Physicians suffer infertility too

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During residency, my colleagues and I used to joke about the fact that a full maternity leave was not supported by our benefits; however, neither were birth control pills. In retrospect I wonder if we joked because, like our benefits providers, we too did not want to acknowledge that fertility is a serious issue for female physicians. Turns out that our benefits providers were right—if you just ignore fertility, it *will* go away.

Because residency overlaps with most women's prime years for egg quality, we finish our training with tens, or hundreds, of thousands fewer eggs than we started with. This loss has significant consequences for our future family lives and emotional well-being. In an American study of 600 female physicians, 24.1% of those who had tried to conceive had been diagnosed with infertility, at an average age of 33.7 years.[1] The diagnosis and subsequent treatment of infertility is another potential stressor for female physicians, who are already at higher risk of burnout than their male colleagues as a result of challenges with work–life integration and gender bias.[2]

And it's not only the time lost and stressful working conditions that might harm female physicians' fertility. An article published in *JAMA Surgery* earlier this year highlighted the increased rates of infertility (32.0% versus 10.9%) and pregnancy complications (35.3% versus 14.5%) that affect female surgeons compared to the general population.[3,4] These rates were attributed to the reproductive hazards encountered in the operating room, including sharps injury, intraoperative use of toxic agents, and exposure to radiation, surgical smoke, and anesthetic gases.[4] The authors concluded that remediation of this issue should focus on "controlling exposure rather than restricting surgeons' activity."[4]

In another recent article, "Physician fertility: A call to action," a group of female physicians with personal experiences of infertility decried the lack of institutional policies, insurance coverage, and leave for female physicians seeking fertility treatment.[5] "Fertility should not be a factor that limits women's engagement in the medical workforce," they wrote, pointing out the critical importance of women in medicine, a fact supported by a study of 1 583 028 hospitalizations in which female internists had better mortality and readmission outcomes than their male counterparts.[5]

So, data show that infertility is prevalent—in both our practices and personal lives. We can take steps to address this by raising awareness, educating our trainees, and working to reduce the societal stigma of infertility.

This is the third issue of the *BC Medical Journal* in which I have had the privilege of being guest editor to discuss fertility. In May and June 2018, the journal published articles on infertility, polycystic ovary syndrome, fertility preservation, diabetes in pregnancy, prenatal screening, and recurrent miscarriage. This month's issue contains a two-part review of optimizing natural fertility, which addresses some of patients' most common fertility questions pertaining to lifestyle (exercise, weight, coital practices, pesticides) and environmental toxins (plastics, smoking, cannabis, caffeine, alcohol). The third article in this issue reviews donor egg pregnancy, which is becoming an increasingly popular choice for women who cannot conceive with their own eggs. Thank you to all our readers for caring about the issue of infertility and participating in the conversation. ■

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