2009 the Italian Constitutional Court banned most of the limits of the law, as a limitation of couple’s rights to have access to the best possible medical treatment and to reduce any possible higher risk of complications. Our program decided to immediately fulfill the Court indications, following the guidelines proposed by our National Fertility Societies regarding the number of oocytes to be used and embryos to be transferred. Aim of the study was to analyze our results in fresh cycles in comparison with those obtained before the introduction to these new roles.

Materials and Methods: We retrospectively analyzed 3276 IVF/ICSI performed in our program between January 2008 and December 2009. 2488 cycles before the Law modifications and 1028 after the Law modification. In general no more than 2 embryos were transferred in patients less than 37 years after the new regulation and all normal cleaved embryos (up to 3) before. Our intention to treat analysis showed a statistical power to detect a 3% difference in pregnancy rate per started cycle between the 2 studied periods.

Results: No significant difference was found among female age (36.6 ± 3.9 vs. 36.7 ± 3.9 p = 0.52), basal FSH (7.87 ± 3.63 vs. 7.95 ± 3.50 p = 0.62), years of infertility (3.43 ± 2.38 vs. 3.32 ± 2.10 p = 0.95) and number of oocytes retrieved (8.98 ± 5.75 vs. 9.28 ± 6.01 p = 0.45). The number of suspended cycles was 10.72% vs. 8.66% (p = 0.069) and the number of fertilization failure was 6.27% vs. 5.54% (p = 0.41). The number of oocytes used (2.73 ± 0.69 vs. 4.62 ± 1.88 p = < 0.001), embryos obtained (2.06 ± 0.95 vs. 3.36 ± 1.80 p = < 0.001) and the mean number of embryos replaced (2.06 ± 0.95 vs. 2.35 ± 0.73 p = < 0.001) was significantly higher after removal of previous limitations. The pregnancy rate per started cycle was significantly higher (23.44 vs. 20.42 p = 0.05) after the introduction of the Law modifications. The implantation rate was not significantly different (13.51 ± 26.78 vs. 15.11 ± 28.02 p = 0.118), although a positive trend toward a better result was observed. In 17.9% of patients pre and 11.08% post only one embryo was available for transfer (p = 0.001). Pregnancies were single in 74.10% pre vs. 71.30% post, twins in 23.43% pre vs. 27.00% post and the triplets rate was 2.45% pre and 1.68% post and, although not statistically significant, a higher twin rate and a reduced high order pregnancy rate was observed.

Conclusions: Our results after the first 7 months of a personalized treatment oriented to give to couples the best treatment option, reducing the risk of multiple pregnancies, shows that a significantly improvement in pregnancy rate per started cycle is achievable and will probably improve in the future, as this scientific approach come to a standardized practice. Although a larger study is needed to details special classes of patients, our preliminary data show a rapid achieving of the same pregnancy rate we obtained before the introduction of the Italian Law in 2004 with a significantly older population of patients.

O-242 Reproductive autonomy and welfare of the child assessments in infertility treatment
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Introduction: One of the most controversial aspects of the regulation of infertility treatment, in the UK, is that, ‘account must be taken of the welfare of the child who may be born as a result of the treatment.’ In 2005 the Human Fertilisation and Embryology Authority (HFEA) modified its guidance and stated, ‘there should be a presumption to provide treatment, unless there is evidence that the child to be born, or any existing child of the family, is likely to suffer serious medical, physical or psychological harm.’ This was seen as bringing a ‘lighter touch’ to welfare of the child assessments. The revised Human Fertilisation and Embryology Act, which came into force in October 2009, kept this provision (with modification to the need for a father requirement). One of the main focuses of ethical debate over welfare of the child in the bioethical literature has been concern over its impact on reproductive autonomy. John Harris, for example, argues that such a provision is an unjustified restriction on reproductive autonomy, as did the House of Commons Technology Committee in 2005; while others think that such autonomy has not been restricted enough (Baroness Deech for example). This paper approaches this debate by presenting the results of a qualitative study on clinicians’ views on welfare of the child.

Materials and Methods: Twenty-two qualitative semi-structured interviews were conducted with infertility clinicians in the UK. Interviews lasted on average an hour and were tape recorded and transcribed. A modified grounded theory method of data collection and analysis was used. The overall aim of the study was to explore how infertility clinicians approached ethical problems in their everyday practice and this paper reports on one aspect of this data – how they thought about and managed welfare of the child issues in their practice.

Results: This study found that there were some practical problems with welfare of the child assessments. These included the difficulty in getting information about potential recipients and the unsatisfactory situation of having to rely on their honesty to report any reasons why they might not be suitable for treatment. There were also some ethical issues raised: it was felt that the infertile were being discriminated against as such assessments are not carried out for those who can conceive ‘naturally’ and it was an intrusion as most recipients were suitable for treatment. However, despite these concerns, generally, the clinicians thought a minimal requirement to consider the welfare of the child (such as the one that has been in place since 2005) was necessary. In practice, although there were some restrictions on reproductive autonomy due to welfare of the child considerations, clinicians did not consider that these were unduly burdensome on the people being assessed. The clinicians adopted a very laissez faire approach to their assessments: they rarely refused to treat people outright, but favoured postponing treatment to allow the person to modify their lifestyle and only considered ‘back door’ cases (such as a history of child abuse) to warrant completely refusing treatment.

Conclusion: For the clinicians in this study the onus was on respecting patients’ autonomy as far as possible. However, a minimal conception of ‘welfare of the child’ assessments was seen as necessary to safeguard future children. It will be argued that more stringent criteria would be unworkable in practice and no provision at all would deprive providers of infertility services of a valuable tool in their clinical practice.