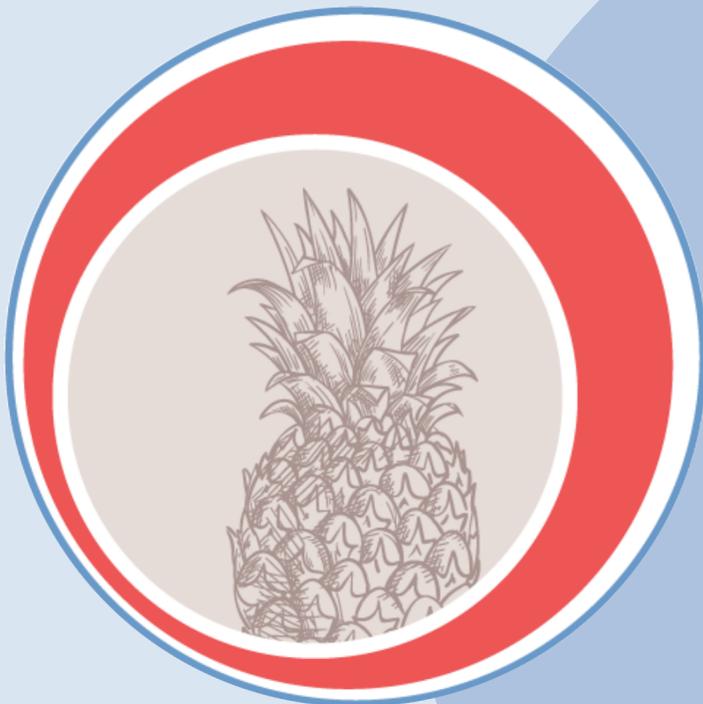




PHYSICIAN INFERTILITY: ANSWERING THE CALL TO ACTION

Proceedings of the Physician Fertility Summit



On June 12, 2021, the American Medical Women's Association hosted the first-ever Summit focused on the impact of fertility issues among women physicians. Our vision is an environment where women physicians can thrive, without having to choose between having a career or building a family.

Summit speakers included CEOs, entrepreneurs, academicians, clinicians, and innovators — leaders who are changing the future of family-building in medicine.

*Organized by the
American Medical
Women's Association*

ACKNOWLEDGMENTS

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The American Medical Women’s Association was honored to host the first-ever Summit focused on the impact of fertility issues among women physicians. Recognizing that medical training coincides with the optimal time for family-building necessitates a process to ensure women in medicine are informed, prepared, and supported to make these personal choices. Our vision is an environment where women physicians can thrive, whether in practice, research, or academia, without having to choose between having a career or building a family. Summit speakers included CEOs, entrepreneurs, academicians, clinicians, and innovators - leaders who are changing the future of family-building in medicine.

The Summit was held in June 12, 2021.

INTRODUCTION

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***“If we want to change the landscape for physician infertility, these are conversations that are absolutely important to have.”
— Torie Comeaux Plowden, MD, MPH***

For over a century, the American Medical Women’s Association (AMWA) has been at the forefront of advancing women in medicine, advocating for equity, and improving healthcare. Family building and career/life balance have always been important issues to AMWA, yet recent data show that nearly 1 in 4 women physicians report a diagnosis of infertility, a rate almost double that of the general population. When “Physician Fertility: A Call to Action” was published in 2019, AMWA rose up to answer that call. The AMWA Physician Fertility Committee was launched the following spring and soon grew to over 160 members, organized under an executive committee and 4 subcommittees (research, advocacy, education, and media). One of the key outcomes of the group was to host this first-ever Physician Fertility Summit.

Within the general public, topics concerning infertility are also being shared and discussed. The NOVA documentary *Fighting for Infertility*, which featured Summit Co-chair Dr. Cindy Duke, underscores many of the issues surrounding infertility as well as the intersectionality with race, ethnicity, and LGBTQ+ identities. This Summit also addresses these topics and lays out a roadmap for addressing this growing challenge faced by women in medicine.

KEYNOTE PANEL

"PHYSICIAN FERTILITY: A CALL TO ACTION"

VINEET M. ARORA, MD, MAPP

Professor of Medicine, University of Chicago

ARIELA L. MARSHALL, MD

Associate Professor of Medicine, Mayo Clinic Rochester

ARGHAVAN SALLES, MD, PHD

Special Advisor for DEI Programs, Stanford Dept. of Medicine; Senior Research Scholar, Clayman Institute for Gender Research

HINA TALIB, MD (MODERATOR)

Associate Professor, Pediatrics, Ob / Gyn and Women's Health, Albert Einstein College of Medicine

"The call to action, really, is to educate our trainees and our practicing physicians about their risk of infertility, so that they can take action to mitigate that risk."

— Vineet M. Arora, MD, MAPP

In their keynote, Drs. Ariela Marshall, Vineet Arora, and Arghavan Salles (authors of "[Physician Fertility: A Call to Action](#)") shared insights from their personal infertility journeys, both successes and failures, and the motivation from those experiences to ensure that other women physicians would have an easier path. They underscored the need for education, greater awareness, and more data to fully understand the lived burden of infertility, not just for women but also for all genders and people with any sexual orientation. Knowledge is power. When trainees and young physicians are educated about their risk of infertility, they can take actions to mitigate that risk.

The support of leadership is key. Program directors and other institutional leaders should understand the needs of those undergoing fertility treatments so that they can make necessary accommodations, just as they would for other medical conditions. Emotional support is equally important, as the experience of infertility can be overwhelming for trainees, both from a financial standpoint and a logistics perspective.

"Infertility is a medical condition and it needs to be treated just the same as any other."

— Ariela L. Marshall, MD

For too long, women in medicine have suffered in silence. Sharing stories and information reinforces the fact that people are not alone. But this conversation must be more than just a moment. We need to normalize the discussion around physician fertility. Let's advocate for everyone to have a routine fertility check-up that would help them understand and explore their options. As physicians who are stewards of well-being for our patients, we need to do this for ourselves as well.

INFERTILITY 101

TEMEKA ZORE, MD

Fertility Specialist, Spring Fertility

“Female age is one of the most important factors that goes into treatment and success rates.”

— Temeka Zore, MD

Dr. Temeka Zore provided an overview of fertility and the process of a natural pregnancy, beginning with deposition of sperm which travel from the vagina, through the uterus, and into the fallopian tubes. During ovulation, the ovary releases an egg into the fallopian tube which is picked up by the fallopian tube and fertilized by the sperm. The fertilized embryo is implanted into the uterus where the pregnancy will grow. Along this pathway, there are multiple points where an abnormality can prevent successful conception. The biggest impact on fertility treatment success is related to female age due to the age-related decline in egg quantity and quality.

Treatment options are targeted at specific causes of infertility in this pathway:

- Anovulation: In this situation, the person with ovaries may not ovulate regularly. Causes can be due to polycystic ovary syndrome (PCOS), TSH/prolactin disorders or functional hypothalamic amenorrhea (FHA). Many times oral medications like clomiphene or letrozole can promote ovulation, coupled with timed intercourse or insemination depending on the partner's sperm parameters. Some patients may not respond to oral medications (those with FHA) and may require injections to stimulate follicle growth or may need to proceed with *in vitro* fertilization (IVF).
- Tubal factor (IVF needed): We need at least one open, functioning fallopian tube in order to spontaneously conceive. If there is a blockage or dysfunction of both fallopian tubes, IVF becomes necessary.
- Fertilization failure (IVF with ICSI needed): We are unable to see whether fertilization occurs *in vivo* as there is no test for fertilization in the body. However, up to 5-8% of couples unexplained infertility may have failed fertilization which can occur when the sperm are unable to penetrate the egg. This can be overcome with intracytoplasmic sperm injection (ICSI) where one motile sperm is directly inserted into each egg to allow fertilization to occur.
- Embryo development (IVF): while there is no test to actually measure embryo quality *in vivo*, we know that the number and quality of eggs will decline with increasing female age. During IVF, however, we can assess whether the embryos are dividing normally and even do additional testing to determine whether they are chromosomally normal.
- Implantation failure (diagnosed after IVF): This is diagnosed after a patient is unable to conceive after the transfer of chromosomally normal embryos. This a rare cause of infertility, but causes may include the uterus or other factors.

INFERTILITY 101

During infertility evaluations, the basic workup includes the following:

- Ovarian Reserve Testing: anti-Müllerian hormone (AMH, a hormone produced by the ovarian follicles), Day 3 follicle-stimulating hormone (FSH) / estrogen, antral follicle count (AFC).
- Male Evaluation: semen analysis.
- Uterine Evaluation: vaginal ultrasound, saline infusion sonohysterogram (SHG), hysterosalpingogram (HSG), other possible tests.
- Possible hormonal testing including thyroid or prolactin disorders based on patient history.

Treatment options differ, depending on the individual or couple, and taking into consideration age and desired family size.

- Oral medications (clomiphene or letrozole to help ovaries grow more follicles) +/- timed intercourse or intrauterine inseminations. Success rate 5-15% depending on female age and other fertility factors.
- IVF: injections of gonadotropins (FSH and Luteinizing Hormone - LH) to help ovaries develop follicles) This involves 8-12 days of injections, 5-6 ultrasounds and blood draws, and the egg retrieval (procedure under anesthesia). The eggs are then fertilized in the lab and embryos are created, followed by the embryo transfer.

LGBTQ+ treatment options vary depending on what gametes (sperm, eggs) the partners are bringing into this process, presence of a uterus, age, and number of children desired.

- If both partners have ovaries, donor sperm is needed (from a donor or sperm bank)
 - Natural cycle/IUI: self track ovulation using ovulation predictor kits and then when they get the positive surge they come for an IUI
 - Medicated cycle/IUI: we add clomiphene or letrozole to grow one or more follicles and then combine that with monitoring and insemination (if no regular periods or if they've failed prior natural cycle treatments)
 - IVF: using autologous eggs
 - Reciprocal IVF (One partner undergoes the IVF process and the other partner carries the pregnancy - shared parenthood.)
- If both partners have sperm - donor eggs are needed (from a donor or egg bank)
 - IVF + gestational carrier

INFERTILITY AND MENTAL HEALTH

ALICE D. DOMAR, PHD

Executive Director, Domar Center for Mind/Body Health
Director of Integrative Care, Boston IVF
Associate Professor of Obstetrics, Gynecology, and
Reproductive Biology, Harvard Medical School

HINA J. TALIB, MD (MODERATOR)

Associate Professor, Pediatrics, Obstetrics and
Gynecology and Women's Health Albert Einstein College
of Medicine

"Studies have shown that women with infertility have the same levels of anxiety and depression as do women with cancer, HIV, and heart disease."

— Alice Domar, PhD

Dr. Alice Domar provided a detailed overview about mental health issues related to infertility. The session was moderated by Dr. Hina Talib.

Impact of Infertility

Infertility is an emotionally intense short-term crisis in one's life. Studies have shown that women with infertility have the same levels of anxiety and depression as do women with cancer, HIV, and heart disease. In fact, feelings of anxiety or depression are normal for patients with infertility. During the COVID-19 pandemic, studies found that women reported that infertility was as stressful if not more stressful than the pandemic. Imagine the catastrophic impact, then, when most infertility centers had to close for several months during the pandemic. And for physicians who experienced the pause, it was often doubly painful, as those who didn't have children or who weren't pregnant were among the early physicians being asked for COVID care deployment.

Infertility impacts relationships with family, friends, and colleagues. Friends and colleagues may be insensitive to the experience and offer misguided comments that convey a blame the victim mentality. It can also be excruciating for individuals going through infertility to hear about the pregnancies of others, almost to the point of phobia. And in fact, data shows that jealousy of other people's pregnancies is far more common in women than in men, which can cause a lot of dissension within the couple. Men and women simply don't react to infertility in the same way or at the same time. Women tend to want to talk about it more, while men prefer focus on problem solving. Challenges with infertility may also impact sexuality, intimacy, spontaneity, putting even more strain on the couple's relationship.

A lot of individuals will tend to withdraw from family and friends during this time. They don't go home for holidays. They don't join friends for social events. A couple in their first crisis can feel isolated from people who traditionally could have offered a lot of support.

Infertility can impact one's career as well as financial security. Fertility treatments require frequent appointments for monitoring, that can interfere with work schedules or work-related travel. The workplace environment may also expose one to pregnancy news or insensitive comments. And unless one has insurance coverage or financial resources, the cost of treatment can make it challenging to proceed.

INFERTILITY AND MENTAL HEALTH

Infertility can impact religious or spiritual beliefs. Many patients with infertility report that it's the first time God hasn't answered their prayers, so they wonder if their infertility is a punishment for past wrongdoing.

Finally, infertility can impact body image and self-esteem. Perceptions of femininity or masculinity often include fertility. Some of the fertility medications may also lead to weight gain. It can also feel hurtful to know that what comes easily to other people is a struggle for you and your partner.

Stress and Fertility

When we talk about stress and infertility, which comes first? Infertility causes a tremendous amount of stress, but that stress can also decrease or hamper fertility. There have been a number of studies which show that women who are the most stressed before an IVF cycle have lower pregnancy rates compared to women who are less stressed. There have also been studies that show that the more distressed a woman is before her first cycle, the more likely she is to drop out of treatment, even after only one treatment cycle. In fact, the number one reason why insured patients drop out of treatment is stress. That feels catastrophic because by the time someone gets to IVF, it's unlikely that they'll get pregnant on their own.

There are many ways to reduce stress, including stress management strategies, relaxation techniques, appropriate nutrition, and exercise. Relaxation techniques can have two distinct benefits: immediate short-term changes in anxiety levels and several weeks later, a carry-over effect with decreased anxiety throughout the day. Nutrition is important because body mass indices below 20 or above 35 are associated with lower fertility rates. And finally, women who exercise moderately have been found to have higher rates of fertility.

In addition, patients can reduce stress from a psychological perspective by challenging automatic negative thoughts through cognitive restructuring, seeking out social support, writing about the experience, maintaining self-nurturance, and giving up perfectionism. This last one is a big issue in medicine. There's nothing wrong with wanting to be a good daughter, wife, friend, son, physician, family member – all of us want to be good at what we do. But wanting to be perfect in everything can lead to anxiety and dissatisfaction.

"Technically correct medical care is not the goal, it's the floor. And the treatment of the whole patient is critical. And the only way to do that is to look globally, look 360, and include mental health."

— Alan Penzias, MD

INFERTILITY AND MENTAL HEALTH

In many ways, the emotional challenges of infertility can be harder to bear than the physical challenges of the treatment itself, and conversely, the psychological burden can impact the success of the treatment as well. Treating the whole patient is critical, and the only way to do that is to care for our patients globally, so that they have the stamina and the resilience to complete the number of cycles that it might take for them to get pregnant. Research indicates that women who receive some kind of counseling or cognitive behavioral interventions are more likely to get pregnant than women who did not. Let's change our perspective from "treating patients" to "caring for patients." Fertility touches everything that makes us human, so without caring for that aspect of people, we fail our mission.

To learn more, read *Conquering Infertility: Dr. Alice Domar's Mind/Body Guide to Enhancing Fertility and Coping with Infertility*.

***"Let's change our perspective from 'treating patients' to 'caring for patients.' Fertility touches everything that makes us human, so without caring for that aspect of people, we fail our mission."
— Alice Domar, PhD***

ADVOCACY

BARBARA COLLURA, MA

President and CEO, RESOLVE: The National Infertility Association

ERICA KAYE, MD, MPH

Assistant Professor, Department of Oncology, St. Jude Children's Research Hospital

ROOHI JEELANI, MD

Reproductive Endocrinologist and Infertility Specialist
Vios Fertility Institute (Moderator)

ALAN PENZIAS, MD

Associate Professor of OB/Gyn and Reproductive Biology
Harvard Medical School

CHRISTINA YANNETSOS, MD

Assistant Professor of Emergency Medicine
University of Colorado Anschutz Medical Campus

***"It only takes one voice, at the right pitch, to start an avalanche."
— Dianna Hardy***

Every individual can become a fierce advocate for physician fertility. This session, moderated by Dr. Roohi Jeelani, highlighted many opportunities for advocacy. Resources are available through RESOLVE: The National Infertility Association to help physicians advocate within their respective institutions and at the state and federal level. Barbara Collura, President and CEO of RESOLVE highlighted three fundamental ways that physicians can advocate:

1. State level advocacy addresses insurance policies that are regulated under state legislation. Currently 19 states have passed fertility insurance coverage, but only 13 of those states include IVF coverage, and only 11 out of those have fertility preservation laws for iatrogenic medically induced infertility. RESOLVE hosts state advocacy days and provides a toolkit and access to a state advocacy network for those who want to help, particularly in states without an insurance mandate. Even with insurance mandates, access may still be limited. For example, Massachusetts is touted as having one of the best laws, yet only one-third of women in Massachusetts actually fall under the state mandate because of a loophole that exempts self-insured companies from being required to provide infertility benefits.
2. Federal level advocacy addresses plans that are regulated by the federal government and concern federal employees, active duty military, and veterans. RESOLVE organizes a federal advocacy day every year.
3. Advocacy directed at self-insured private employers. These employers are often exempt from state laws. RESOLVE's Coverage at Work program supports individuals in reaching out to their HR departments to advocate for fertility benefits and helps them at every step until full coverage is achieved.

***"As of April 2021, 19 states have passed fertility insurance coverage. Only 13 of those states include IVF coverage. 11 out of those, even fewer, have fertility preservation laws for iatrogenic medically induced infertility."
— Roohi Jeelani, MD***

ADVOCACY

"They have those state laws because people, like you, advocated."

— Barbara Collura, MA

Dr. Christina Yannetsos shared her personal story about fighting for access in Colorado and the founding of Colorado Fertility Advocates. Her advocacy story began with her first visit to a reproductive endocrinologist whose treatment recommendations totaled \$25,000. As a recent residency graduate still saddled with student loans and a former international athlete who had been reassured that menstrual irregularities were normal, Dr. Yannetsos felt that the system had failed her. No one up until that time had ever mentioned fertility concerns. She knew then that she had to make a change in the system.

Through various networks, she built a coalition of diverse stakeholders, including a political ally who had been through IVF. Within a year, they helped pass the first of several bills in Colorado that improved fertility benefits. The most recent bill was signed into law last week.

Dr. Yannetsos' state advocacy led to institutional advocacy and gaining benefits for hundreds of thousands of people.

Dr. Yannetsos outlined important steps in the advocacy process:

- Find your tribe, build a coalition, find political allies. These might include infertility support groups, reproductive endocrinology clinics, donor egg groups, ART attorneys and professional organizations.
- Get personal, arm yourself with knowledge and data because data drives change. Know the statistics on prevalence, including differences based on race and ethnicity.
- Be firm, and persistent, make your ask, and follow up. Keep asking.
- Institutional advocacy can lead to state advocacy which can, in turn, further support institutional advocacy.

"Make sure that you use your voice.

Make sure that you get personal. Make sure that you are persistent.

You are one person that can make a change."

— Christina Yannetsos, MD

Dr. Erica Kaye shared how she channeled a decade of personal grief into advocacy. "It took me several years of grieving my infertility journey and our pregnancy losses to feel empowered and to be able to step into that vulnerability. Translating that grief into advocacy work helped me find meaning in our journey." She recognized that those in decision-making leadership roles would be most influenced by data, projected cost savings, and improved employee recruitment and retention strategies. Using the medical literature and resources from RESOLVE and other groups, she crafted a data-driven argument for why infertility matters in medicine, which was published in the *New England Journal of Medicine*. She also wrote op-eds and empowered colleagues and

ADVOCACY

friends to raise awareness through existing avenues for communication - institutional surveys, newsletters, and town halls. Within 12 months of this coordinated effort, her institution adopted comprehensive fertility coverage for all faculty and staff. The momentum has now been leveraged into a statewide movement for fertility coverage.

Dr. Kaye highlighted four important pillars of her advocacy:

1. Persistence. Create a data-driven argument and keep asking.
2. Vulnerability. Stories help give a face to the data. Sharing stories also empowers others to share their stories and opens up the dialogue. One voice is meaningful but many voices in aggregate, particularly in a coordinated wave, can move mountains. Stories about iatrogenic infertility can also help state level efforts, particularly when addressing the needs of cancer survivors, who otherwise might not have viable options for fertility preservation.
3. Courage. One voice can make a difference.
4. Community. Invite colleagues and friends to support your efforts.

***"Four Important Pillars of Advocacy —
Persistence, Vulnerability, Courage, Community"
— Erica Kaye, MD, MPH***

Dr. Alan Penzias highlighted the importance of encouraging physicians to become advocates, even during early stages of their career. Working closely with patient advocate groups can help one understand the issues that patients are facing; exposing young trainees to advocacy early on helps them develop both an understanding of the policy world and the skills to influence it.

***"People should know about their fertility, and it just should become part
of the fabric of what makes us great doctors and great physicians."
— Alan Penzias, MD***

Ultimately, infertility impacts physician well-being, and this is an area of focus throughout healthcare. Program and institutional leaders should advocate for their physicians and trainees from that perspective. After all, providing fertility benefits is pro-family. Increasing fertility education within medical training should also aim to normalize pregnancy and family planning. Partnerships between ASRM, AMWA, and RESOLVE will help build up advocates, so that together we can achieve the goal of better fertility benefits coverage.

WHAT YOU NEED TO KNOW ABOUT BENEFITS AND COVERAGE

CINDY DUKE, MD, PHD

Founder & Medical Director, Nevada Fertility Institute
Clinical Assistant Professor
University of Nevada School of Medicine

Chrissy Guidry, DO

Assistant Professor of Surgery
Tulane University School of Medicine

JANELL GAUDIN, ESQ

Attorney at Law

TINA LAVOIE

Practice Manager, Nevada Fertility Institute

***"We need to talk about how we can advocate to make sure that fertility benefits and fertility coverage becomes more of the status quo for all patients in the United States, but especially for those of us within medicine."
— Cindy Duke, MD, PhD***

This panel, which was moderated by Dr. Cindy Duke, discussed challenges of fertility coverage and the importance of contract negotiation.

Finances can prove to be a big hurdle to accessing and initiating fertility care. Therefore, it's important to advocate for fertility benefits and fertility coverage, so that they can become more of the status quo for all patients in the United States, especially for those within medicine.

Medical training can be long, arduous, and expensive. Physicians may put off family planning until after their training, only to encounter challenges with fertility. It can be disheartening to find that one can't just "flip a switch" when wanting to start a family. Even more discouraging is the realization that infertility treatment may not be covered outside of certain mandated states, despite a diagnosis with an ICD-10 code. The burden of financing fertility treatment often compounds high student loan debt, adding even more stress to the family.

Infertility benefits are often assumed to cover all treatment, but frequently, the benefits cover only diagnostic tests like semen analysis, blood work, or the hysterosalpingogram but not actual treatment. Or intrauterine insemination (IUI) is covered, but not *in vitro* fertilization (IVF). Some insurances provide full benefits coverage, only up to a certain age, and patients are often surprised to find that they have aged out of utilizing what benefits they do have. Tina LaVoie highlighted the importance of reading the fine print of insurance policies to know the specific fertility benefits that are offered and asking specific questions about potential exclusions. Obtaining a list of universal CPT codes that will most likely be billed by your fertility clinic for your particular treatment (IVF or IUI or egg freezing) can also be helpful in estimating out of pocket costs or help you secure an insurance plan that does have adequate coverage.

WHAT YOU NEED TO KNOW ABOUT BENEFITS AND COVERAGE

"Contract negotiation helps ensure access to and protection of fertility benefits."

— Janell Gaudin, JD

Contract negotiation helps ensure access to and protection of fertility benefits. Janell Gaudin spoke on three main areas of negotiation:

- Legislation: Federally, there are three main laws that may apply: The Family and Medical Leave Act, The Pregnancy Discrimination Act, and the Americans with Disabilities Act. These laws help determine what rights an individual might qualify for and what is offered. Within mandated states, there may be additional state legal provisions.
- Employer policies - this includes both what is in writing and what one learns by talking to others. Even if it is not in writing, employers have an obligation to uphold a standard that has been created by precedent. So if an allowance is given for one employee, it will need to be given to others.
- Employment contracts are important to negotiate and review carefully, both from a direct and indirect approach. The direct approach entails negotiating leave time upfront and knowing what the return-to-work process might look like. The indirect approach involves making time and space for the individual person, for example on-call days, general leave, and sick-leave days. This option provides flexibility for future pregnancies.

Frequently, physicians have rights that they either don't know about or are not willing to assert. But there are ways to be both kind and firm - and it's important to approach these negotiations from a human standpoint because fertility touches every aspect of life.

Dr. Chrissy Guidry shared insights from her personal journey. After completing her surgical training which included fellowships in trauma and critical care, she met and married her husband and began to consider family planning options. At her first visit with a reproductive endocrinologist, she was shocked to find that her chances for conception were low and that donor eggs were being recommended. Tulane at the time had no fertility coverage, so Dr. Guidry used CapexMD, a fertility loan program, to finance \$31,000 for fertility treatment. When she realized that a neighboring institution did provide fertility benefits for their employees, she began to speak with Tulane's HR department about fertility coverage. After multiple attempts with little progress, she contacted one of the CEOs who helped push for faculty to get coverage. Other physicians were also advocating. As a result of these collective efforts, Tulane is now planning to cover fertility benefits. Dr. Guidry encouraged attendees to not give up, to keep knocking on doors because their collective advocacy would help future physicians. She also urged every medical student and resident to consider family planning options early and not wait, even if that meant having a child during residency.

"Consider family planning options early and don't wait..."

— Chrissy Guidry, DO

CREATING ALLIANCES AND INVITING PARTNERSHIPS

TORIE COMEAUX PLOWDEN, MD, MPH

Chief, Department of Gynecologic Surgery and
Obstetrics, Womack Army Medical Center

The Physician Fertility Summit provided a window into the many areas where we can impact change for physicians and their interest in family building. Understanding one's own fertility is the first step in becoming empowered to make decisions that might affect future outcomes—both personally as well as for our colleagues. Within medicine, we need to normalize having children whenever the time is right for each individual. By recognizing the impact of infertility on mental health and well-being, we can better support our colleagues, trainees, and patients. Physicians often graduate with a mountain of educational debt, so access to benefits will absolutely impact career decisions.

"This Summit is just the beginning..."
— Torie Comeaux Plowden, MD, MPH

This Summit is just the beginning of AMWA's work to bring stakeholders together around this important issue. Our vision is to create a network of allies to help change the landscape of physician infertility. This means raising awareness through education, supporting individuals in their personal fertility journeys, and advocating for coverage at the local, state, and national levels. By working together, we can help ensure that all physicians have options for family planning, if they so choose.

BREAKOUTS

Egg Freezing

VALERIE LIBBY, MD, MPH

Reproductive Endocrinologist
Shady Grove Fertility, Atlanta

ASHLEY KIM, MD

Resident Physician
Kaiser Permanente LA Medical Center

NICOLE VESTAL

Medical Student, Keck School of Medicine of the
University of Southern California

Advocacy 101: A Roadmap to Coverage at Work

PAULA AMATO, MD

Professor of Obstetrics and Gynecology
Oregon Health & Science University

AMANDA RUSH

Senior Manager for Coverage at Work
RESOLVE: The National Infertility Association

"Ask Us Anything: Answering Your Fertility Questions!"

TORIE COMEAUX PLOWDEN, MD, MPH

Chief, Department of Gynecologic Surgery and
Obstetrics, Womack Army Medical Center

AMELIA KELLY, MD

Resident Physician
Obstetrics and Gynecology, New York University

MORGAN LEVY

Medical Student
University of Miami, Miller School of Medicine

Supporting Faculty and Trainees

ELIZA LO CHIN, MD, MPH

Executive Director
American Medical Women's Association

CINDY DUKE, MD, PHD

Founder & Medical Director, Nevada Fertility Institute
Clinical Assistant Professor
University of Nevada School of Medicine

RESOURCES

Applications:

- FertiCalm App - an app that shares cognitive behavioral relaxation strategies for typical situations that may cause stress

Organizations:

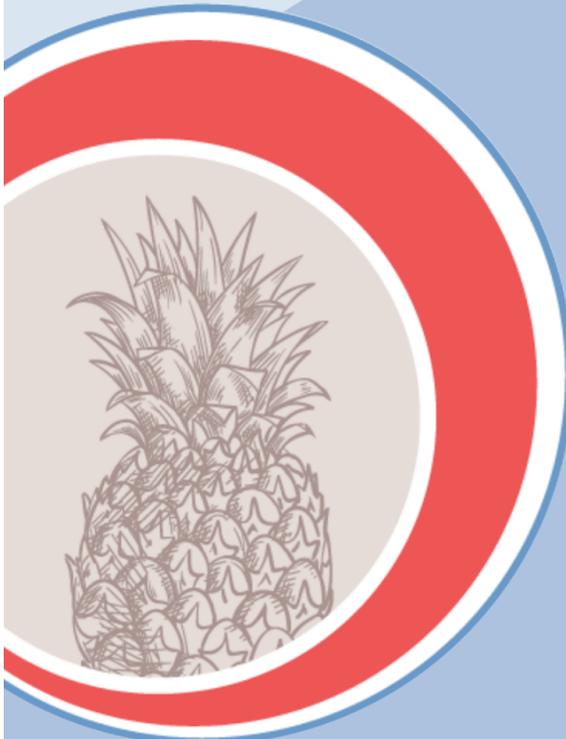
- RESOLVE: The National Infertility Association — (resolve.org)
- American Society for Reproductive Medicine — (asrm.org)
- Boston IVF Fertility Clinic — (BostonIVF.com)
- Domar Center for Mind, Body, Health at Boston IVF — (domarcenter.com)
- American Medical Women's Association (amwa-doc.org)
- FertilityIQ — (fertilityiq.com)

Template for Writing an Op-Ed

Download the Toolkit



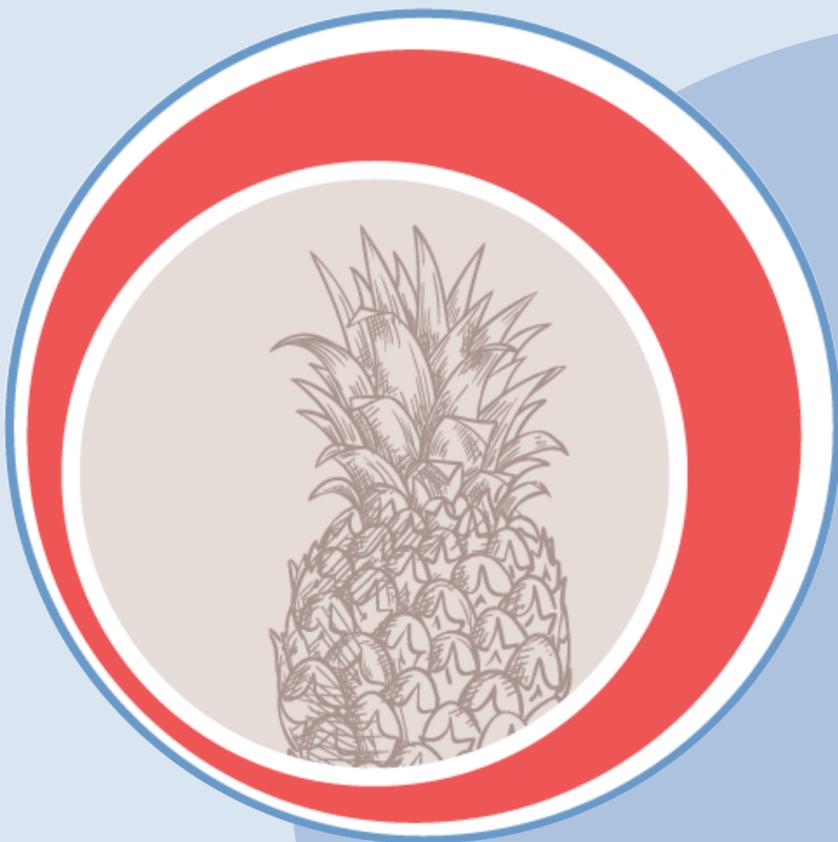
COVERAGE AT WORK TOOLKIT



A Partnership
between the
American Medical
Women's
Association &
RESOLVE: The
National Infertility
Association

AMWA's post-summit plans include workshops, coaching groups,
educational outreach, research, and advocacy training.
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