Infertility among physicians

Infertility affects 24% to 33% of physicians—which is significantly higher than the 12% rate in the general population.[1] A 2024 review on physician infertility highlighted that while many health care workers face challenges like delayed family planning, arduous schedules, and workplace exposures, infertility rates are uniquely high among physicians.[1] Key concerns include financial pressures and the conflict between career demands and family building. Duty hours and the length of medical training are major factors in childbearing decisions.[1,2]

Many related studies have focused on surgeons, who have some of the longest residencies and most physically demanding jobs. A *JAMA Surgery* study found that female surgeons were nearly twice as likely as nonsurgeon partners of male surgeons (48% versus 27%) to experience pregnancy complications, even after controlling for age, work hours, in vitro fertilization use, and multiple gestation.[3]

In a survey of 4533 female physicians, 28% had undergone fertility treatment and 41% had experienced miscarriage. Female surgeons were older at first pregnancy and had fewer children and more preterm births than those in other medical specialties.[4] The study called for culture change to make workplaces more supportive of pregnancy and outlined initiatives that can be taken at all levels of a physician's career to improve fertility and make pregnancy less risky. The infographic in the study may be useful if you're seeking pregnancy or supervising physicians of reproductive age.[4]

The faces of infertility are as varied as physicians themselves—including women, men, transgender physicians, those with a same-sex partner, and individuals having babies on their own. Despite persistent stigma, it's crucial to recognize that infertility is *not* just a women's problem.

The American Society for Reproductive Medicine has updated the definition of *infertility* to reflect modern experiences. It now refers to the "inability to achieve a successful pregnancy based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors" and specifically includes the use of donor gametes and pregnancy as an individual or with a partner.[5]

Despite being a wide-reaching problem, women, or people with ovaries, may bear a disproportionate burden of infertility. Already at a higher risk of burnout and gender bias than their male colleagues, they also face the logistics of seeking fertility treatment. For example, scheduling early morning monitoring for in vitro fertilization can be difficult on operating room days, and pregnancy complications are unpredictable. Training programs and schedulers are not always accommodating, and even in supportive group practices, woman physicians may feel guilt about inconveniencing their colleagues.[4]

Canadian Fertility Awareness Week is 20–26 April 2025. Consider taking a moment to reflect on the impact of infertility in our profession and who around you might be struggling silently. I have previously written in the *BCMJ* on infertility topics, including infertility workup [2019;60:203-209], donor eggs [2020;62:328-332], egg freezing [2016;58:573-577], ectopic pregnancy [2021;63:112-116], and male infertility [2022;64:126-130]. There are many more resources available from the Canadian Fertility Andrology Society and the American Society for Reproductive Medicine. Starting a conversation or sharing resources can be a powerful step in breaking the stigma. ■

—Caitlin Dunne, MD, FRCSC

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Death by typographical error?

Our work as physicians has many challenges, and I'm sure we all have lists of pet peeves related to it. The administrative burden and long work hours would probably be near the top of the list, followed closely by poor work–life balance, difficult patient encounters, and difficult patients.

The administrative burden is something that requires system change, and I will not attempt to solve that on this page. I once used long work hours to avoid going home, but I don't need to do that anymore. I devoted a previous editorial to this topic [*BCMJ* 2023;65:278,287]. A healthy work–life balance is still a work in progress for me and probably will be for the foreseeable future.

Difficult patient encounters may be influenced by both patient and physician factors. I am guilty of often running behind schedule. Many patients understand that one or more patients ahead of them required more of my time than was budgeted for, but some patients, in their impatience, forget too quickly that they once benefited from my extra time, care, and attention. They will often express anger toward my staff but be very pleasant toward me. We have instituted a zero-tolerance policy for this type of behavior. When my staff bring this to my attention, I will offer the patient a chance to apologize to my staff or face being fired from my practice. I would rather lose one patient than one member of our amazing office staff.

We all have difficult patients. They come in all shapes and sizes. Some may be manipulative, dependent, lonely, or too embarrassed or afraid to ask the question most important to them. All these challenges have been increasing over many years but seem considerably worse in the last few years.

Since the pandemic, patients seem to be more anxious about their health. There seems to be a higher level of somatization in general, with patients presenting with a long list of vague and unrelated symptoms. This leads to longer consultations, more ordering of tests, and more referrals to specialists. Although the public still has a high level of trust in physicians, according to the Canadian Medical Association 2025 health and media annual tracking survey, they are also very likely to be exposed to health misinformation.[1]

Before a patient comes to see us, they have often researched their symptoms online, including on various social media sites. The veracity of their information seems less important to them. Several factors are in play here. Many patients do not have a family physician, and those who do will often wait weeks to get in to see them. It is becoming more arduous, time-consuming, and frustrating to counteract their health misinformation. I love the saying "Please do not confuse your Google search with my medical degree." Unfortunately, many patients put more stock in their online search than their physician's knowledge and experience.

Between their online search and getting in to see their physician, patients will often have been influenced by misinformation.

Between their online search and getting in to see their physician, patients will often have been influenced by misinformation. They have often made a diagnosis and started some form of treatment, which may not be in their best interest and may be opposite to the treatment they require. I am concerned that, sooner or later, someone will die because they mixed up medical terms in their online search. They may confuse hypertension with hypotension, hyperthyroid with hypothyroid, melasma with melanoma, colposcopy with colonoscopy, or exacerbation with exasperation. In completing their certification of death form, I may have to enter a cause of death of "Death by typographical error." ■

—David B. Chapman, MBChB

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