American Medical Women's Association

resolve
THE NATIONAL INFERTILITY ASSOCIATION

PHYSICIAN FERTILITY SUMMIT 2023

Held June 17, 2023

PROCEEDINGS

American Medical Women's Association

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The American Medical Women's Association's 2nd Physician Fertility Summit, held June 17, 2023, convened physicians, trainees, and key stakeholders to tackle the often-unspoken challenges of infertility and family-building in medicine, including topics less commonly discussed, like LGBTQ perspectives and male infertility. communities. This half-day, all-virtual event shared insights on fertility preservation and IVF, and explored policy barriers—empowering attendees with knowledge, tools, and advocacy strategies to shift workplace culture .

ACKNOWLEDGEMENTS

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Executive Director
American Medical Women's Association

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WELCOME

ELIZABETH GARNER, MD, MPH
President, American Medical Women's Association (AMWA)

Dr. Elizabeth Garner opened the 2023 Physician Fertility Summit by highlighting the critical challenges women physicians face regarding fertility, largely due to the delays in childbearing imposed by medical training and career demands. She emphasized AMWA's commitment to supporting physician fertility and reproductive health, underscoring the need for systemic changes to better accommodate the reproductive needs of healthcare professionals

THE LANDSCAPE OF PHYSICIAN FERTILITY: OPPORTUNITIES FOR CHANGE

TORIE COMEAUX PLOWDEN, MD, MPH
Chief, Department of Gynecological
Director, REI Division, WRNMMC
Co-Chair, AMWA Physician Fertility Committee

"We need to change the culture of medicine and normalize and support fertility and family building at all career stages."

– Dr. Torie Comeaux Plowden

Dr. Torie Comeaux Plowden shared a word cloud illustrating the overwhelming fertility concerns faced by women physicians when deciding if or when to start a family. These challenges affect not only those experiencing infertility but also those navigating career constraints while considering parenthood.

While infertility affects 1 in 8 U.S. couples and 1 in 6 globally, studies show that 1 in 4 female physicians experience infertility —double the national average. A 2016 study found that among surveyed female physicians:

- 24% had infertility diagnoses
- 29% wished they had tried to conceive earlier.
- 17% would have chosen a different specialty.
- 7% would have pursued egg freezing (likely higher today due to improved access).

Emotional and Professional Toll

Infertility leads to burnout, anxiety, guilt, and stigmatization, particularly for physicians balancing demanding careers. Some studies have also shown that female physicians who have experienced infertility or high-risk pregnancies and or spontaneous miscarriages are more likely to experience substantial rates of burnout.

We need to change the culture of medicine and normalize and support fertility and family building at all career stages. People should be allowed to expand their families when they want to, and should be supported in doing so, even if they are trainees. This is an issue of reproductive justice -- the human right to maintain personal bodily autonomy, the right to have children, the right to not have children, and the right to parent children within safe and supportive environments.

THE LANDSCAPE OF PHYSICIAN FERTILITY

A 2019 article, “Physician Fertility: A Call to Action,” proposed key strategies: increasing fertility awareness in medical training, providing insurance coverage for fertility care, and supporting workplace policies for those undergoing treatment. By normalizing family-building discussions during training and encouraging leadership to implement supportive policies, we can change the landscape of physician fertility. More research can also help drive policy change.

AMWA has been working on this issue now for several years. In 2021, we launched education campaigns and held the first Physician Fertility Summit. In 2022, our leaders published research studies and promoted social media campaigns. That same year, we were awarded the Hope Award for Advocacy by RESOLVE: The National Infertility Association. In 2023, we partnered with ARC Fertility to expand HR fertility benefits.

We invite you to join us in this work. Together, we can create systemic change in medicine to ensure that physicians can build families without professional or financial barriers.

PANEL 1: PERSPECTIVES ON PHYSICIAN FERTILITY:

CHRISTINA YANNETSOS, MD (CO-MODERATOR)
Assistant Professor of Emergency Medicine
University of Colorado Anschutz Medical Campus

VRUNDA DESAI, MD, FACOG (CO-MODERATOR)
Vice President, Medical Affairs, CooperSurgical
Adjunct Assoc. Professor of OB/GYN and Reproductive Sciences, Yale School of Medicine

TURNING GRIEF INTO ADVOCACY

ERICA KAYE, MD, MPH
Associate Professor, Department of Oncology
Director, Quality of Life and Palliative Care Research Program
St. Jude Children’s Research Hospital

Dr. Erica Kaye opened with a reflection on the emotional weight of discussing infertility and pregnancy loss, acknowledging that it can be difficult and deeply personal. She emphasized the importance of giving oneself grace in deciding when, how, and if to share one’s experiences, noting that for years, she did not speak about her own fertility struggles due to feelings of fear and shame. Over time, she found healing and meaning in sharing their story, which not only helped in processing her grief but also fostered solidarity with others facing similar challenges.

Dr. Kaye and her husband began trying to conceive during residency, experiencing multiple pregnancy losses and rounds of IVF. Ultimately, they built their family through a combination of IVF, open adoption, and surrogacy. In sharing this story, Dr. Kaye emphasized their openness to discussing these experiences and the importance of normalizing conversations around diverse family-building paths.

These personal struggles ultimately led to advocacy for expanded fertility benefits. Strategic storytelling and coordinated advocacy with others successfully lead to the implementation of comprehensive fertility benefits for faculty and staff at her institution. Their efforts included:

TURNING GRIEF INTO ADVOCACY

- Writing about infertility and advocacy for both medical and general audiences.
- Organizing and mobilizing faculty and staff to share their experiences with HR.
- Demonstrating to institutional leadership, the impact of infertility on employees and their families.

Dr. Kaye has also been involved in state-level advocacy through Tennessee Fertility Advocates, lobbying for legislative expansion of fertility benefits. While progress has been made, Tennessee's current sociopolitical climate has prevented comprehensive, equitable fertility coverage at the state level. Recent efforts have shifted toward empowering individuals to push for change within their own workplaces, and Tennessee Fertility Advocates has provided tools to help employees advocate for fertility benefits at the institutional level, one workplace at a time.

Every journey is different, but the power of storytelling can drive change. Dr. Kaye recently wrote a piece for Good Morning America and included a photograph depicting her IVF journey. She concluded with these thoughts, "A picture is worth a thousand words… I've seen how there is more storytelling around pregnancy loss. And I think even in just the last five years, I've noticed a sea change of comfort, reduction in stigma and willingness of people to share those stories. Where I think we still need a lot more storytelling is from those in the trenches about what the experience of IVF is like, how grueling, how isolating how emotionally, physically, spiritually, existentially and financially devastating it can be. Because the more awareness around that experience, the more momentum there will be for research, advocacy and supportive interventions to better lift up and support those going through these really hard experiences."

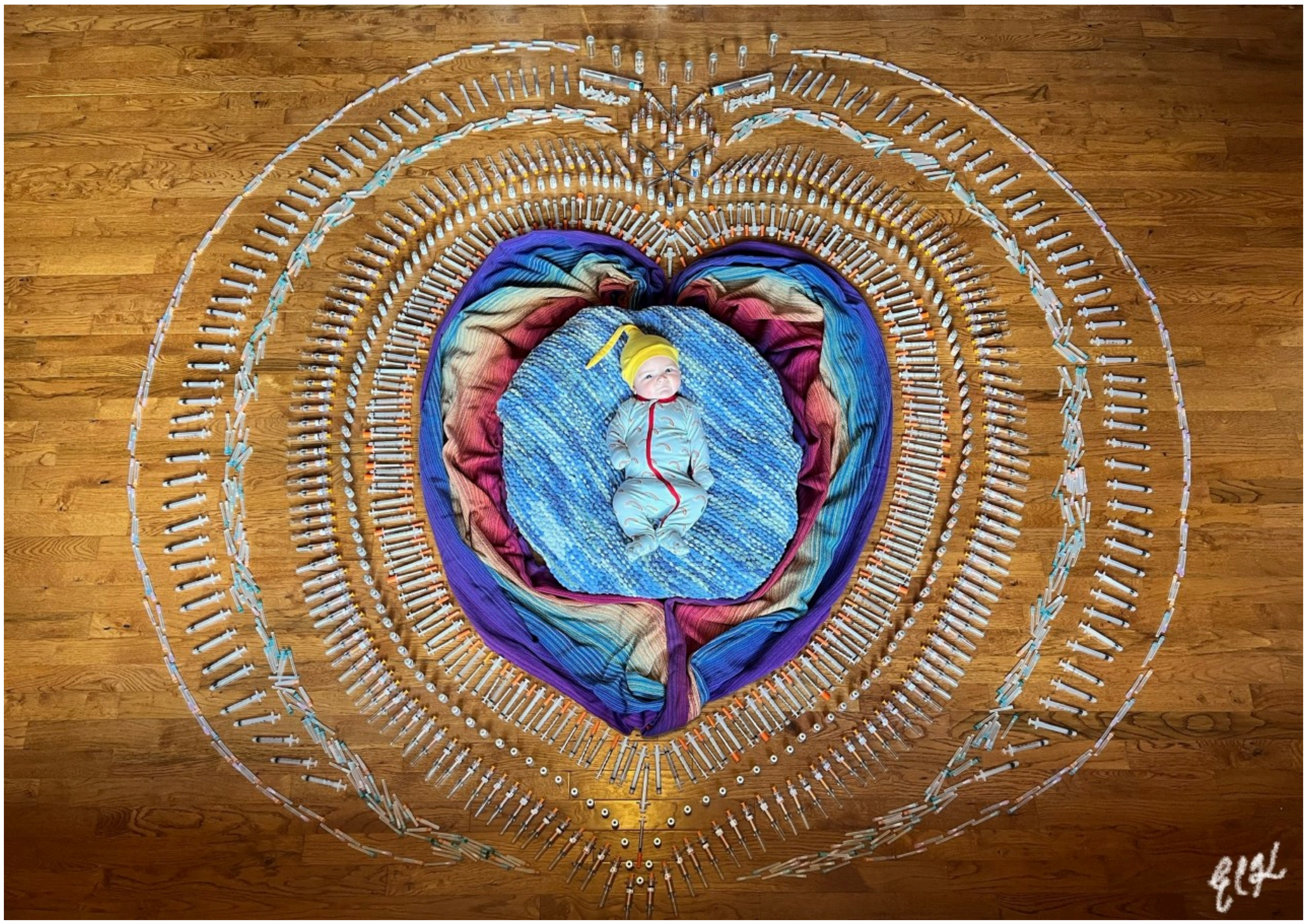

Photo courtesy of Dr. Erica Kaye

A MEDICAL STUDENT'S PATH TO EGG FREEZING

ALISA MALYAVKO, BS, MS
MS3 at George Washington University School of Medicine and Health Sciences

Alisa Malyavko shared her unconventional path to medical school and how her perspectives on family planning and work-life balance evolved over time. Her awareness of fertility preservation began early, influenced by her mother's unsuccessful IVF attempt. Learning about age-related fertility challenges during medical training further solidified her interest in egg freezing.

In July 2020, before starting medical school, she consulted Shady Grove Fertility but ultimately chose to delay the process, prioritizing her studies while remaining open to future options. In 2023, during a research year in orthopedic surgery, Ms. Malyavko attended conferences where women physicians candidly discussed infertility struggles. Inspired by a mentor's story, she revisited the idea of egg freezing and scheduled an appointment in March 2023. By chance, her cycle allowed her to begin treatment immediately, leading her to start the process the next day.

Ms. Malyavko described the physical and emotional challenges of undergoing fertility treatment. The daily injections became increasingly taxing despite her medical training, and side effects were more intense than expected. Fortunately, the timing aligned well, allowing her to complete treatment just before resuming rotations. She had ten mature eggs frozen, but she was advised to undergo a second round for better chances of success.

While Ms. Malyavko was fortunate to receive financial support from her parents, she acknowledged the high cost of egg freezing and the challenges of balancing it with medical training. She emphasized that fertility discussions are becoming more common among medical students and residents and encouraged those interested to explore their options. Ms. Malyavko concluded by stressing the importance of normalizing fertility preservation conversations and welcomed questions from those considering similar paths.

FERTILITY JOURNEY AND ADVOCACY

ARIELA MARSHALL, MD
Associate Professor of Clinical Medicine, University of Pennsylvania School of Medicine
Co-Chair, AMWA Fertility Advocacy Committee
Chair of Curriculum IGNITEMed

Dr. Ariela Marshall, a hematologist at Penn Medicine, shared her deeply personal journey with infertility and the challenges physicians face in family-building. As the first doctor in her family, she was unaware of the impact of prolonged medical training on fertility and assumed, based on her mother's experience of having a child at 40, that she would not face difficulties. Infertility was never discussed during her medical training, leaving her unprepared for the challenges ahead.

Dr. Marshall met her husband during residency, married at 32, and postponed family building until she was established as an attending. At 35, she and her husband began trying to conceive but soon realized they needed medical assistance. She was diagnosed with PCOS and hypothalamic amenorrhea, leading to multiple failed treatment attempts before moving to IVF.

Undergoing four IVF cycles over a year was a physically and emotionally grueling process. Due to PCOS, she had an excessive response to stimulation, causing multiple cycle cancellations. She described the highs and lows of these cycles—starting with hope and optimism, followed by setbacks such as failed cycles, declining embryo counts, and delays.

FERTILITY JOURNEY AND ADVOCACY

Dr. Marshall emphasized that infertility can be deeply isolating and finding a support system is essential. She found comfort in two colleagues who had been through IVF—one a mentor who had navigated the process years earlier, and another a peer who provided ongoing encouragement. While online fertility support groups exist, she cautioned that the overload of information can sometimes be overwhelming rather than helpful.

Her first embryo transfer failed, an experience she described as devastating. In March 2020, just before fertility clinics shut down due to COVID-19, she had the last embryo transfer performed at her clinic. The procedure was successful, and she later gave birth to her child—though she experienced severe postpartum complications, a separate challenge that she briefly mentioned.

Dr. Marshall turned her infertility struggles into a platform for change. She began researching the high prevalence of infertility among female physicians (1 in 4) and the unique challenges they face compared to the general population. This led her to write and advocate for increased awareness, insurance coverage, and institutional support, co-author an academic medicine paper calling for systemic reform, and be featured in The New York Times, amplifying the discussion on fertility and medical training.

Dr. Marshall emphasized that early awareness, institutional support, and systemic change are critical for physicians facing infertility. She advocates for proactive fertility education for medical trainees to encourage informed decision-making, more accessible fertility preservation options like egg and embryo freezing, and better workplace policies to support physicians undergoing infertility treatment.

FERTILITY PRESERVATION AND HEALTHCARE BARRIERS IN TRANSGENDER MEDICINE

PASQUALE PATRIZIO, MD, MBE, HCLD, FACOG
Professor and Chief, Division of Reproductive Endocrinology and Infertility
Department of OB/Gyn & Reproductive Sciences, University of Miami, Miller School of Medicine

Dr. Patrizio provided an overview of the transgender population in the U.S., noting that approximately 0.6% of adults, or 1.4 million individuals, identify as transgender. However, this figure does not account for minors, suggesting underestimation. The age of gender identity recognition varies, with 57% realizing their gender incongruence by age 15. The highest prevalence of transgender identification occurs between ages 18-24 (43% for trans men, 24% for trans women).

There are five major barriers to fertility preservation: (1) Lack of knowledge among both patients and healthcare providers, (2) Lack of time in medical visits to discuss options, (3) Limited resources for counseling and education, (4) Unclear referral pathways for patients seeking fertility preservation, and (5) High costs of procedures and limited insurance coverage.

Additionally, misuse of terminology remains a challenge. Proper language—such as referring to individuals as "transgender people" rather than "transgenders"—is essential for respectful and inclusive healthcare.

Comparing surveys from 2010 and 2015, there have been improvements in healthcare experiences for transgender individuals. The percentage of transgender patients needing to educate providers dropped from 50% to 24%. Reports of denied medical care decreased from 19% to 8%. Verbal harassment in medical settings declined from 28% to 6%. However, significant disparities remain, including higher risks of HIV (5x) and suicide (40%), underscoring the need for continued progress.

Fertility preservation should be discussed before initiating gender-affirming treatments. Guidelines from organizations such as the American Society for Reproductive Medicine (ASRM) and Endocrine Society emphasize the importance of reproductive counseling.

FERTILITY PRESERVATION AND HEALTHCARE BARRIERS IN TRANSGENDER MEDICINE

Available options include:

- For trans women: Semen freezing (established) and experimental spermatogonial stem cell cryopreservation.
- For trans men: Egg freezing, embryo freezing, and ovarian tissue freezing (now considered standard).

There are additional clinical considerations in fertility preservation for trans men. Testosterone therapy may need to be paused before ovarian stimulation, though protocols vary. Abdominal ultrasound is preferred over vaginal ultrasound for monitoring and retrieval to prevent gender dysphoria. Oocyte retrieval via the transabdominal route can be performed if a vaginal approach was declined.

The high cost of fertility preservation—ranging from $10,000-$20,000 in the U.S.—remains a major obstacle. Coverage varies widely. Some states provide Medicaid coverage for gender-affirming care. Others explicitly exclude transgender healthcare services. The lack of financial support forces many patients to take out loans or rely on personal savings.

Multidisciplinary care is needed, including psychologists and social workers to address mental health concerns, endocrinologists and reproductive specialists to provide fertility options, and surgeons for gender-affirming procedures.

Medical institutions must train staff on gender-affirming care and proper terminology, establish clear referral pathways for fertility preservation, and develop financial assistance programs to improve accessibility.

Fertility preservation is a critical aspect of transgender healthcare, and early discussions can prevent future regret. Healthcare providers must proactively educate, counsel, and advocate for policy changes to expand access. Resources are available from advocacy organizations to improve care for transgender patients.

MALE FERTILITY AND ENDOCRINE HEALTH

CRAIG NIEDERBERGER, MD, FACS
Clarence C. Saelhof Professor and Head, Department of Urology, UIC College of Medicine
Professor, Department of Bioengineering, UIC College of Engineering

Male infertility accounts for 50% of infertility cases worldwide, yet it remains underrepresented in medical discussions. Historically, infertility care has been female-focused, leaving gaps in male reproductive education and healthcare. Efforts are underway in andrology to increase awareness and integrate male fertility into mainstream medical discussions.

The male and female endocrine systems function similarly, though with different target organs. Testosterone converts to estradiol, which regulates negative feedback on the hypothalamic-pituitary axis. Despite this knowledge, male reproductive treatments lag behind, as most drugs have lost patent protection, reducing financial incentives for research. A multi-center FSH trial is currently underway, marking progress in male fertility treatment.

A key misconception is that testosterone supplementation improves fertility. In reality, exogenous testosterone suppresses testicular testosterone production, acting as an effective male contraceptive. Clinicians must avoid prescribing testosterone to men seeking fertility treatment.

Challenges exist in diagnosing male infertility. Semen analysis is an unreliable predictor of male fertility potential**.** The WHO manual provides reference ranges based on fertile couples but lacks meaningful data on infertile populations. Sperm morphology is also highly variable and technician-dependent, making it a poor predictor of fertility. In fact, intracytoplasmic sperm injection (ICSI) achieves similar success rates with abnormal sperm morphology. Testosterone levels do correlate strongly with infertility. Even men with normal sperm counts can have low testosterone levels, reinforcing the need for

MALE FERTILITY AND ENDOCRINE HEALTH

hormonal evaluation in fertility workups. It's important not to use the total testosterone but to calculate the bioavailable testosterone because testosterone binds to the sex hormone-binding globulin (SHBG). Male testosterone levels decline gradually with age, compounded by rising SHBG, which further reduces bioavailable testosterone. This decline has systemic effects, contributing to osteopenia and fractures (similar to postmenopausal bone loss), loss of muscle mass and metabolic changes, and cognitive decline and sexual dysfunction. Men with infertility also face increased risks of cancer, suggesting a broader cellular differentiation issue affecting overall health.

Key Takeaways

- Semen analysis alone is insufficient for diagnosing male infertility; endocrine parameters, particularly testosterone, provide more insight.
- Free testosterone tests are unreliable; instead, clinicians should measure SHBG and albumin and use online calculators for accurate testosterone levels.
- Male infertility is not just a sperm issue—it is a systemic health issue that requires a holistic approach to diagnosis and treatment.
- Testosterone therapy should never be prescribed for men seeking fertility treatment.
- Male infertility is associated with long-term health risks, including metabolic disorders, osteoporosis, and cancer, requiring ongoing monitoring.

PANEL 2: MAKE YOUR VOICE HEARD: INSIGHTS ON NEGOTIATION AND ADVOCACY

THE ROLE OF ORGANIZATIONAL ADVOCACY

MARCELLE CEDARS, MD
Professor and Director of Reproductive Endocrinology & Infertility
Director of Center for Reproductive Health, University of California, San Francisco

"Fertility advocacy matters...Personal stories from physicians and patients are crucial in influencing policymakers." ***- Dr. Marcelle Cedars***

Dr. Marcelle Cedars, a past president of the American Society of Reproductive Medicine (ASRM), emphasized the central role of advocacy in advancing fertility care and coverage. ASRM, for example, actively works to expand access to reproductive health services, both for its members and for patients. Yet the fragmented U.S. healthcare system presents significant challenges, with most Americans lacking insurance coverage for infertility treatments, which are often deemed elective.

Current Landscape of Infertility Coverage in the U.S.

- Employer-sponsored insurance covers over half of Americans, but fertility coverage is inconsistent.
- Medicaid (19%) and Medicare (18%) provide little to no fertility benefits.
- Direct purchase plans (ACA exchanges) offer mixed coverage.
- Tricare and military coverage remain limited, though recent efforts have expanded fertility benefits for veterans and active-duty personnel.

ASRM has successfully advocated for a 2023 federal mandate to cover fertility preservation for cancer and iatrogenic conditions for federal employees. A 2024 expansion will include fertility drugs and insemination.

THE ROLE OF ORGANIZATIONAL ADVOCACY

Since insurance regulation is largely state-driven, state-level efforts have proven more effective than federal initiatives. However, state political climates vary, with Republican-led states presenting greater challenges in passing fertility mandates.

Successful advocacy strategies have included:

- Building coalitions with organizations like RESOLVE, the Alliance for Fertility Preservation, and industry partners.
- Tailoring approaches to state-specific political and healthcare landscapes.
- Engaging professional lobbyists familiar with legislative processes.
- Investing in long-term efforts, as passing legislation often takes multiple sessions.
- Taking incremental wins, recognizing that small policy changes can lead to broader acceptance.

Opposition to fertility coverage primarily comes from employers and insurance companies, citing cost concerns; religious groups, opposing reproductive interventions; and legislators conflating fertility coverage with abortion and transgender care, necessitating clear messaging to separate these issues.

Cost remains a key argument against coverage, but ASRM has provided data-driven counterarguments by demonstrating actual costs of infertility treatment, highlighting workforce benefits (e.g., talent retention in tech companies), and comparing international policies, showing that fertility coverage is feasible in other high-income nations. Founded in 2021-2022, the ASRM Center for Policy and Leadership (CPRL) provides white papers and policy briefs used in advocacy efforts, talking points for meetings with legislators, insurers, and employers, and resources to support grassroots advocacy efforts.

Fertility advocacy matters. Public support for fertility coverage is increasing. Personal stories from physicians and patients are crucial in influencing policymakers. Even failed legislative attempts can shift the marketplace, encouraging private insurers to expand coverage. Raising awareness reduces stigma and normalizes conversations about infertility.

Advocacy is essential to expanding fertility coverage, influencing policy, and normalizing infertility as a medical condition. Together, we must push for legislative changes, educate policymakers, and empower patients to share their experiences.

STATE-LEVEL ADVOCACY FOR INFERTILITY INSURANCE COVERAGE

KERRY TIPPER
City Attorney, Denver City Attorney's Office

"...strategic bipartisan advocacy, personal storytelling, and data-driven arguments can lead to meaningful policy change." ***- Kerry Tipper***

Kerry Tipper shared her personal connection to infertility advocacy, highlighting that she became pregnant through IVF while working on Colorado's House Bill 1158, which established a state insurance mandate for infertility coverage. She emphasized the importance of state-level legislative efforts, noting that while the federal government is often stalled, state legislatures serve as "laboratories of democracy," where meaningful change can take root.

Key Factors in Colorado's Legislative Success

- Bipartisan Strategy: Despite a Democratic majority, bipartisan support was essential given a tight Senate balance and Republican filibuster threats.
- Personal Storytelling: Physicians, cancer survivors, veterans, and families affected by infertility shared their experiences, shifting hearts and minds of legislators.
- Addressing Misinformation: The insurance industry and some conservative legislators opposed the bill based on cost concerns and misconceptions about multiple births, requiring data-driven arguments to counter stereotypes.
- Engaging Skeptical Lawmakers: Some legislators privately expressed support despite being unable to vote in favor due to political pressures, reinforcing the need for continued advocacy.

STATE-LEVEL ADVOCACY FOR INFERTILITY INSURANCE COVERAGE

The Role of Coalition Building

- Grassroots mobilization empowered individuals to share their infertility experiences, fostering broader support.
- Veterans' stories highlighted gaps in coverage, even for those with service-connected disabilities.
- LGBTQ+ advocacy played a key role, especially given Colorado's governor's personal connection to fertility issues.

Overcoming Opposition: Insurance Industry & Cost Concerns

- The insurance industry was the primary opponent, citing potential cost increases. However, they failed to provide evidence of significant premium hikes in states with existing mandates.
- State comparisons (18 states had passed mandates at the time) helped normalize infertility coverage and provide cost data.
- The business case for coverage was emphasized, particularly as tech companies with fertility benefits attract top talent.

Key Lessons for Future Advocacy Efforts

- Leverage physician voices—the credibility of medical professionals is powerful in legislative settings.
- Invest in professional lobbying teams—ensuring bipartisan credibility helps build trust across the aisle.
- Take a long-term approach—policy change is a marathon, not a sprint, often requiring multiple legislative attempts.
- Recognize the marketplace effect—as more states pass fertility mandates, insurance companies may push for a federal standard to create uniformity.

The Colorado fertility mandate is a model for other states, proving that strategic bipartisan advocacy, personal storytelling, and data-driven arguments can lead to meaningful policy change. Grassroots efforts, legislative advocacy, and coalition-building can help expand fertility coverage nationwide.

MILITARY AND VETERAN ADVOCACY FOR INFERTILITY COVERAGE

TYLER AND CRYSTAL WILSON
Military Veteran and Caregiver

"...one voice can encourage many others to come forward."

- Tyler & Crystal Wilson

Crystal and Tyler Wilson shared their deeply personal journey with infertility, shaped by Crystal's endometriosis diagnosis in 2004 and Tyler's combat injuries in 2005, which left him paralyzed. When they sought fertility treatment through the VA, they were met with no coverage options, despite the direct connection between Tyler's injuries and their need for IVF.
Determined to change the system, they turned to advocacy, initially sharing their story on social media, which connected them with RESOLVE, Wounded Warrior Project, and Paralyzed Veterans of America.

The Long Road to Federal Policy Change

- In 2012, Senator Patty Murray introduced an IVF for Veterans bill, which faced multiple reintroductions before gaining traction.
- The Wilsons testified before Congress, met with legislators, and used media outlets to raise awareness.
- Storytelling became their most powerful tool, helping legislators see the real-life impact of infertility policies on wounded veterans.

The Wilsons paid $44,000 out-of-pocket for their first child, scraping together funds through grants, family support, and clinic discounts. They refused to accept that other veterans should face the same financial burden for a medical issue directly linked to service-related injuries. So began their advocacy journey.

MILITARY AND VETERAN ADVOCACY FOR INFERTILITY COVERAGE

There were particular challenges in military and VA fertility coverage. The VA's fertility coverage remains limited, requiring veterans to fit narrow criteria (heterosexual couples using their own gametes). Many veterans with severe combat injuries, such as lost reproductive organs, are excluded from coverage. Fertility preservation before deployment is now covered, but there is still no comprehensive federal policy for all affected veterans.

The Wilsons found that sharing their experience inspired others—both civilians and fellow service members—to speak up about infertility challenges. Legislators who were initially skeptical or opposed to fertility coverage changed their perspectives after hearing personal stories from constituents. Their advocacy extended beyond Washington, influencing state-level legislation in Colorado and helping to establish Colorado Fertility Advocates.

Lessons Learned in Advocacy

1. Make policymakers accountable—when meeting with legislators, use your name and story so they remember who they are voting for.
2. Engage physicians and clinics—doctors can connect advocates with other patients willing to share their experiences.
3. Build coalitions—organizations like RESOLVE and veterans' groups provide credibility and legislative expertise.
4. Prepare for the long fight—federal policy change is a marathon, requiring consistent pressure and coalition-building.
5. Address stigma—male veterans, in particular, often hesitate to discuss infertility, but one voice can encourage many others to come forward.

The Wilsons continue to push for expanded military and veteran infertility coverage, recognizing that while progress has been made, there is much work left to do. Their advocacy serves as a model for grassroots activism, proving that personal stories, persistence, and coalition-building can drive systemic change.

SUMMARY

BETSY CAMPBELL (MODERATOR)
Chief Engagement Officer, RESOLVE, The National Infertility Association

Betsy Campbell concluded the session by emphasizing the power of storytelling in advocacy, highlighting how sharing personal experiences can restore a sense of control in the often-unpredictable journey of infertility. She recognized Crystal and Tyler Wilson's impactful work in both Colorado and national veterans' advocacy, underscoring how one voice can ignite broader change.

Attendees were urged to begin advocacy within their own organizations, noting that many employers are unaware of gaps in family-building coverage until employees raise the issue. The AMWA-RESOLVE Coverage at Work Toolkit, developed in collaboration with the American Society for Reproductive Medicine (ASRM) is available through AMWA and provides resources and templates to help employees advocate for fertility benefits. Success stories demonstrate that even one individual's request can drive change in workplace coverage.

PANEL 3: SELF-CARE, MENTAL WELLBEING, AND YOUR REPRODUCTIVE LIFE JOURNEY

JESSICA BELL VAN DER WAL, MBA (MODERATOR)
CEO & Co-Founder
Frame Fertility

THE PSYCHOLOGICAL IMPACT OF INFERTILITY AND STRESS RESEARCH

ALICE DOMAR, PHD
Chief Compassion Officer, Inception
Director, Inception Research Institute
Associate Professor of Obstetrics, Gynecology, and Reproductive Biology
Harvard Medical School

"...women experiencing infertility report levels of anxiety and depression comparable to those with cancer, AIDS, or heart disease."

- Dr. Alice Domar

Dr. Domar, a leading researcher on stress and fertility for 37 years, highlighted the profound psychological impact of infertility. Research has shown that women experiencing infertility report levels of anxiety and depression comparable to those with cancer, AIDS, or heart disease. A study during the early COVID-19 pandemic found that patients still ranked infertility as an equal or greater source of stress than the pandemic itself. Yet despite decades of work demonstrating the emotional toll of infertility, broader awareness remains a challenge.

Why Patients Drop Out of Fertility Treatment

- Financial barriers are the top reason for discontinuing treatment in places without insurance coverage.
- In states like Massachusetts, where insurance covers up to six IVF cycles, stress—not cost—is the leading cause of dropouts.
- Procreation is a fundamental instinct, and the fact that stress can drive people to abandon treatment is a failure of the healthcare system.

A Call for Change: Caring for Patients, Not Just Treating Them

Dr. Domar urged fertility providers to shift from simply treating infertility to truly caring for patients, incorporating mental health support into fertility care to reduce dropout rates and improve patient well-being.

Does Stress Impact IVF Success?

While many believe stress negatively affects fertility, proving this scientifically is difficult due to the complex interactions of stress, infertility treatments, and medication effects. Prior research indicates that psychological interventions improve pregnancy rates, suggesting stress may influence fertility outcomes.

There is currently a study using OTO, a device measuring 54 physiological stress markers (e.g., cardiac reactivity, EEG, EKG) involving 240 women undergoing their first IVF cycle and tracking stress during the stimulation phase and frozen embryo transfer (FET). Results from this study are expected soon and aim to provide conclusive evidence on the link between stress and IVF success.

Mental healthcare plays a critical role in fertility care. There is a need for systemic changes to better support patients emotionally. Future findings may further validate stress reduction as a clinical strategy to improve reproductive outcomes.

INTEGRATING LIFESTYLE MEDICINE INTO FERTILITY CARE

RASHMI KUDESIA, MD, MSC, FACOG, DIPABLM
Director of Patient Education CCRM Fertility Houston
Assist. Clinical Professor
Houston Methodist Hospital

"Lifestyle medicine should be an integral part of fertility care, not just for patients with infertility but for all individuals seeking to optimize reproductive health." ***- Dr. Rashmi Kudesia***

Dr. Kudesia emphasized the importance of lifestyle medicine in fertility treatment, highlighting that evidence-based lifestyle interventions can empower patients and potentially reduce the need for intensive fertility treatments like IVF. Unlike traditional fertility care, which often relies solely on medications and procedures, lifestyle medicine offers patients greater autonomy over their reproductive health.

Dr. Kudesia outlined several critical questions driving her research and clinical approach:

1. Can lifestyle interventions reduce the need for fertility treatments in some cases?
2. Does pre-treatment lifestyle optimization improve IVF success rates?
3. Can lifestyle counseling enhance patients' quality of life and emotional resilience during treatment?
4. How does preconception health impact long-term health outcomes and epigenetics in offspring?

There are six pillars which show how lifestyle factors influence fertility.

- Nutrition: Whole-food, plant-based diets have been linked to improved egg and sperm quality.
- Physical Activity: Regular movement supports hormonal balance and metabolic health.
- Avoiding Toxins: Reducing alcohol, smoking, and environmental exposures supports fertility.
- Sleep: Essential for hormonal regulation and overall health.
- Stress Management: Chronic stress can impact ovulation, sperm health, and pregnancy outcomes.
- Social Connectedness: Having a strong support system improves emotional resilience.

Research supports the importance of lifestyle medicine. A major study from Australia found that preconception lifestyle changes significantly increase natural conception rates, underscoring the potential to reduce reliance on medical interventions. For conditions like polycystic ovary syndrome (PCOS), research shows that lifestyle interventions can improve ovulation rates and lead to faster, more successful pregnancies compared to immediate medical intervention. Dietary and lifestyle changes improve embryo quality, implantation rates, and overall IVF success. A whole-food, plant-based diet rich in fruits, vegetables, healthy fats, and lean proteins benefits both egg and sperm quality. Weight management, metabolic health, and stress reduction are key factors influencing fertility outcomes.

Some of the specific challenges for physicians include delayed childbearing due to career demands, logistical constraints, including long work hours and shift schedules, making conception timing difficult, workplace pressures to schedule pregnancies around training and career milestones, and limited fertility counseling within the medical profession, despite physicians being highly educated in healthcare.

Many physicians struggle with infertility as their first experience of "lack of control" over an outcome. High-achieving individuals often expect data-driven answers, but fertility science involves both art and evidence-based medicine. Skepticism toward lifestyle interventions is common, but research increasingly supports their impact on fertility.

There is a need for community spaces for physicians navigating infertility (such as AMWA's coaching program and physician fertility groups). Shifting the workplace culture to recognize that fertility treatments are not elective but essential medical care. Physicians must prioritize their own reproductive health rather than always putting patients and careers first. Lifestyle medicine should be an integral part of fertility care, not just for patients with infertility but for all individuals seeking to optimize reproductive health. By acknowledging and addressing the unique fertility challenges faced by physicians, the medical community can better support both patients and providers in their reproductive journeys.

REPRODUCTIVE IDENTITY

AURÉLIE ATHAN, PHD
Associate Professor of Research, Teachers College Columbia University

"...reproductive identity is a lifelong, evolving process shaped by personal experiences, cultural expectations, and systemic influences."
- Dr. Aurélie Athan

Dr. Aurélie Athan introduced the concept of reproductive identity, emphasizing that decision-making around parenthood is complex, fluid, and deeply personal. This framework builds on existing models of reproductive life planning, extending beyond the traditional "if, when, how" approach to also consider "who"—who we are as individuals, how we define our reproductive choices, and how external influences shape those choices.

Societal changes, medical advancements, and policy shifts have created a new era of reproductive decision-making, where individuals delay or opt out of parenthood, pursue nontraditional family-building paths, and navigate rising infertility rates.

Reproductive life planning (RLP) began in the 1960s with human rights movement and was originally framed around pregnancy prevention. Since that time, RLP has become integrated into the modern reproductive justice frameworks. It has expanded to include questions about desire, timing, personal values, and life goals: Do you want children? How would you feel if you were unable to have children? How do career, education, and relationships influence your decision? How do personal values, religion, and cultural beliefs shape your choices?

By broadening the discussion beyond contraception and family planning, reproductive identity allows individuals to navigate their fertility journey with greater self-awareness.

Challenges in Reproductive Identity Formation

- Lack of education: Fertility awareness is not integrated into standard sex education curricula, leaving many individuals unprepared for fertility-related decisions.
- The timing dilemma: People often do not actively consider reproductive choices until they face infertility or a reproductive crisis.
- Heteronormativity in reproductive planning: Discussions around family-building have historically excluded men and LGBTQ+ individuals, failing to capture the full spectrum of reproductive identities.
- Workplace and societal pressures: Individuals face bias and discrimination based on their reproductive choices, particularly in professional settings where parenthood may impact career progression.

Reproductive identity formation is a non-binary, spectrum-based process that fluctuates over time. Key dimensions include:

- Direction: A person's general inclination toward or away from parenthood.
- Intensity: The degree of certainty or ambivalence about reproductive desires.
- Centrality: How important reproductive identity is to one's overall sense of self.
- Fluidity: The ability to move between certainty and uncertainty over time.

By integrating reproductive identity into legislative and advocacy efforts, policymakers can better address the diverse needs of individuals navigating fertility challenges. Early reproductive education can empower individuals with fertility knowledge. Workplace policies should support diverse reproductive choices, including fertility preservation, parental leave, and pregnancy loss accommodations. Reproductive justice initiatives help ensure equitable access to fertility treatments and family-building resources.

Ultimately, reproductive identity is a lifelong, evolving process shaped by personal experiences, cultural expectations, and systemic influences. By acknowledging its complexity and integrating it into fertility care, education, and policy, individuals can navigate their reproductive journeys with greater autonomy and confidence.

PANEL 4: FERTILITY PERSPECTIVES: THE IMPACT OF DOBBS ON PATIENTS AND PRACTITIONERS

PERSONAL TESTIMONY ON THE IMPACT OF ABORTION BANS

DANI MATHISEN, MD
OB/GYN Resident

A current OB/GYN intern shared her deeply personal experience navigating restrictive abortion laws in Texas following the passage of SB8, which banned abortion after six weeks. During her anatomy scan, she and her medical team discovered that her daughter had multiple lethal fetal anomalies, with no chance of survival in utero or after birth.

Despite this devastating diagnosis, Texas law prevented her doctors from offering guidance or care options. Instead, her providers could only suggest seeking "an additional perspective" out of state, a veiled reference to leaving Texas for abortion care. With financial assistance from her family, she traveled to New Mexico to receive the necessary medical care, though she expressed how painful it was to be forced to seek treatment away from her own doctor, home, and support system.

Initially hesitant to share her story, she waited six months before speaking publicly due to discomfort with the stigma surrounding abortion. She would tell people that she had a miscarriage or a stillbirth, as that was an easier explanation. After the Dobbs decision, she realized that staying silent was no longer an option, emphasizing that speaking openly about abortion is a form of advocacy in itself. There is a power to sharing stories, especially when speaking to legislators. Her goal was to make at least one other abortion patient feel less alone—a mission that unexpectedly led to meeting President Biden, speaking at the Capitol, and becoming a national advocate for reproductive rights.

She urged others to speak up about abortion in all spaces, stating that normalizing conversations is essential to dismantling stigma. Her testimony highlighted the real-life consequences of restrictive abortion laws, reinforcing the urgent need for policy change and expanded access to comprehensive reproductive healthcare.

PHYSICIAN ADVOCACY AND THE IMPACT OF ABORTION BANS ON FERTILITY CARE

SERENA H. CHEN, MD
Division Director Reproductive Medicine, CBMC
Chief Advocacy Officer, IRMS CCRM NJ
Founder and VP, Doctors For Fertility NFP
Clinical Associate Professor, Rutgers NJ and Rutgers RWJ Medical Schools

Dr. Serena Chen co-founded Doctors for Fertility (DFF) to address barriers to fertility care and combat the impact of restrictive laws on reproductive medicine. DFF collaborates with ASRM and RESOLVE, while also engaging in legislative advocacy and political action to influence state and federal policies. A key focus is on fertility preservation and infertility treatment access, which remains out of reach for many Americans, including physicians themselves.

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The Dobbs decision has severely affected reproductive healthcare, including pregnancy management and IVF. The criminalization of medical procedures and vague legal language have left physicians uncertain about how to practice within new restrictions. In states like Texas, even discussing abortion options can be illegal, leading to a chilling effect on patient counseling. Many fertility clinics and providers now operate under legal uncertainty, with laws defining embryos as legal persons, restricting IVF embryo management and disposal.

Physician advocacy is crucial, but not all physicians feel comfortable or safe publicly advocating for abortion rights. These physicians can still engage in meaningful advocacy by speaking about the dangers of extreme government mandates in medicine, highlighting how restrictive laws contradict medical standards of care, and framing the issue around patient safety and physician autonomy rather than abortion itself.

Physicians must also become active in legislative discussions to prevent laws that criminalize standard medical practices. Many current reproductive laws are written without medical expertise, leading to policies that effectively legislate malpractice. Advocacy efforts must engage policymakers across party lines, emphasizing that these laws endanger patient care and provider autonomy. In many cases, behind-the-scenes lobbying and political action are necessary to reshape harmful legislation.

Physicians can also counter misinformation by being visible on social media, publicly discussing the medical realities of reproductive care, and advocating for policies that protect reproductive healthcare access. Every voice matters and protecting fertility and pregnancy care requires active participation from the medical community.

SUMMARY

DAVID ADAMSON, MD, FRCSC, FACOG, FACS (MODERATOR)
Founder and CEO, ARC Fertility
Clinical Professor, ACF, Stanford University
Associate Clinical Professor, University of California San Francisco

The Dobbs decision extends far beyond abortion, significantly impacting IVF, embryo management, and broader reproductive care. In addition, the misguided application of personhood laws, which equate embryos with fully developed individuals, fundamentally alters medical decision-making and patient autonomy. There have been many unintended consequences of abortion bans on reproductive healthcare; restrictive laws affect early pregnancy care and fertility treatments because lawmakers often fail to anticipate the full impact of their legislation on reproductive medicine. Advocacy and education are essential in ensuring access to comprehensive reproductive care in the U.S.

CURIOSITY AND CONNECTIONS: EXPERTS TO ANSWER YOUR QUESTIONS

AIMEE EYVAZZEDEH, MD, MPH
Host, The Egg Whisperer Show
Valerie Libby, MD, MPH
Board Certified OB/GYN
Reproductive Endocrinologist Shady Grove Fertility, Atlanta

AURÉLIE ATHAN, PHD
Associate Professor of Research, Teachers College Columbia University

CHRISTINA YANNETSOS, MD
Assistant Professor of Emergency Medicine
University of Colorado Anschutz Medical Campus

VRUNDA DESAI, MD, FACOG
Vice President, Medical Affairs, CooperSurgical
Adjunct Assoc. Professor of OB/GYN and Reproductive Sciences
Yale School of Medicine

Breakout sessions allowed individuals to ask specific questions on a variety of topics and gain insights from the Summit faculty.

PHYSICIAN FERTILITY SUMMIT 2023

June 17, 2023 | 12 – 4 pm ET

Introduction

Elizabeth Garner, MD, MPH
President, AMWA

The Landscape of Physician Fertility: Opportunities for Change

Torie Comeaux Plowden, MD, MPH
Director, REI Division, WRNMMC
Co-Chair, AMWA Physician Fertility Committee

Perspectives on Physician Fertility
Physician & Trainee Reflections, Egg Freezing, LGBTQ+ & Male Fertility

Ariela Marshall, MD
Assoc. Professor of Clinical Medicine
Co-Chair, AMWA Fertility Advocacy Committee, Chair of Curriculum IGNITEMed

Erica Kaye, MD, MPH
Assoc. Professor, Dept of Oncology; Director of Research, Quality of Life and Palliative Care Division, St. Jude Children's Research Hospital

Valerie Libby, MD, MPH
Board Certified OB/GYN Reproductive Endocrinologist Shady Grove Fertility, Atlanta

Alisa Malyavko, BS, MS
MS3 at George Washington University School of Medicine and Health Sciences

Christina Yannetsos, MD
Assist. Professor of Emergency Medicine, University of Colorado Anschutz Medical Campus

Craig Niederberger, MD, FACS
Clarence C. Saelhof Professor & Head, Dept. of Urology, UIC College of Medicine
Prof., Dept. of Bioengineering UIC College of Engineering

Pasquale Patrizio, MD, MBE, HCLD, FACOG
Professor & Chief, Div. of Repro. Endocrinology & Infertility, Dept. of OB/Gyn & Repro. Sciences Univ. of Miami, Miller SOM

Vrunda Desai, MD, FACOG
VP, Medical Affairs CooperSurgical; Adjunct Assoc. Professor of OB/GYN & Repro. Sciences, Yale SOM

Make Your Voice Heard: Insights on Negotiation and Advocacy

Marcelle Cedars, MD
Professor and Director of Reproductive Endocrinology & Infertility, UCSF; Director of Center for Reproductive Health, UCSF

Kerry Tipper
City Attorney, Denver City Attorney's Office

Tyler and Crystal Wilson
Military Veteran and Caregiver

Betsy Campbell
Chief Engagement Officer
RESOLVE: The National Infertility Association

Self-Care, Mental Wellbeing, and Your Reproductive Life Journey

Alice Domar, PhD
Chief Compassion Officer, Inception
Director, Inception Research Institute
Assoc. Professor of Obstetrics, Gynecology, and Reproductive Biology
Harvard Medical School

Rashmi Kudesia, MD, MSc, FACOG, DipABLM
Director of Patient Education
CCRM Fertility Houston
Assist. Clinical Professor
Houston Methodist Hospital

Aurélie Athan, PhD
Associate Professor of Research, Teachers College
Columbia University

Jessica Bell Van Der Wal, MBA
CEO & Co-Founder
Frame Fertility

Fertility Perspectives: The Impact of Dobbs on Patients and Practitioners

Serena H. Chen, MD
Division Director Reproductive Medicine, CBMC
Chief Advocacy Officer, IRMS CCRM NJ
Founder and VP, Doctors For Fertility NFP
Clinical Assoc. Professor, Rutgers NJ and Rutgers RWJ Medical Schools

Dani Mathisen, MD
OB/GYN Resident

David Adamson, MD, FRCSC, FACOG, FACS
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