AMERICAN MEDICAL ASSOCIATION ORGANIZED MEDICAL STAFF SECTION

Resolution: 6
(I-25)

Introduced by: Albert L. Hsu, MD

Subject: "Ethical IVF" and "Restorative Reproductive Medicine"

Referred to: OMSS Reference Committee
(xxxx, MD, Chair)

Whereas, restorative reproductive medicine (RRM) is a selective rebranding of certain medical practices in ways that mislead patients and threaten access to timely, effective fertility care including in virto fertilization (IVF); and

Whereas, some organizations suggest that RRM is a safer and more effective alternative to evidence-based infertility treatments; and

Whereas, the Arkansas legislature has passed, and the U.S. Congress has introduced, legislation that would codify RRM coverage in statute and refers to IVF as "suppressive" or "circumventive" to natural fertility[1,2]; and

Whereas, Board-certified physicians providing infertility assessment and treatment are trained to provide a comprehensive assessment of patients' medical, surgical, and family histories and social determinants of health as the standard of care to optimize wellness and fertility and pregnancy outcomes; and

Whereas, while some symptoms of some infertility-associated conditions such as polycystic ovary syndrome (PCOS), endometriosis, and erectile dysfunction can be improved through attention to diet and lifestyle, medical and technological intervention may be necessary for successful pregnancy with these conditions; and

Whereas, other fertility-associated conditions such as azoospermia, bilateral tubal blockage, and uterine agenesis are treatable only with medical and technological intervention; and

Whereas, delays in accessing evidence-based fertility treatments such as IVF can further exacerbate age-related infertility; and

Whereas, in the spirit of patient autonomy, it is reasonable to offer the techniques recommended by RRM and/or holistic medicine to all patients, as some patients have moral, religious, or ethical concerns regarding IVF; and

Whereas, "both in nature and in the laboratory, only a minority of fertilized eggs result in live birth;"[3] and

Whereas, "not all IVF embryos are of adequate quality for transfer, and most transferred embryos result in negative pregnancy test results or miscarriages and, rarely, ectopic pregnancies;"[3] and

Whereas, “efforts to apply a religious and moral lens to regulate and interfere with the practice of IVF on the basis of a mistaken perception that all fertilized eggs are early human beings, would make standard-of-care IVF practice impossible;”[3] and

Whereas, “by equating all fertilized eggs with live-born children, the broadly worded measures in ‘Personhood’ bills would consign fertility patients to less effective treatments;”[3] and

Whereas, RRM has been proposed as a holistic approach that “restores fertility” by treating underlying issues with some claiming that its success rates are as good as IVF, however there is no evidence that RRM can match the effectiveness of IVF and other reproductive technologies and studies show no proof that it is an equally-effective alternative to conventional fertility treatments; and

Whereas, much of what is proposed in RRM is part of a standard fertility workup, including optimizing preconception health; and

Whereas, many backers of RRM oppose IVF on moral or religious grounds, such as certain belief about embryos, and RRM is fueled by an anti-IVF and anti-abortion agenda; and

Whereas, over 12 million babies have been born via IVF worldwide and IVF is backed by rigorous research, constantly improving techniques, and decades of data and success; and

Whereas, for many patients, IVF offers the highest chances of pregnancy per cycle, as well as the opportunity to cryopreserve embryos for future fertility; and

Whereas, over 95 percent of IVF pregnancies result in singletons (due to efforts to promote single embryo transfer) reducing the risks of preterm birth; and

Whereas, over intense initial opposition, IVF has transformed reproductive care over the past fifty years; and

Whereas, our American Medical Association is committed to safeguarding public health infrastructure and maintaining the integrity of evidence-based medicine; therefore be it

RESOLVED, that our American Medical Association oppose any efforts to limit patient access to the full scope of evidence-based fertility treatments, including but not limited to in vitro fertilization (IVF), intrauterine insemination (IUI), and third-party reproduction (New HOD Policy); and be it further

RESOLVED, that our AMA continue to advocate for increased NIH funding for women’s health, including reproductive health, to expand research on the potential underlying causes of infertility (Directive to Take Action); and be it further

RESOLVED, that our AMA acknowledge that practices considered “restorative reproductive medicine” constitute part of what reproductive endocrinology and infertility physicians, urologists, and other fertility specialists regularly provide through patient-centered evaluation and individualized treatment of underlying conditions (New HOD Policy); and be it further

RESOLVED, that our AMA acknowledge that intrauterine insemination (IUI) in vitro fertilization (IVF), and third-party reproduction, including egg donation, sperm donation, embryo donation, and the use of gestational carriers, are important parts of the comprehensive, evidence-based

infertility treatment options that should be offered to patients and may sometimes be the most successful option for family-building for many patients (New HOD Policy); and be it further

RESOLVED, that our AMA work with other interested organizations to publicize that the "restorative reproductive medicine" (RRM) movement may be unhelpful for some fertility patients because:

1. The RRM movement is derailing momentum and siphoning resources from efforts to expand access to fertility care, such as state insurance mandates for cancer cryopreservation and state mandates for the diagnosis and management of infertility, including in vitro fertilization (IVF); and
2. RRM is anti-IVF at its core and some individuals and couples will require gamete cryopreservation for cancer and other indications, embryo cryopreservation, IVF, and third-party reproduction; and
3. For some patients, RRM will hinder access to effective treatments such as IVF by favoring less successful therapies; and
4. RRM has no answer for the utilization of oocyte cryopreservation for fertility preservation for cancer patients and other iatrogenic causes of infertility;

(Directive to Take Action); and be it further

RESOLVED, that our AMA work with other interested organizations to publicize that "ethical IVF" is a misnomer and generally unhelpful for many fertility patients because:

1. "Ethical IVF" is an insidious marketing and branding tool used to imply that anyone who opposed their point of view in inherently unethical; and
2. "Ethical IVF" is a heteronormative construct that would take us back to IVF treatments from the 1980s which had low success rates; and
3. "Ethical IVF" specifically promotes fertilizing one oocyte at a time, which will drive up costs and thereby lower the likelihood that patients will expand their families due to financial barriers; and
4. "Ethical IVF" fails to appreciate that over half of embryos, both in nature and in the embryology laboratory, will not result in a live birth as those embryos will rather result in miscarriages, stillbirths, ectopic pregnancies, or negative pregnancy tests; and
5. "Ethical IVF" opposed cryopreservation of embryos, which will encourage transfer of more embryos than recommended by national standards increasing the risk of potentially dangerous multiple pregnancies; and
6. For some patients, "Ethical IVF" will delay treatments, reduce success rates, drive up costs, and hinder access to fertility treatments; and
7. The "Ethical IVF" movement is derailing momentum for expanding access to fertility care;

(Directive to Take Action); and be it further

RESOLVED, that our AMA work with other interested organizations to oppose and denounce efforts to apply an ideological lens of "embryo personhood" arguments to restrict in vitro fertilization and other assisted reproductive technologies with a report back at the 2026 Interim Meeting (Directive to Take Action); and be it further

RESOLVED, that our AMA reaffirm its policies to support fertility preservation, third-party reproduction, and access to in vitro fertilization (Reaffirmation); and be it further

RESOLVED, that our AMA-OMSS immediately forward this resolution to the American Medical Association House of Delegates for consideration at the 2026 Interim Meeting (Directive to Take Action).

Fiscal Note: (Assigned by HOD)

Received: 10/3/2025

REFERENCES

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2. RESTORE Act, S. 1882, 119 Congress. (2025). https://www.congress.gov/bill/119th-congress/senate-bill/1882
3. Hsu AL, Carr EJ, Losch J, Crockin S, Parry JP. In defense of in vitro fertilization: time to get involved in state-level advocacy! *Fertil Steril*. 2024 Dec;122(6):977-982. doi: 10.1016/j.fertnstert.2024.10.018. Epub 2024 Oct 22. PMID: 39442684.
4. ASRM.org: "How Restorative Reproductive Medicine violates Reproductive Autonomy and Informed Consent," at https://www.asrm.org/news-and-events/asrm-news/press-releasesbulletins/fertility-and-sterility-publishes-editorial-piece-on-how-restorative-reproductive-medicine-violates-reproductive-autonomy-and--informed-consent/
5. ASRM.org: "ASRM Primed Cohort Members Meet with Congressional Offices to Advocate for IVF Access and Educate About Realities of Restorative Reproductive Medicine, at https://www.asrm.org/news-and-events/asrm-news/press-releasesbulletins/asrm-primed-cohort-membersincluding-physicians-providers-and-expertsmeet-with-congressional-offices-to-advocate-for-ivf-access--educate-about-realities-of-restorative-reproductive-medicine/
6. ASRM.org: "ASRM Hosts Capitol Hill Briefing for Policymakers – Congressional Staff to Hear from Providers and Patients About Importance of IVF Access – Realities and Limitations of Restorative Reproductive Medicine," at https://www.asrm.org/news-and-events/asrm-news/press-releasesbulletins/asrm-hosts-capitol-hill-briefing-for-policymakers--congressional-staff-to-hear-from-providers--patients-about-importance-of-ivf-access-realities-and-limitations-of-restorative-reproductive-medicine/
7. ASRM.org: "SRS Warns Against Limiting Access to IVF Under the Guise of Restorative Care," at https://www.asrm.org/news-and-events/asrm-news/press-releasesbulletins/srs-warns-against-limiting-access-to-ivf-under-the-guise-of-restorative-care/
8. Seifer DB, Feinberg EC, Hsu AL. Ovarian Aging and Fertility. *JAMA*. 2024 Nov 26;332(20):1750-1751. doi: 10.1001/jama.2024.18207. PMID: 39470648.

RELEVANT AMA POLICY

Protecting Access to IVF Treatment D-425.989

1. Our American Medical Association opposes any legislation or ballot measures that could criminalize in-vitro fertilization.
2. Our AMA will work with other interested organizations to oppose any civil or criminal legislation or ballot measures or court rulings that would:
    a. equate gametes (oocytes and sperm) or embryos with children; and/or
    b. otherwise restrict or interfere with evidence-based care for Assisted Reproductive Technology (ART).
3. Our AMA, through the AMA Task Force to Preserve the Patient-Physician Relationship, will report back at I-24, on the status of, and AMA's activities surrounding, proposed ballot measures or legislation and pending court rulings, that would:
    a. equate gametes or embryos with children; and/or
    b. otherwise restrict or interfere with evidence-based care for Assisted Reproductive Technology (ART).

Citation: Res. 217, A-24

Infertility and Fertility Preservation Insurance Coverage H-185.990

1. Our American Medical Association advocates for third-party payer health insurance carriers, as well as state and federal initiatives to make available insurance benefits for the diagnosis and treatment of recognized infertility and for reproductive and family planning purposes.
2. Our AMA supports payment for fertility preservation therapy services by all payers including when infertility may be caused directly or indirectly by necessary medical treatments.

Citation: Res. 150, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Appended: Res. 114, A-13; Modified: Res. 809, I-14; Appended: Res. 012, A-22; Modified: Res. 224, I-22; Modified: Res. 101, A-24

Resident and Fellow Access to Fertility Preservation H-310.902

1. Our American Medical Association encourages insurance coverage for fertility preservation and infertility treatment within health insurance benefits for residents and fellows offered through graduate medical education programs.
2. Our AMA 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.

Citation: Res. 302, A-22

Increased Education and Access to Fertility Resources for U.S. Medical Students H-295.846

1. Our American Medical Association will encourage interested parties to develop gender- and sexual minority-inclusive initiatives in medical education that raise awareness about:
    1. how peak child-bearing years correspond to the peak career-building years for many medical students and trainees;
    2. the significant decline in oocyte quality and quantity and increase in miscarriage and infertility rates, with increasing age in medical students and trainees;
    3. the high rate of infertility among medical students, trainees, and physicians; and
    4. various fertility preservation options and including cryopreservation of oocytes and sperm and associated costs.
2. Our AMA will encourage interested parties to increase access to strategies by which medical students can preserve fertility (such as cryopreservation of oocytes, sperm, and embryos), with associated mechanisms for insurance coverage.

Citation: Res. 306, A-23

Infertility Benefits for Veterans H-510.984

1. Our American Medical Association supports lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries.
2. Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries.
3. Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process.
4. Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries.
5. Our AMA supports additional research to better understand whether higher rates of infertility in servicewomen may be linked to military service, and which approaches might reduce the burden of infertility among service women.
6. Our AMA will work with interested organizations to encourage TRICARE to cover:
    1. Fertility preservation procedures (cryopreservation of sperm, oocytes, or embryos) for medical indications, for active-duty military personnel and other individuals covered by TRICARE.
    2. Gamete preservation for active-duty military personnel and activated reservist military personnel.
7. Our AMA supports expansion of reproductive health insurance coverage to all active-duty service members and veterans eligible for medical care regardless of service-connected disability, marital status, gender or sexual orientation.

Citation: CMS Rep. 01, I-16; Appended: Res. 513, A-19; Appended: Res. 101, A-22; Appended: Res. 801, I-22; Reaffirmed: Res. 005, I-24

Disclosure of Risk to Fertility with Gonadotoxic Treatment H-425.967

Our AMA: (1) supports as best practice the disclosure to cancer and other patients of risks to fertility when gonadotoxic treatment is used; and (2) supports ongoing education for providers who counsel patients who may benefit from fertility preservation.

Citation: Res. 512, A-19

Right for Gamete Preservation Therapies H-65.956

1. Fertility preservation services are recognized by our AMA as an option for the members of the transgender and non-binary community who wish to preserve future fertility through gamete preservation prior to undergoing gender affirming medical or surgical therapies.

2. Our AMA supports the right of transgender or non-binary individuals to seek gamete preservation therapies.

Citation: Res. 005, A-19

Preserving Access to Reproductive Health Services D-5.999

1. Our American Medical Association recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right.
2. Our AMA opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion.
3. Our AMA will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, fertility preservation, contraception, and abortion.
4. Our AMA supports shared decision-making between patients and their physicians regarding reproductive healthcare.
5. Our AMA opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients.
6. Our AMA opposes the imposition of criminal and civil penalties or other retaliatory efforts, including adverse medical licensing actions and the termination of medical liability coverage or clinical privileges against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services.
7. Our AMA will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services.

8. Our AMA will advocate for legal protections for medical students and physicians who cross state lines to receive education in or deliver reproductive health services, including contraception and abortion.

Citation: Res. 028, A-22; Reaffirmed: Res. 224, I-22; Modified: BOT Rep. 4, I-22; Appended: Res. 317, I-22; Reaffirmation: A-23; Appended: Res. 711, A-23; Reaffirmed: Res. 014, A-25

Protecting Evidence-Based Medicine, Public Health Infrastructure and Biomedical Research D-440.905

1. Our AMA affirms that protecting science, clinical integrity, and the patient-physician relationship is central to the organization's mission.
2. Our AMA assertively and publicly leads the House of Medicine in collective, sustained advocacy for federal and state policies, proposals, and actions that safeguard public health infrastructure, advance biomedical research, improve vaccine confidence, and maintain the integrity of evidence-based medicine and decision-making processes.
3. Our AMA will report back at the 2025 Interim Meeting of the AMA House of Delegates on the actions taken to implement this policy.

Citation: Res. 242, A-25

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.

AMA Principles of Medical Ethics: I,V,VII

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Citation: Issued: 2016

4.2.4 Third-Party Reproduction

Third-party reproduction is a form of assisted reproduction in which a woman agrees to bear a child on behalf of and relinquish the child to an individual or couple who intend to rear the child. Such arrangements can promote fundamental human values by enabling individuals or couples who are otherwise unable to do so to fulfill deeply held desires to raise a child. Gestational carriers in their turn can take satisfaction in expressing altruism by helping others fulfill such desires.

Third-party reproduction may involve therapeutic donor insemination or use of assisted reproductive technologies, such as in vitro fertilization and embryo transfer. The biological and social relationships among participants in these arrangements can form a complex matrix of roles among gestational carrier, gamete donor(s), and rearing parent(s).

Third-party reproduction can alter social understandings of parenthood and family structure. They can also raise concerns about the voluntariness of the gestational carrier's participation and about possible psychosocial harms to those involved, such as distress on the part of the gestational carrier at relinquishing the child or on the part of the child at learning of the circumstances of his or her birth. Third-party reproduction can also carry potential to depersonalize carriers, exploit economically disadvantaged women, and commodify human gametes and children. These concerns may be especially challenging when carriers or gamete donors are compensated financially for their services. Finally, third- party reproduction can raise concerns about dual loyalties or conflict of interest if a physician establishes patient-physician relationships with multiple parties to the arrangement.

Individual physicians who care for patients in the context of third-party reproduction should:
(a) Establish a patient-physician relationship with only one party (gestational carriers, gamete donor[s] or intended rearing parent[s]) to avoid situations of dual loyalty or conflict of interest.

(b) Ensure that the patient undergoes appropriate medical screening and psychological assessment.
(c) Encourage the parties to agree in advance on the terms of the agreement, including identifying possible contingencies and deciding how they will be handled.
(d) Inform the patient about the risks of third-party reproduction for that individual (those including individuals), possible psychological harms to the individual(s), the resulting child, and other relationships.
(e) Satisfy themselves that the patient's decision to participate in third-party reproduction is free of coercion before agreeing to provide assisted reproductive services.

Collectively, the profession should advocate for public policy that will help ensure that the practice of third-party reproduction does not exploit disadvantaged women or commodify human gametes or children.

AMA Principles of Medical Ethics: I,II,IV

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Citation: Issued: 2016

4.2.5 Storage & Use of Human Embryos

Embryos created during cycles of in vitro fertilization (IVF) that are not intended for immediate transfer are often frozen for future use. The primary goal is to minimize risk and burden by minimizing the number of cycles of ovarian stimulation and egg retrieval that an IVF patient undergoes.

While embryos are usually frozen with the expectation that they will be used for reproductive purposes by the prospective parent(s) for whom they were created, frozen embryos may also offer hope to other prospective parent(s) who would otherwise not be able to have a child. Frozen embryos also offer the prospect of advancing scientific knowledge when made available for research purposes. In all of these possible scenarios, ethical concerns arise regarding who has authority to make decisions about stored embryos and what kinds of choices they may ethically make. Decision-making authority with respect to stored embryos varies depending on the relationships between the prospective rearing parent(s) and any individual(s) who may provide gametes. At stake are individuals' interests in procreating.

When gametes are provided by the prospective rearing parent(s) or a known donor, physicians who provide clinical services that include creation and storage of embryos have an ethical responsibility to proactively discuss with the parties whether, when, and under what circumstances stored embryos may be:
(a) Used by a surviving party for purposes of reproduction in the event of the death of a partner or gamete donor.
(b) Made available to other patients for purposes of reproduction.
(c) Made available to investigators for research purposes, in keeping with ethics guidance and on the understanding that embryo(s) used for research will not subsequently be used for reproduction.
(d) Allowed to thaw and deteriorate.

(e) Otherwise disposed of.

Under no circumstances should physicians participate in the sale of stored embryos.

AMA Principles of Medical Ethics: I,III,IV,V

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Citation: Issued: 2016