per transfer of 24–28% in Canada and USA, while European countries reporting slightly lower results overall (Centers for Disease Control and Prevention – CDC 2006, European IVF-Monitoring Programme *et al.* 2006, Gleicher *et al.* 2007, Gunby *et al.* 2007). Women who are most likely to benefit from oocyte donation are those who are typically older in reproductive age or have premature ovarian failure, gonadal dysgenesis, history of oophorectomy, poor response to hormonal or conventional stimulation, or have a genetic disorder and seek to avoid the disorder in their offspring through the use of an oocyte donor (Sauer *et al.* 1992, World Health Organization 2002, American Society for Reproductive Medicine 2004, CDC 2006). In part, because of the high success rate using donor oocytes and the willingness of many women in industrialized countries to delay childbearing, the prevalence for donor oocyte treatment is escalating worldwide with over 100,000 treatment cycles completed in USA alone (Abdalla *et al.* 1998, Tarlatzis & Pados 2000, Söderström-Anttila & Hovatta 2002, European IVF-Monitoring Programme *et al.* 2006, Sauer & Kavic 2006).

Malone's (1957) seminal description of nurses' role in the care of infertile patients provided a foundation for the now widely acknowledged stance that nurses assume a strategic and significant role in the care of women who undergo infertility treatment (Jones 1994, Olshansky 1996, Schoener & Krysa 1996, Sandelowski 1999, Mitchell *et al.* 2005). For women who undergo infertility treatment using donor oocytes, nursing care is critical if not vital (Goode & Hahn 1993). Nurses orchestrate multiple aspects of patient management including assisting the recipient woman to select the oocyte donor, educating her about the donor–recipient's physiological and hormonal processes, assessing her for grieving, providing emotional awareness and support, addressing parenting concerns and managing anxiety related to ethical and legal issues engendered in a third-party reproductive procedure (Goode & Hahn 1993, Allan 2001, 2002).

The discipline of nursing has a rich history of advancing the profession through pursuing a wide depth and breadth of understanding related to aspects of caring. The view of Leininger (1984, 1986) that human care is the central focus and essence of nursing across cultures instilled a curiosity about the concept of caring among professional nurses that pervades nursing scholarship to this day. Indeed, nurse theorists, researchers and clinicians have all contributed significantly to advance understanding in this area (Morse *et al.* 1990, Swanson 1999). Although there is a formidable amount of knowledge on caring, there is, however, little empirical knowledge that describes what nurses actually do or how they behave that illustrates caring (Paley 2001).

Despite the increased global demand and success of donor oocyte treatment and the significant contribution of nurses in the management of women undergoing this treatment, little is known about behaviours that oocyte recipient women perceive as caring. The purpose of this paper is to describe pregnant, donor oocyte recipient women's perceptions of the essence of caring behaviour among nurses and other health-care providers who they encountered in the clinic

environment. The findings reported here are significant; as to our knowledge, this description of caring behaviour among nurses and other healthcare providers by pregnant, donor oocyte recipient women will be the first reported in the literature. Furthermore, these data are from a larger study, which sought to describe the women's overall lived experience of establishing conception with donated oocytes. A detailed description of the women's overall lived experience when receiving donor oocytes and their disclosure decisions are reported elsewhere (Hershberger 2007, Hershberger *et al.* 2007).

Methods

A qualitative design was used to investigate the overall lived experience of pregnant, donor oocyte recipient women and a descriptive phenomenological approach guided the investigation (Husserl 1962). A Husserlian approach was selected for this study as we set out to discover and describe the universal essences of the experience that were common to all of the participants (Lopez & Willis 2004). Extensive and detailed information pertaining to the methods has been delineated previously (Hershberger 2007).

After appropriate Institutional Review Board approval was obtained, a purposive sample of eight women was recruited from a large, urban infertility medical centre located in USA. All of the participants were married, Caucasian, well educated (range = 16–20 years) and conceived using donated oocytes and the sperm of their respective spouse. The women used their own personal funds and also their private health insurance funds, if available, to finance the cost of donor oocyte treatment. At the time of data collection, women were between 9–23 weeks gestation and 33–46 years of age (mean = 40.6 years). The duration of active infertility treatment ranged from 12 to 60 months (mean = 2.3 years). It should be noted that five of the women received infertility treatment exclusively at the recruiting infertility centre and the remaining three women had undergone infertility treatment or sought consultation at another clinic prior to receiving donor oocyte treatment at the recruiting centre. In addition, depending upon the gestational age of the participant, she was either transitioning into obstetrical care from the infertility clinic or had recently made the transition into obstetrical care exclusively.

The data were collected from each woman as she completed two separately occurring, individual, audiotaped, in-depth interviews with the first author. Each of the interviews began with a broad open-ended question, 'What has it been like for you to be a recipient of a donated egg?' Probes, specific to eliciting descriptions of caring behaviour, were used, such as 'Please think about the nurses and other healthcare providers who took care of you during your infertility treatment using donated eggs. Think of those healthcare providers who showed that they cared about you or made it easier for you. What did they say or do?'

All of the interviews took place away from the clinic setting and were performed at either the woman's home (81%) or at a private business office designated by the woman (19%). Each woman also completed a short demographic questionnaire. After each of the interviews was obtained, the audiotaped recording was transcribed, reviewed for accuracy by the first author and corrected if necessary.

The first author also kept a methodological and reflexive journal to document decisions about the methods, procedures, field notes, observations and both participant and investigator reactions to the interviews. To acknowledge investigator bias and to enhance congruence with Husserlian phenomenology, assumptions, perceptions and observations were written, bracketed and summarized in the reflexive journal before the start of data collection. Data from the methodological and reflexive journal were incorporated into the analysis and served to augment and refine the narrative data generated from the participant interviews. An honorarium of US \$25.00 was provided to each woman on completing the first interview.

An adaptation of Colaizzi's (1978) formulated the basis of the phenomenological analysis to illuminate the complex nature of the experience. The data analysis proceeded through immersion with the data, use of detailed case summaries, identification of significant statements, codes and ultimately the emergent themes. Efforts to establish and enhance the trustworthiness of the data and analysis included maintaining a journal detailing methodological and reflexive information, which served to document prior knowledge of the phenomenon and also served as an audit trail (Rodgers & Cowles 1993); collecting thick descriptive data (Davies & Dodd 2002), from which to base the analysis; and maintaining consistency in the methodology (Rose *et al.* 1995).

In this paper, we describe the women's perceptions of nurses' and other healthcare providers' caring behaviours that support oocyte recipient women whilst they are receiving care in the infertility clinic and transitioning into obstetrical care.

Results

The participants described five themes of caring behaviour among nurses, physicians and other healthcare providers including clinical psychologists and embryologists that formulate the essence of the experience. The five themes or components of caring behaviour are: (1) being available, (2) providing communication, (3) exhibiting compassion, (4) demonstrating competency and (5) promoting empowerment. It is important to note that the themes are dynamic, in that the women varied as to the hierarchy or value of one caring behaviour component over another at any given point in time or throughout their entire experience. For example, some women stated they valued the caring behaviour of 'exhibiting compassion' above all the other components consistently throughout their entire experience. Other women valued this component at varying periods or at precise moments during their experience. Furthermore, some women placed a higher value on one or more of the remaining four components. Noteworthy also is that the components, whilst reported as separate entities, are not mutually exclusive. Each of the components is described in detail below using a rich narrative of the women's words to illustrate the phenomena.

Being available

Being available was described by the participants as providing ongoing access to and, when appropriate, being humanly present with the nurses and other healthcare providers at the clinic. All of the women reported that the awareness and belief that the nurses and, if necessary, other health providers were available to them at any given moment, especially in the event of unforeseen concerns or circumstances, was indicative of caring behaviour.

From the initial human interaction with nurses and other healthcare providers, the women identified caring behaviours associated with being available. In particular, verbal and non-verbal communication between the woman and the provider at their initial meeting set a foundation for and established trust and honesty between patient and provider.

Periods where nurses or other providers were physically present with the woman were also viewed as caring. As one woman stated: 'She [the nurse] spent an extraordinary amount of time with me I felt for sitting down and walking through what do I need to expect ... To me that showed that I was really dealing with a care facility that was top-notch.' In addition to being with the woman at a particular time, the awareness that nurses were there over a continuum of time: 'They've been along the journey' was also viewed as supporting care.

The perception that providers were available for unanticipated concerns and could be contacted at any hour on any day with a quick response time promoted a sense of care. In describing the

importance of this behaviour, one woman quickly offered the following exemplar where her physician stated to her:

You can call me any time and you [can] call and talk to the receptionist and ask her for my direct line. If you get my voice mail, I will call you back within twenty-four hours. If you need to talk to me, you have somebody find me!

Whether or not the women took advantage of contacting the nurses or healthcare providers outside of the typical clinic hours was not significant; however, clearly knowing that they could contact them and the healthcare providers would respond – at anytime, if necessary, enhanced care.

The importance of the nurses being available to the women was also manifest when the women expressed a desire to spend longer amounts of time in personal consultation with nurses when their worries and deepest fears about donor oocyte treatment were surmounting. Several women gave specific examples for when nurses should allow extra contact time. These examples include the reporting of doleful events such as a negative beta human chorionic gonadotropin (β -hCG) level or when serial β -hCG levels are decreasing postembryo transfer. Noteworthy as well, is the perception by the women that the nurses were managing care for multiple individuals amidst time restraints and high workload requirements as the following quotation elucidates:

[When] you're given bad news; you're getting it over the phone while you're at work and you're trying to sort through reactions ... Sometimes you wish you had a little longer to talk to them [the nurses]. They are so hard pressed with time that you feel like you're on and off pretty quickly. So you're kind of left sitting there.

Providing communication

The ability of nurses and healthcare providers to effectively communicate, predominately to educate and inform the women about complex biological and reproductive processes, medications, treatment plans, cycle requirements and procedures was perceived as beneficial and supportive and viewed as a component of caring behaviour. The women described specific examples of behaviour which they perceived as caring. Of particular help to the women were educational classes they participated in and use of supplementary brochures, forms or pamphlets that explicitly provided information about medications, treatment plans, cycle regimes and scheduling of reproductive interventions, such as the date of the donor-conceived embryo transfer, as the following example illustrates:

I liked the fact that you kind of knew where the next stages were. You went in for your shots, they explained everything, how you take your medicine was in a pamphlet so if you forgot or had a question you could go back through that information. So I thought the educational process of where your next step was, was great.

The women also described specific areas where they felt more communication between nurses and patients would enhance oocyte recipient care. In particular, the women requested more education and information about the affects of alternative therapies and navigating disclosure decisions. Having trusted providers discuss these issues and address the current scientific findings or lack thereof was perceived as adding to the overall quality of care. One recipient woman expressed frustration about the lack of education on alternative therapies by nurses and healthcare providers when she said, 'I would have done it [alternative therapy] in a heartbeat, you know, but I went through two and a half to three years without doing anything.' Several women suggested that nurses need to provide more information and education on detailed aspects of the experience of oocyte recipients, for example, disclosure decisions. As one recipient woman stated:

Well, part of me wants to have some information about other people that have done this before. So I would like to read personal accounts, anonymous or what- not of women that have done this, that have raised children. That would be interesting to me. [Particularly] what they have found works as far as telling them and all that stuff.

The key to providing communication is the ability of nurses and other healthcare providers to convey explicit information about complex data regarding the individual woman's response to the donor oocyte treatment process in a clear and cogent manner. Several women described instances where they either did not receive explicit information from healthcare providers or they misunderstood or misinterpreted information they received. For example, one woman who felt her individual plan of care was not reviewed from previous treatment cycles stated, 'Oh, no, I didn't think that they [healthcare providers] were looking at the past IVF cycles at all, because why repeat what you just did when it was a failure?'

Providing communication also included conveying appropriate social dimensions of care such as when it is acceptable for the woman to have a support person present with her at the clinic. As one woman reflected upon an ultrasound procedure 'I didn't know, you don't really know, is he [husband] supposed to be here? Is he not? Nobody really tells you.' Information and direction on the appropriateness of the woman's supportive individual to be present during procedures and testing was perceived as important and essential in providing salubrious care.

Exhibiting compassion

Nurses and healthcare providers exhibited compassion through words and behaviours that express respect and empathy and by demonstrating an understanding of the woman's unique infertility experience and her personal values. Recipient women expressed awareness that they were in a 'fragile' state during the donor oocyte treatment process and perceived caring when nurses' behaviours were considerate of their vulnerability and conveyed an understanding of the scope and seriousness of their situation. For example, the women praised nurses who gave parental ownership of the developing donor oocyte offspring to the recipient women. Recognition that the resulting child would be 'your child' and not exclusively 'my husband's child' or 'the egg donor child' enhanced caring.

Consistent with exhibiting compassion were specific verbal statements made by nurses that expressed encouragement or understanding of the women's unique experience. Statements that were made within a perceived 'judgement' context were viewed as detrimental to caring or considered non-caring behaviour. Table 1 provides illustrations of caring and non-caring statements compiled directly from the women's voices.

In regard to women's personal values, some donor oocyte recipient women valued maternal genetic lineage and wanted to know that they had exhausted all treatment using their own oocytes before they would consider using donor oocytes. As one woman stated:

My last IVF round of my own, she told me they [oocytes] are not as mature as they need to be – 'This doesn't look good but we will give a try so that we know that we tried everything.' So she used the same things that I had raised as my hopes like knowing we tried everything.

For other women, the potential to become pregnant expediently or to establish a 'healthier' pregnancy using donor oocytes was valued higher than maternal genetic lineage. These women felt compassion and perceived caring when healthcare providers moved quickly into the donor oocyte treatment process.

Often the women stated they needed time on their own to process their experience and find meaning and make sense of it. The nurses' ability to understand this need and allow the woman

‘space’ when she needed it was ‘respectful’ and enhanced caring. Conversely, some women reported a desire for ‘venting’ their deepest concerns about the donor oocyte process to an empathetic and respectful nurse.

Demonstrating competency

Competency was demonstrated by nurses and healthcare providers when the woman achieved and maintained a healthy pregnancy and through behaviours where a high level of technical, ethical and organizational knowledge and skill were observed by the women. For some of the recipient women, the caring component of competency was of eminent importance. As one woman stated, ‘I don’t necessarily need a lot of handling and a lot of sympathy or empathy from my healthcare professionals, I just want them to be really competent and really good at what they do – and that makes me feel good.’

When the women observed that nurses and other healthcare providers were working diligently and in a team approach to achieve pregnancy for the women, caring was enhanced. As one woman surmised, ‘They honestly have a desire to get you pregnant. They really do. That’s their job, they work hard at it; everybody there works hard at it. They want it to happen.’

In addition to the observed behaviours that exhibited competency, the women also perceived competency when they were aware of nursing clinical expertise in the area of assisted reproduction. When asked specifically about caring behaviours, one participant summed up many of the women’s perceptions when she said:

I would say that overall the fact that IVF is a separate process versus the rest of the infertility is really important so that you feel like you are being cared for by people who are experts in that. So for example, the nursing team was all specific to donor IVF, so I think that was really rewarding.

Organizational aspects of patient care within the infertility clinic, specifically the awareness that patient testing and hormonal cycles are being scheduled in an appropriate and efficient manner further demonstrates competency. As one participant said, ‘That kind of order is huge’. Another woman who underwent infertility treatment at two separate clinics said at one clinic she felt she had to be ‘vigilant’ about ‘knowing everything and keeping everything set and knowing what to do’. She went on to say:

When I got to [the recruiting infertility clinic], everything was just...I felt like they’ve got it under control. When [the nurses] layout the schedule for you, then that’s your schedule. That means a lot to me, too. That just makes me feel like on top of everything else I don’t have to worry about – I mean I have to remember to do this stuff, but you just felt like they have done this before and you’re in good hands, so that [pauses] just the competence.

Lastly, several women indicated that participating in this investigation, initiated by nurses and supported by the recruiting clinic, demonstrated that the nurses and other providers at the clinic were interested in providing the highest level of competent care possible to donor oocyte recipient women.

Promoting empowerment

Empowerment occurred when nurses and other providers encouraged the women to engage in aspects of decision making and when nursing professionals acted in ways to promote the women’s sense of control and understanding over their infertility treatment and subsequent obstetrical care. The women experienced a greater sense of caring and well-being when they were involved in the decision-making process. For example, one woman said that when she was engaged in specific aspects of the donor oocyte process such as choosing the donor, she

found nurses and physicians caring by ‘...kind of lay[ing] out the options for you and [stating] here's how some people deal with it and here's how different people deal with it’ as opposed to having providers say ‘Well, here's what you do, this is how you do it.’ By providing objective information and laying out rational choices, the women felt in control of their infertility experience and empowered ‘to make good decisions’.

The women described an astute awareness of the subtle intricacies of the donor oocyte recipient experience that are transmitted to recipient women at the infertility and obstetrical clinics by healthcare providers. In particular, several women reported difficulty in making personal decisions about how to navigate the short- and long-term implications of donor oocyte use because of conflicting behaviours by nurses and other providers. As one recipient woman conveyed, ‘the infertility clinic sells *hope*’ and ‘the OB [obstetrical] clinic sells *caution* [italics added]’. Women perceived caring behaviour when nurses and providers offered ‘balance’, ‘realism’ and continuity of the donor oocyte experience by their professional healthcare members, especially when transitioning from infertility to obstetrical care.

Several specific caring behaviours that established a sense of control over the donor oocyte experience were delineated by the women. One participant revealed that she had kept a personal journal of her infertility treatment with assistance from nursing professionals. She viewed these actions as establishing and maintaining her sense of awareness, greater involvement and ultimately control over her infertility. The act of writing and recording personal experiences within the donor oocyte process, such as medications and responses, test results, fluctuations in mood and thoughts, current or future disclosure decisions along with information and encouragement provided by nurses, was empowering.

Another woman narrated how she developed a ‘hope box’, with encouragement and direction she received from nurses. The hope box was a small decorative container where information about the oocyte donor, such as the donor's health history and picture, and information supporting the establishment of pregnancy, such as β -hCG level reports, post-transfer ultrasound pictures and personal cards and notes received from close relatives and friends who supported her throughout the process, were kept as reminder of her donor oocyte recipient journey.

Model exemplar of caring behaviour

In the voice of a pregnant, donor oocyte recipient woman, Table 2 provides a model exemplar case demonstrating the essence of caring behaviour.

Discussion

The findings presented here delineate five themes or components of caring behaviour of nurses and other healthcare providers as described by pregnant, donor oocyte recipient women. It is important to note that the components are dynamic and the degree to which each of the components must be exhibited at any given point in time for any particular recipient woman is unknown. Furthermore, we have tried to describe the components cogently; however, it is at times difficult to compartmentalize specific behaviours into one theme over another and we acknowledge that the caring behaviours as described are not mutually exclusive. What is clear is that recipient women voiced the five components as essential for caring to take place in the infertility and obstetrical clinic environment.

Examining these results with the findings from other similar investigations that aimed to understand the meaning of caring in British infertility centres, Allan (2001, 2002) identified dimensions of ‘being available, providing communication and demonstrating competency’ as significant to caring. However, Allan purported that emotional intimacy (i.e. ‘exhibiting

compassion') between nurse and patient was much less efficacious as was 'promoting empowerment'. Allan's participants were not composed entirely of individuals undergoing donor oocyte treatment; therefore, it is difficult to surmise whether the less identified components are more valued by donor oocyte recipient women or are a result of cultural differences between infertile women in USA and Britain.

Other related conceptualizations of caring behaviour within a perinatal context and emerging from phenomenological research (Swanson 1991), which have identified the dimensions of 'knowing' – striving to understand an event; 'being with' – being emotionally present; 'doing for' – providing needed physical care; 'enabling' – facilitating a woman's passage through life transitions and 'maintaining belief' – sustaining faith that the woman will get through the event, are extended by the findings presented here. These results both broaden and deepen our understanding of caring behaviour as presented by Swanson and add to our understanding of behaviours that enhance the care of women who are enduring burgeoning reproductive challenges.

Notable is the emergence of empowerment in this study as a component of caring behaviour. This may be related to the extensive decisions recipient women are required to make throughout their treatment such as choosing the oocyte donor, deliberating disclosure decisions and if necessary, arranging for the disposition of any supernumerary embryos. From a theoretical perspective, the addition of the component of 'promoting empowerment' extends early frameworks on caring in the nursing profession (Benner 1984, Watson 1985) and adds empirical data to the more recent analysis and models of caring that include this dimension (Falk-Rafael 2001, Brilowski & Wendler 2005).

In several related studies examining pregnant women and individuals who receive care in a clinic-centred environment, investigators identified dimensions of 'promoting empowerment'. Berg's (2005, p. 11) synthesis of three qualitative studies to develop a Midwifery model of caring for pregnant women at high risk identified a 'shared responsibility' element where women stressed the need to be involved and maintain a sense of control in their care. Anderson and Funnell (2005) propose a new paradigm of care for another population of patients, diabetics, who also require a significant amount of care in the clinic environment. These investigators challenge healthcare providers to develop empowering treatment plans that promote optimal decision making among patients to enhance their well-being and health. Although there are similarities and differences among high-risk pregnant women, diabetics and pregnant, donor oocyte recipient women, further research examining the role of control and empowerment in these populations and the impact it has or does not have on health would be beneficial.

The strength of this study is the detailed description and immediate application of the components of caring behaviour that can directly enhance the care of donor oocyte recipient women in the clinic environment. Ideally, nurses who are practising can use the information provided here and also advocate for practice settings that enable caring behaviours. For example, anticipating concerns about alternative therapies or encouraging patients to keep a personal journal or hope box may be immediately beneficial to some women. Ensuring high standards of professional knowledge by providing adequate and continuous mentoring activities for novice infertility and obstetrical nurses and advocating for continuing and advanced educational programmes would add to the quality of care. Dialogue and discussion about establishing advanced certification for nurses specific to ART in further building and demonstrating competency should be encouraged. Furthermore, because nurses are vital in managing care for donor oocyte recipient women, it is imperative that nurses advocate for and deliver the highest standard of care obtainable. The importance of nursing care cannot be

overstated and was poignantly exemplified by a recipient woman who remarked: 'I didn't deal with my doctor a whole lot; I dealt with the nursing staff certainly a lot more.'

Although we have delineated several important findings and implications of this study, we emphasize prudence in view of the study's limitations. Foremost, the qualitative nature of the investigation included a small sample size from USA. Cultural and legislative differences may influence donor oocyte recipient women's experience and may significantly alter the women's perceptions of caring behaviour. Replication of this study on an international level would further enhance understanding. It is also unclear whether caring behaviour is more significant within or across the various healthcare provider groups (e.g. physician, nurse and psychologist). Future research aimed at differentiating essential caring behaviours among the divergent groups could ameliorate care. Additionally, all of the women in this study were pregnant and, therefore, their infertility treatment and care may have been viewed optimally. The extent to which this influenced the women's perception of caring behaviours is unknown and research with women who undergo donor oocyte treatment but do not achieve pregnancy would provide additional insight and understanding.

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Table 1

Exhibiting compassion: caring and non-caring verbal statements

Caring statements

The next time [treatment cycle] it is going to be hopefully better.

Do you want to talk? I am here if you ever want to talk.

This donor did not work out but we are going to move on.

Who cares how you got pregnant – however you got there, it is great.

You are going to be a great mother.

It does not really matter how you got pregnant – just that you are.

The donor oocyte process is a marathon – not a sprint.

Non-caring statements

I know how you feel.

It is going to be fine; it [oocyte treatment] is going to work.

What are you doing [using donor oocytes]?

Why are you having children at your age?

Oh, just relax.

Start the adoption proceedings.

Table 2

Model exemplar of the essence of caring behaviour

The one thing that I found very helpful is when a couple of weeks ago I had an appointment just with a nurse [being available]. And she also a high-risk nurse, so I had a chance to meet her in almost a consultation manner. I met with her to go through paperwork, go through timing [providing communication], just general get to know you. So when I met with her today, it felt very familiar and comfortable. It felt like I already know her, so that helped a lot. And what was helpful today as they did another ultrasound and she was as excited about this as we were [exhibiting compassion]. So I think just that how genuine she was as a caretaker and the fact that she is qualified from a high-risk perspective [demonstrating competency] draws me to that a lot more. Because I just feel a greater degree of confidence [promoting empowerment]