Resolution: 1
(November 2022)

Introduced by: Albert L. Hsu, MD

Subject: Encouraging discussion of family-building plans and pre-conception counseling with all individuals, as part of United States Preventive Services Task Force recommended routine health maintenance

Referred to: YPS Reference Committee

Whereas, According to several organizations, for couples in which the female partner is under 35 years of age, “infertility is a disease historically defined by the failure to achieve a successful pregnancy after 12 months or more of regular, unprotected sexual intercourse;” 1 and

Whereas, Infertility affects 10-15% of couples,2 but affects approximately 25% of female physicians, with the rate of female physicians seeking fertility evaluation and treatment at six times higher than that of the general population; 3,4,5 and

Whereas, Women of advanced maternal age have increased risks of adverse pregnancy outcomes, including lower chances of live birth and increased risks of miscarriage and birth defects; 6 and

Whereas, The peak child-bearing years unfortunately correspond to the peak career-building years for many; and

Whereas, According to the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine, “the goal of pre-pregnancy care is to reduce the risk of adverse health effects for the woman, fetus, and neonate by working with the woman to optimize health, address modifiable risk factors, and provide education about healthy pregnancy;” 7 and

Whereas, “Pre-pregnancy counseling is appropriate whether the reproductive-aged patient is currently using contraception or planning pregnancy. Because health status and risk factors can change over time, pre-pregnancy counseling should occur several times during a woman’s reproductive lifespan, increasing her opportunity for education and potentially maximizing her reproductive and pregnancy outcomes;” 7 and

Whereas, “Many chronic medical conditions such as diabetes, hypertension, psychiatric illness, and thyroid disease have implications for pregnancy outcomes, and should be optimally managed before pregnancy;” 7 and

Whereas, “Male infertility may occasionally be the presenting manifestation of an underlying life-threatening condition,” and so the evaluation of the infertile male includes identification of “life- or health-threatening conditions that may underlie… fertility or associated medical comorbidities that require medical attention;” 8 and

Whereas, “The burden of infertility includes psychological, social and physical suffering. Documented consequences include: anxiety, depression, lowered life satisfaction, grief, fear,
guilt, helplessness, reduced job performance, marital duress, dissolution and abandonment;

economic hardship, loss of social status, social stigma, social isolation and alienation,
community ostracism, and physical violence;” 9, 10, 11, 12 and

Whereas, The consequences of unwanted childlessness can “vary considerably, from an almost
universal decrease in well-being in infertile individuals, to significant emotional and
psychological effects, disruption in social relationships and, at the severe end of the spectrum,
death due to domestic violence, suicide or starvation and disease exacerbated by neglect;” 9, 10
and

Whereas, “It is often argued that public resources should not be used to help infertile couples
reproduce when the planet is already home to a huge (and growing) population which may not
be able to be sustainably supported,” but this overpopulation argument “denies the importance
of reproductive autonomy and distributes social responsibility for population pressures unfairly
on the infertile;”; 9,10 and

Whereas, “Infertility is often denied classification as a public health issue because of concerns
over the cost of treatment,” but cost-effective and creative solutions to infertility (such as
preventing STIs) are potentially available, and infertility treatment should be considered part of
international efforts to promote women’s reproductive health;10 and

Whereas, The discipline of public health can should be used to address infertility, by raising
awareness of the scope and significance of unwanted childlessness, improving collection and
surveillance of health data, generating informed public debate, and developing public policies on
infertility and its treatment;

Whereas, The U.S. Preventive Services Task Force13 works to improve the health of people
nationwide by making evidence-based recommendations about clinical preventive services;
therefore, be it

RESOLVED, That our AMA work with other interested organizations to advocate for the United
States Preventive Services Taskforce to encourage discussion of family-building plans and pre-
conception counseling with all individuals starting at age 30, as part of routine health
maintenance (Establish New HOD Policy).

Fiscal note: TBD

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Relevant AMA Policy:
Preconception Care H-425.976
1. Our AMA supports the 10 recommendations developed by the Centers for Disease Control
and Prevention for improving preconception health care that state:

(1) Individual responsibility across the lifespan--each woman, man, and couple should be
encouraged to have a reproductive life plan;
(2) Consumer awareness--increase public awareness of the importance of preconception health
behaviors and preconception care services by using information and tools appropriate across
various ages; literacy, including health literacy; and cultural/linguistic contexts;
(3) Preventive visits--as a part of primary care visits, provide risk assessment and educational
and health promotion counseling to all women of childbearing age to reduce reproductive risks
and improve pregnancy outcomes;
(4) Interventions for identified risks--increase the proportion of women who receive interventions as follow-up to preconception risk screening, focusing on high priority interventions (i.e., those with evidence of effectiveness and greatest potential impact);
(5) Inter-conception care--use the inter-conception period to provide additional intensive interventions to women who have had a previous pregnancy that ended in an adverse outcome (i.e., infant death, fetal loss, birth defects, low birth weight, or preterm birth);
(6) Pre-pregnancy checkup--offer, as a component of maternity care, one pre-pregnancy visit for couples and persons planning pregnancy;
(7) Health insurance coverage for women with low incomes--increase public and private health insurance coverage for women with low incomes to improve access to preventive women’s health and pre-conception and inter-conception care;
(8) Public health programs and strategies--integrate components of pre-conception health into existing local public health and related programs, including emphasis on inter-conception interventions for women with previous adverse outcomes;
(9) Research--increase the evidence base and promote the use of the evidence to improve preconception health; and
(10) Monitoring improvements--maximize public health surveillance and related research mechanisms to monitor preconception health.

2. Our AMA supports the education of physicians and the public about the importance of preconception care as a vital component of a woman’s reproductive health.

3. Our AMA supports the use of pregnancy intention screening and contraceptive screening in appropriate women and men as part of routine well-care and recommend it be appropriately documented in the medical record.

Recognition of Infertility as a Disease H-420.952
Our AMA supports the World Health Organization’s designation of infertility as a disease state with multiple etiologies requiring a range of interventions to advance fertility treatment and prevention.

Resident and Fellow Access to Fertility Preservation H-310.902
Our AMA: (1) encourages insurance coverage for fertility preservation and infertility treatment within health insurance benefits for residents and fellows offered through graduate medical education programs; and (2) supports the accommodation of residents and fellows who elect to pursue fertility preservation and infertility treatment, including but not limited to, the need to attend medical visits to complete the gamete preservation process and to administer medications in a time-sensitive fashion.

4.2.1 Assisted Reproductive Technology
Assisted reproduction offers hope to patients who want children but are unable to have a child without medical assistance. In many cases, patients who seek assistance have been repeatedly frustrated in their attempts to have a child and are psychologically very vulnerable. Patients whose health insurance does not cover assisted reproductive services may also be financially vulnerable. Candor and respect are thus essential for ethical practice.

“Assisted reproductive technology” is understood as all treatments or procedures that include the handling of human oocytes or embryos. It encompasses an increasingly complex range of interventions—such as therapeutic donor insemination, ovarian stimulation, ova and sperm retrieval, in vitro fertilization, gamete intrafallopian transfer—and may involve multiple participants.

Physicians should increase their awareness of infertility treatments and options for their patients. Physicians who offer assisted reproductive services should:
(a) Value the well-being of the patient and potential offspring as paramount.
(b) Ensure that all advertising for services and promotional materials are accurate and not misleading.
(c) Provide patients with all of the information they need to make an informed decision, including investigational techniques to be used (if any); risks, benefits, and limitations of treatment options and alternatives, for the patient and potential offspring; accurate, clinic-specific success rates; and costs.
(d) Provide patients with psychological assessment, support and counseling or a referral to such services.
(e) Base fees on the value of the service provided. Physicians may enter into agreements with patients to refund all or a portion of fees if the patient does not conceive where such agreements are legally permitted.
(f) Not discriminate against patients who have difficult-to-treat conditions, whose infertility has multiple causes, or on the basis of race, socioeconomic status, or sexual orientation or gender identity.
(g) Participate in the development of peer-established guidelines and self-regulation.

References:

