Celebrating Women in Medicine

2017: a year kicked off by January’s Women’s March, a protest of about five million people worldwide. Political affiliations aside, as a physician, women’s healthcare provider and lover of science, I found that the March’s platform included many points relevant to reproductive medicine.

As reproductive endocrinologists, we may oftentimes focus on infertility in the current era, but when we stop to recall the “RE” in “REI”, we remember that it is also our job to help girls and young women navigate the pitfalls of puberty and choosing contraceptives, to holistically manage the non-fertility aspects of diagnoses such as polycystic ovary syndrome or endometriosis, to provide expert insight into hormonal management of menopause, and so much more! We must be champions of women’s healthcare, and the key is affordable and easy access to quality care and treatment that is not guided by the whims of insurance companies or racial or socioeconomic disparities. I can’t think of any colleagues who are swimming in free time, but taking on roles in advocacy can be extremely gratifying, and progress can be made!

In June, I was proud to be a part of the ASRM delegation that passed a resolution at the American Medical Association recognizing infertility as a disease.

In the name of September—Women in Medicine month, I honor all those women who are finding an outlet for their leadership skills, however vast or inchoate they may feel, and turning their expertise in reproductive medicine into something more… whether through protest, social media, research, lobbying, philanthropy, volunteering, teaching or otherwise leading, thank you all for your energy… the world needs your voice!

Dr. Kudesia is the Secretary of the ASRM Women’s Council and Assistant Professor at Reproductive Medicine Associates of New York—Icahn School of Medicine at Mount Sinai in New York, NY

Ways to Be Involved with the WC

- Please join us for the annual WC Breakfast at the ASRM Annual Meeting!
- The event is from 7-8:45am on Tuesday, October 31st. You can still register online or onsite if you haven’t already!
- This year’s nomination window has passed, but nominate yourself or a colleague for the ASRM WC Distinguished Service award—this is a great opportunity to be recognized by the Society
- Inspired by this issue’s articles? Submit a piece for a future newsletter
- Active on social media? We are looking to expand our online presence. We will be announcing some new efforts next month; keep an eye out for our group!
“Sure, I can see 22 patients and have two medical students and a resident today... piece of cake! Really?”

I have been working with learners in reproductive medicine as an attending physician for eight years. I’m the medical director of a busy, full service reproductive medicine and ART practice in North Carolina. I love what I do and I take seriously my commitment to helping patients on their fertility treatment journey. Having worked in academic medicine for 8 years, I hope to share some hard earned pearls with other ASRM Women’s Council members about strategies to optimize involvement of learners in the reproductive medicine office while maintaining a brisk pace and connecting with new patients.

Review expectations for involvement up front:

I encourage students in our office to be keen observers and take history when appropriate. I have found students to be excellent sleuths in tracking down records from other clinics to complement a new patient visit and ensure that all the clinical data points needed for a treatment plan are readily available at the consultation. This allows them to practice the reporter role and prepare for a transition to interpreter of the data and even potentially construct a treatment plan.

Recently, I’ve had several students who have successfully completed their ultrasound simulation at our university inquire about performing a transvaginal ultrasound on our patients during their rotation. Gulp! To frame this better for them, I explain that I learned ultrasound as a resident and really focused on my learning as a fellow. Therefore, an invasive ultrasound for obstetrical scan or follicle monitoring is outside the scope of practice expected for a third-year medical student. I feel that stimulation in the classroom setting is a wonderful start of exposure to the field of radiology and imaging, but performing the technical aspects of ultrasound should be reserved for later times of professional development. So, setting expectations for them ahead of time leads to a fulfilling learning environment and avoids disappointment.

Deep dive, not shallow swim: I encourage our students to engage in a specific aspect of the patient care record and to perform a deep dive. For example, rather than PCOS as a topic, let’s dive into the best ovulation induction agent to minimize twin gestation in the PCOS population. I try to guide them on a path of a deeper dive into a topic, rather than just a cursory overview. To facilitate this I give reading assignments prior to arriving in my clinic as well. This way, I’m not teaching the student about what an HSG is, but rather debating the best time to perform the study or the best management of hydrosalpinges in more depth and focus.

Encourage email follow-up with a question of the day: We are all lifelong learners. We should encourage our students and residents to identify resources to advance their knowledge outside of the didactic 1:1 environment in the office clinic. I try to identify a question for follow-up for my learners at the end of a busy clinic day that I know will be difficult and a bit more complex to answer. I ask them to email me with the response. This also allows me to assess their understanding and ability to find resources. The response gives me documentation of follow-up (failure to followup certainly sends an entirely different message but does happen!) and even include their responses in a written summative evaluation.

Time is limited, so this gives me a chance to give feedback without the pressures of a patient in front of me as well.

I wish you all the best and success at having learners with you in the reproductive medicine office! I hope these small suggestions help to optimize your learning environment.

Dr. Johnston-MacAnanny is Chair of the ASRM Women’s Council and Associate Professor at Wake Forest Baptist Medical Center in Winston-Salem, NC.
The Gamble of Life as a Reproductive Scientist

The often quoted line of Confucius, “Find a job you love and you will never work a day in your life,” is one that comes to mind when I contemplate how to begin a blog on working as a scientist in reproductive medicine. Of course, no one is quite so naïve to believe something so black and white. There have been many days that I felt I have worked very hard indeed, but for me this career is as close as I could imagine to the ideal for which Confucius has inspired millions to search.

In most professions, there is a repetition in the daily routine. In clinical embryology that is very much the case. In fact, to become proficient at the techniques literally hundreds of hours are spent doing the same tasks over and over again. Despite performing the same tasks each day, this field of work continues to be challenging and engaging over an entire career because of the people with whom we work. Clinical ART is a multidisciplinary collaboration. I don’t know of any other field of laboratory endeavor in which the scientists work daily with nurses, physicians, mental health professionals and administrators each contributing their specialized skills to provide the best care to infertile patients. Seeing the same challenge through the lens of a different profession has been a wonderful education.

It also is possible that my love affair with my job is not entirely altruistic. In the early 1990s, when I was a junior embryologist, at a work party, I happened to be standing near my then department chairman while he was joking with my boss, the head of infertility and the head of our gyn-oncology unit. They were all joking and teasing each other, and the only phrase I remember verbatim of their banter was the department chairman saying, “you both are addicted to failure.” At the time, I thought that was a bit rude, but over the years, that phrase has played at the edge of my imagination to the point where I now believe it is quite an accurate way to describe this field of medicine.

Compare the gambling addict to the REI or embryology lab director.

Studies of gambling addiction tell us that variable ratio reinforcement is the most addictive. The gambler performs a task and receives a reward, the next four times she performs that same task, but no reward results. In the 1990s this was an accurate description of the pregnancy rate per transfer in ART when most practices were proud of a 20% success rate. Imagine the gambler placing a bet on a horse race by following the advice and watching over the shoulder of a more seasoned punter. She has a few wins, then the dry spell and the inevitable frustration of why something that worked before has not continued to work. So the gambler studies the field guide, getting to know more fully the horses and the jockeys. We too studied the finer details of what worked and what didn’t work, what could be improved and changed. Each time we completed a treatment cycle, we would add the numbers to our “database,” a large poster that took up most of one of the walls in the lab, waiting not so patiently for the result of the pregnancy test. The introduction of a new technique or a change to the culture system would lead to the thrill that I imagine parallels that of the gambler who is sure in the knowledge that her process of choosing which horse to bet on is going to lead to a great leap in the number of wins. Then imagine a team of equally excited gamblers all adding their hard work and dedicated study of horse form and training, and the effects of weather on the track, and you have a reasonable equivalent of an academic REI clinic, but thankfully with the socially acceptable outcome of helping to build families rather than gambling.

What if the great breakthroughs in our field were really a result of the collective addictive disorder? The potential payoff of betting stimulates innate risk-taking tendencies, and the greater the reward the more likely the addicted gambler is to engage in risk-taking behaviors such as ovarian hyperstimulation shoving a sperm inside an oocyte by using a sharp piece of glass and exposing oocytes and embryos to toxic concentrations of anti-freeze to freeze them in a glass-like state. All are outrageously risky but have yielded quantum leap increases in the success of ART.

For the most part, the addicted gambler considers herself “recovering” from, but never cured of the disorder. To gain glimpses of the long-term fate we may be facing if afflicted with ART addiction, we look to those who have gone before us, the early leaders. One example is Howard Jones Jr., presenting his views on the future of reproductive medicine to the thousands gathered at the 2010 ASRM a mere few weeks before his 100th birthday. The signs don’t look good for a recovery from this ART addiction, to which I wholeheartedly hope there isn’t!

Dr. Briton-Jones is the Director of Laboratory Services and Laboratory Rotation Director of the REI Fellowship at Reproductive Medicine Associates of New York—Icahn School of Medicine at Mount Sinai in New York, NY.

“Intracytoplasmic sperm injection—one of the gambles that paid off!”
Striving for Work-Life Balance

If I said I had work-life balance, I think that would be a half-truth. I have a career and I have a life, but most of the time I find myself trying to make sure that the aspect of my life that was neglected last week is prioritized this week. Maybe that is a sort of balance, but it usually does not feel like it. Moreover, I think the only way that I am able to have both work and a life is 1) I have an incredible support network, and 2) I try to set realistic expectations of what success is for me and how I will perform as I attempt to achieve it.

As a newly appointed Assistant Professor of Obstetrics and Gynecology in the Division of Reproductive Endocrinology & Infertility, I am considered early in my career. I don’t feel early in my career, as I have been pursuing this goal for almost half of my life, but it is true in that I only recently completed my fellowship training, began seeing my own patients, and have just started on the path to where I want my career to go. I am a physician-scientist in the Reproductive Scientist Development Program (RSDP). Therefore, I currently spend 25% of my time in clinical practice and 75% doing basic/translational research. Truth be told, I often feel like I am burning the candle at both ends. It is not uncommon for me to start my morning by making a to-do list and follow that up with a 5-10 minute perseveration on how there is no way I will be able not only to achieve all of the items on the list, but even the “Urgent/Important” items (from the Seven Habits of Highly Effective People book…I didn’t have time to read the book, but I picked it up from a recap article). Often, my carefully designed experiments failed and are followed by months of troubleshooting. Or, I am late seeing patients and I am unable to set up an experiment for the following day. Or,

...as a working professional husband and we have two young sons (ages one and three). When my water broke with my first son, I was presenting a poster detailing my work at a research symposium. I began my induction and my husband ran home to wash the clothes and blankets we had purchased but that still had tags on them and were in a shopping bag. I told him, “We don’t have time to read ‘The Happiest Baby on the Block’ but I heard there is a DVD. Buy it please!” Although we are better prepared in many ways now, we routinely have #badmom/#baddad/#badparent moments: “I forgot show-and-tell was today, so I’m going to go buy some pretzels at the corner store, OK?” or “We brought sunglasses, a book, and snacks on our five-mile hike…how exactly did we forget diapers?”

But in both work and home, somehow we persevere, and occasionally I have moments of absolute bliss. It is those moments—I present my research and a mentor I respect tells me “this is incredibly interesting”, a patient tells me through tears that I in some way made her miscarriage more bearable, my son says to me “I like your dress mommy, you’re pretty”—that keep me going through a life that is objectively more often bumps and bruises than triumph. In my experience there is no key to success or silver bullet for failure. I think what I have found most helpful in feeling like overall the scales tip more towards winning than losing is surrounding myself with honest and encouraging people who will help me celebrate my achievements and heal after my failures. Some of that was luck—being born into a close and supportive family—but a lot of it is choice. I chose brilliant mentors who are good people; I chose an institution with amazing leadership and partners who like and respect each other; I chose friends who normalize things for me and remind me of my victories when I’m experiencing a setback; and I chose a true partner in my husband who understands and values both my work and home life, and helps me make my dreams in both come true. Now if you will excuse me…I think that true partner just let my youngest son eat sand while I was writing this essay.

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Kathleen E. O’Neill, MD, MTR

Online Resources for Women in Medicine Month

American Medical Association: https://www.ama-assn.org/women-medicine-month

https://wire.ama-assn.org/ama-news/7-ways-you-should-celebrate-women-medicine-month

National Institutes of Health: https://orwh.od.nih.gov/about/director/messages/women-in-medicine-month/

Association of American Medical Colleges: https://students-residents.aamc.org/choosing-medical-career/article/celebrating-women-medicine-month/