Family Planning in a Medical Career

FAMILY PLANNING FOR MEDICAL LEARNERS

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Objectives

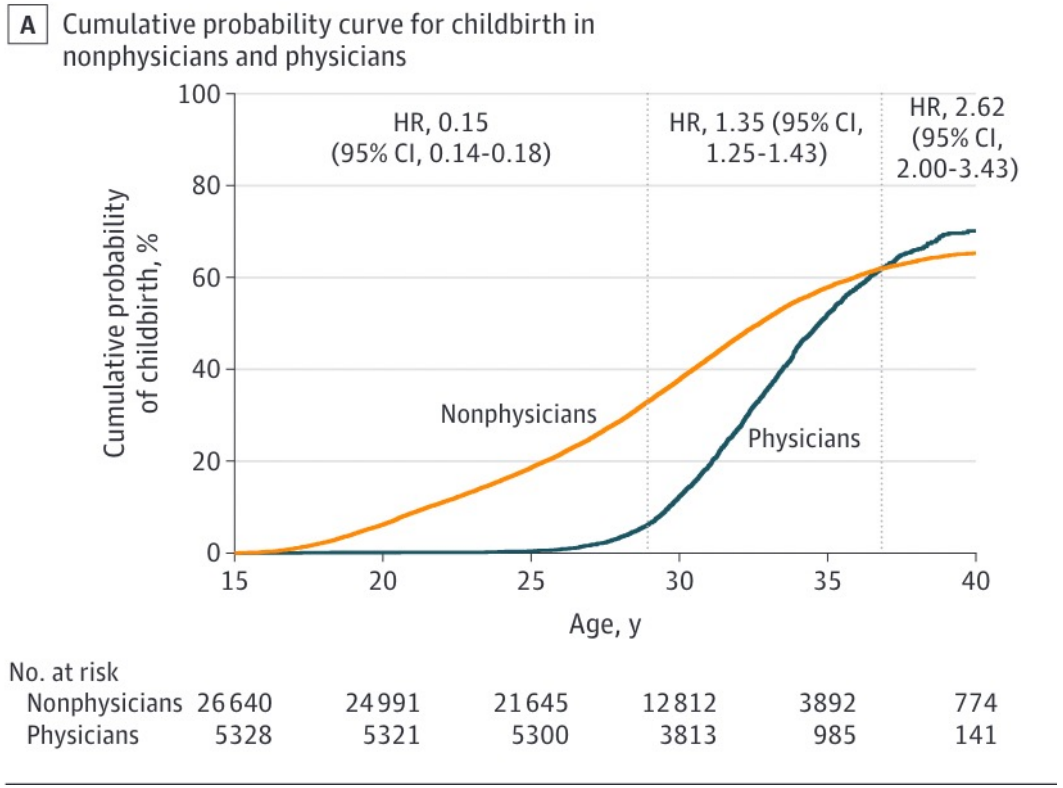
- Review the challenges of planning a family within a medical career
- Review how to approach family planning
- Provide guidance around available resources through UofT/PARO
- Discuss how to bring up family planning goals to your school/residency program
- Discuss family building as an independent physician
- Discuss experiences of balancing family life with a medical career with panelists

About Me

- Finished OBGYN residency at UofT in Jan 2022
- Discovered passion for fertility medicine with patient interactions & personal experiences as a PGY2-PGY3
- First child (Rory) in PGY3, Second (Beatrix) in PGY6 – both conceived through IVF
- Current Reproductive Endocrinology and Infertility (REI) Fellow at Mount Sinai Fertility

Why are we talking about this?

- Parenthood in medicine is seen as an **inconvenience** rather than as a part of life
- Parents, at any stage, can face negative consequences such as **lack of career advancement, exclusion from job/training opportunities, negative referral patterns, resentment from colleagues**
  - This is especially burdensome on women, but **affects everyone**
- This often leads to a **delay in childbearing** for those in medicine
  - Physicians were less likely to bear children between the ages of 15-28 and more likely to bear children over the age of 37
  - Specialist physicians are less likely to bear children in postgraduate training



Cusimano et al, 2021

I wish I hadn’t delayed…

- 42% of female physicians reported being discouraged from starting a family during training
- 49% of female physicians reported negative experiences while pregnant
- 29% of female physicians would have tried to conceive earlier and 7% would have frozen their eggs
- 25% of female physicians report a diagnosis of infertility (15% general population)
- Female physicians were also more likely to experience complications of pregnancy, primarily because of advanced maternal age
- Medical training falls within the years of optimal fertility, but medical students and residents have been shown to have **limited knowledge about family planning and age-related fertility decline**

Cusimano et al, 2021; Cusimano et al, 2022; Stentz et al, 2016 Rangel et al, 2021; Lai et al, 2023

Family Planning : the Hidden Curriculum

Family planning has become a taboo topic	• No explicit information put out by MD program or residency programs • Students are afraid to ask questions for fear of their reputations
Specific Programs are generally discouraging towards family planning	• Information gained from informal conversations, experiences during clerkship and conversations with peers
Residents who have children place a burden on other colleagues	• Having a child is a “personal choice” and it is “unfair” that other colleagues have to work more
Parenting in Medicine is HARD	• Onus is on the trainee/physician to make this all "work" • There is no right time, it's always difficult

We have GOALS…

Education – website, webinars

- Expand upon information available to all trainees (bottom-up movement)

Undergraduate Goals :

- Integration of Family Planning as a professional development module
- Clear parental leave policies
- Availability of mentors/university staff for discussions on impact of family planning on career goals

Postgraduate Goals :

- Critical review of current leaves to identify gaps
- Improvement of University-level resources (i.e. childcare, mentorship, part-time residency options, ancillary staff)
- Provincial & National advocacy for improved resident support in family planning

Faculty Goals

- Review hiring practices and guidelines
- Create support for physicians who are parents and going on leave

The DREAM

- A supportive culture within Medicine from the governmental level (top-down) towards acceptance and appreciation for parenting in medicine (and other wellness issues that impact burnout of physicians)

CASES

Case #1

- E.F. is a 33 year old female medical resident in her first year of Vascular Surgery. She is not currently in a relationship.
  - What are some questions she should consider in her family plan?

Creating Your Family Plan – Essential Questions

Do I want children?	When do I want to start having children?	How many children do I want?	Does my age while my children are growing up matter to me?
Is having a partner before having children important to me?	Is having children who are genetically linked to me important to me?	Am I able/willing to provide eggs/sperm/uterus to support a pregnancy?	Will I have a partner that is able/willing to provide eggs/sperm/uterus?

Other Questions

How will starting a family impact my/our careers? Are there any adjustments we need to make in our work schedule or job responsibilities to accommodate a child?

What are our financial goals and how will starting a family impact our budget?

How will starting a family impact my/our relationship? Are we prepared to make the necessary changes to our lifestyle and daily routines to accommodate a child?

What kind of support will we have? Are there any family members or friends who can help us?

Case #1

- E.F. is a 33 year old medical resident in Vascular Surgery.
  - She wants children
  - She is not currently in a relationship.
  - She'd like to have children within the next 5 years
  - She'd prefer to be younger while they are growing up
  - She is open to single parenthood
  - She would prefer having children that are genetically linked to her
  - She would like to provide eggs and a uterus to support a pregnancy
  - She hopes to have a partner that would provide sperm

What are E.F.’s family planning options ?

- Do nothing, wait to see where life takes her
- Freeze her eggs
- Freeze embryos
- Try to conceive now using donor sperm
- Adopt

What are E.F.’s family planning options ?

- Do nothing, wait to see where life takes her
- Freeze her eggs
- Freeze embryos
- Try to conceive now using donor sperm
- Adopt
- **THESE ARE ALL VALID OPTIONS**

Is everything over at age 35?

- NO! It is not ALL or NONE
- Gradual increase in risks of :
  - Infertility
  - Miscarriage
  - Genetic disorders
  - Pregnancy risks (pre-eclampsia, preterm birth, induction of labour, c-section)

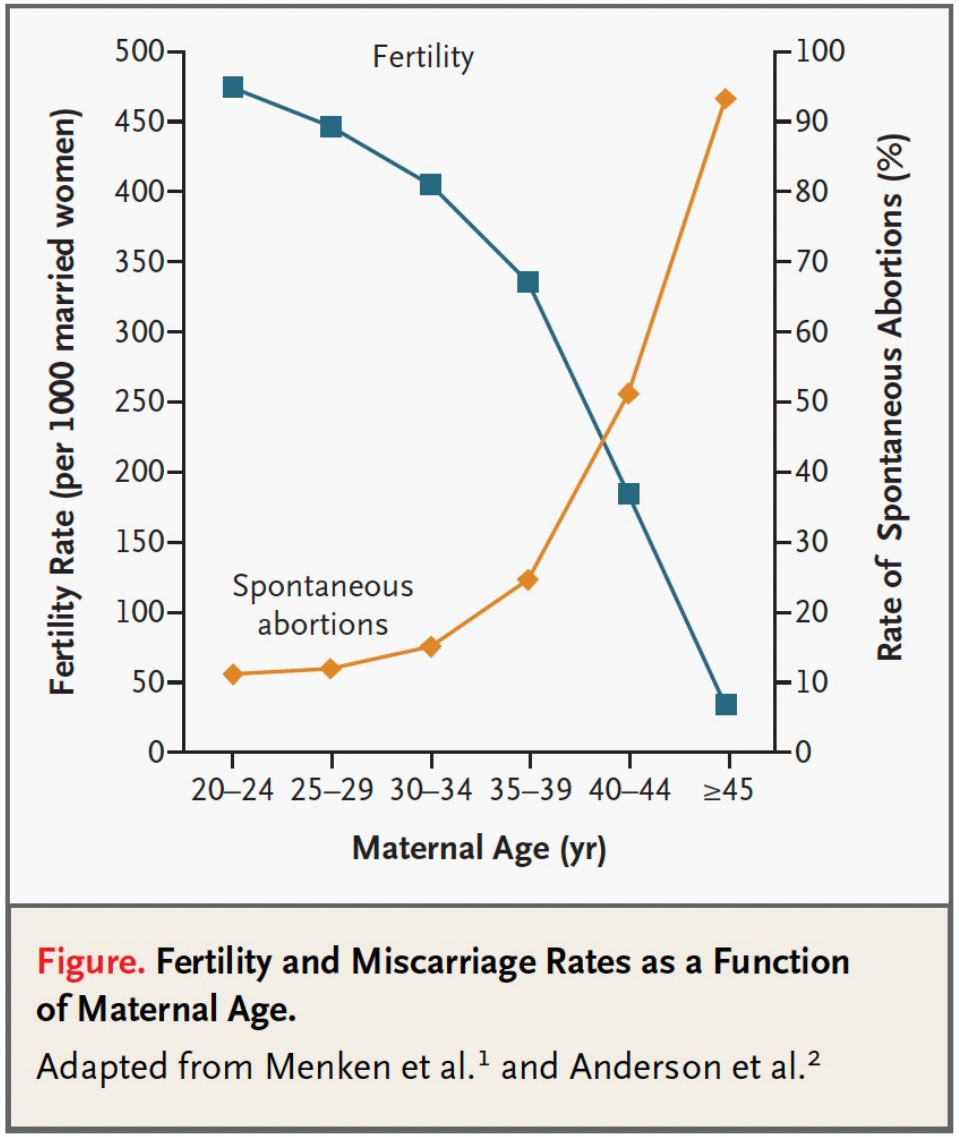
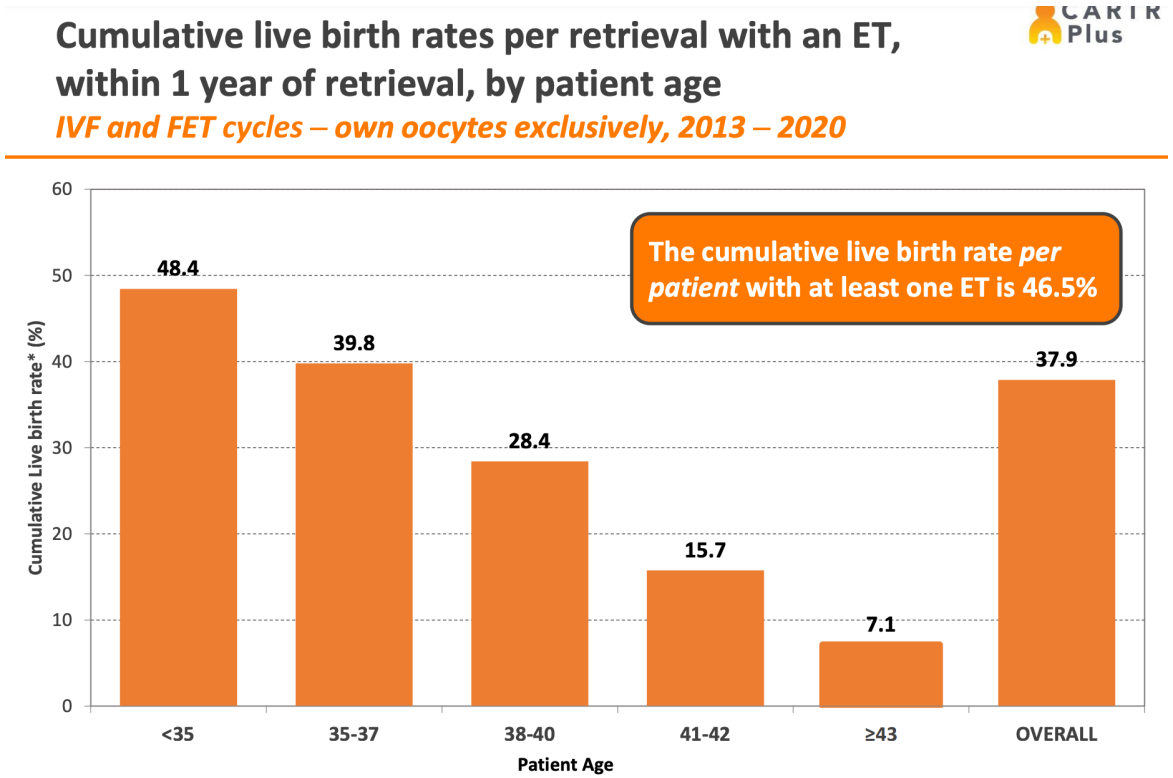
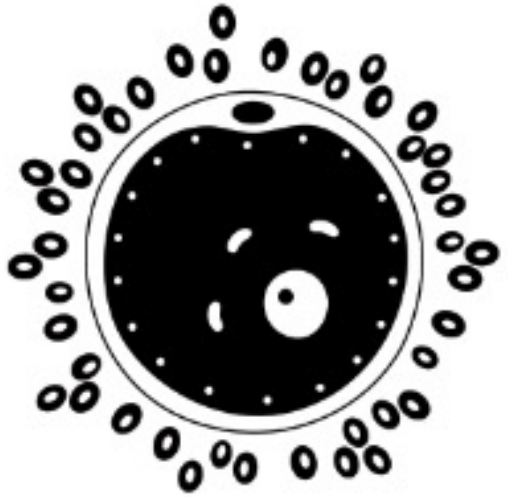


Figure. Fertility and Miscarriage Rates as a Function of Maternal Age.

Adapted from Menken et al.[1] and Anderson et al.[2]

IVF cannot overcome age-related fertility decline



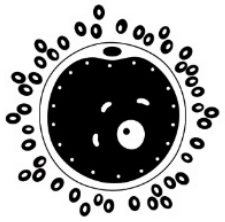


Fertility Preservation
Eggs, Sperm, Embryos

Sperm Freezing – marketing ploy?

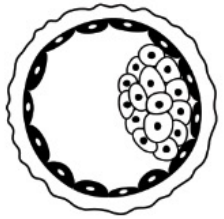
- Sperm is commonly frozen for medical reasons (i.e. prior to cancer treatment)
- International advocacy for consideration of the impacts of age on sperm
- Banking sperm is becoming more of a consideration for men

What is the difference between an egg and an embryo?

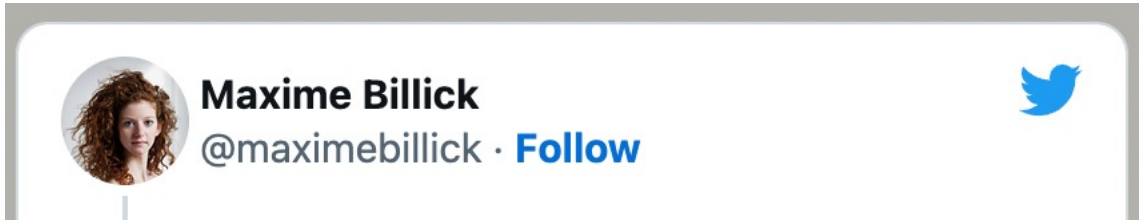


- Egg :
  - Present in Follicles (fluid-filled spaces with the Ovary)
  - Cannot be genetically tested
  - Must be fertilized with sperm to create an embryo in order to lead to a pregnancy

- Embryos :
  - Egg that has been fertilized by sperm and has started to develop
  - Can be transferred into a uterus to create a pregnancy



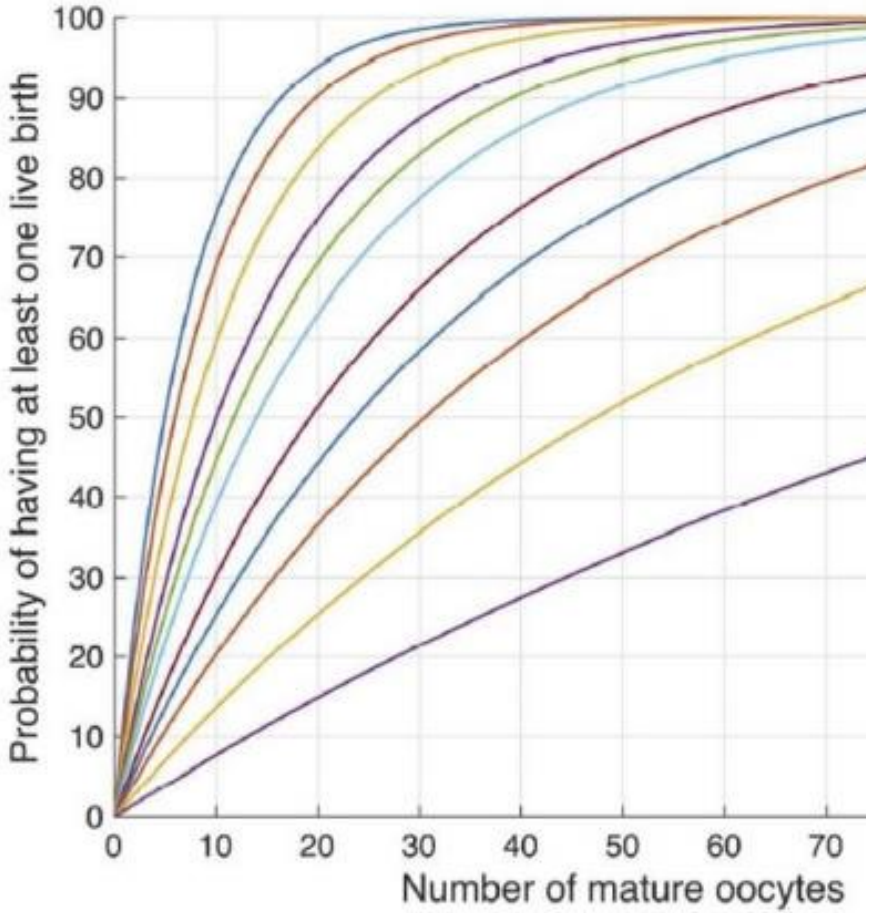
Egg Freezing



“People choose to freeze their eggs for a multitude of reasons. Some have health issues, others haven’t found the right partner, and many just aren’t ready to have children yet. **For me, freezing my eggs seemed like the best way to relieve some of the anxiety and pressure I felt about having children.** To me, it was the ultimate way of taking control of my biological clock. I wanted to achieve my personal goals and have children on my own timeline, not on a timeline prescribed by our patriarchal society, in the way our work and our medical training are arranged. So I said, “Screw the patriarchy. I’m going to do this.” And I did.”

Egg Freezing

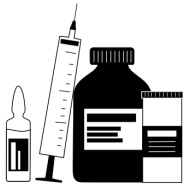
- No longer experimental and unreliable
- Survival of eggs is 80-85%
  - Survival of embryos is 95%
- Considered most cost effective around age 35-37
  - Younger = better quantity & quality
  - Benefit is small under the age of 32



Live birth predictions by age and number of mature oocytes
elihood that a patient of a given age will have at least one
based on the number of mature oocytes retrieve

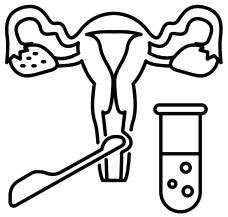
What does Egg Freezing Involve?

NOW



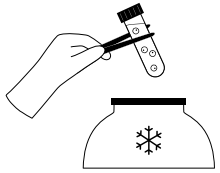
Ovarian Stimulation

- *Taking injectable meds for 10-12 days*
- *Up to 4-5 in person early AM appointments for BW & US*



Transvaginal Ultrasound-Guided Egg Retrieval

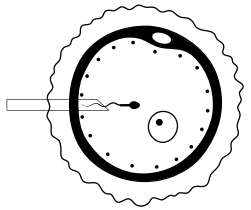
- *30 min procedure*
- *Requires day off work due to sedation*



Egg Freezing

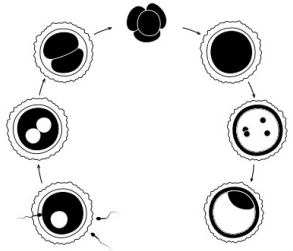
- *Embryologist will update you about number of frozen mature eggs*

IN THE FUTURE



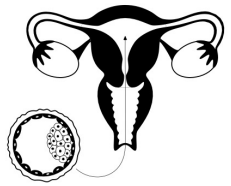
Intracytoplasmic Sperm Injection (ICSI)

- *Eggs fertilized with partner/donor sperm*



Embryos grown

- *Eggs fertilized with partner/donor sperm*
- *Grown to D5/6*



Embryo Transfer

- *Fresh or frozen*
- *Quick procedure, no sedation required*

Egg Freezing - Investment

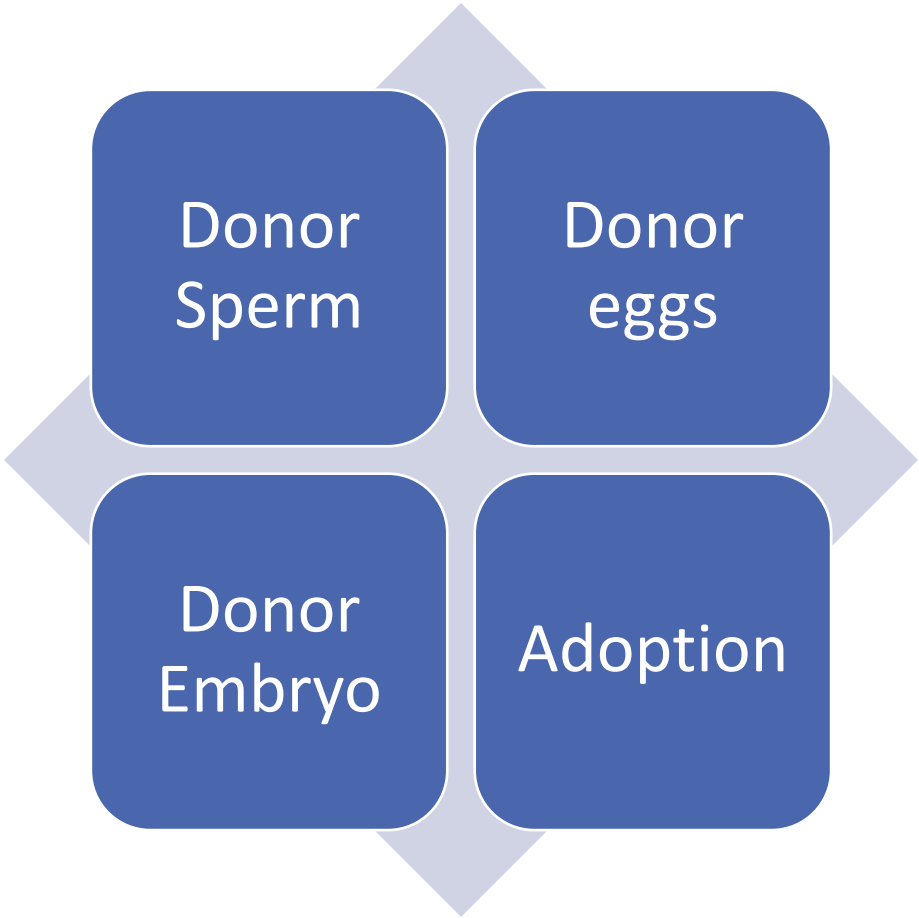
Costs

- Procedure : $8,000
- Storage : $500 per year
- Medications : $3,000 – 8,000, average $5,000
- When using the eggs to create embryos
  - Insemination : $2,500
  - In Ontario, can use government IVF funding if available for fertilization with sperm and creation of embryos

Time commitment – 2-3 weeks

- Initial consultation with REI physician at fertility clinic (need a referral)
- Initial investigations : blood test (AMH) + US
- Review results
- Start cycle :
  - 4-5 early AM monitoring appointments (7-9 AM) over approximately 2 weeks
  - Egg retrieval – 1 day, sedation
- Final review with physician

What are other options to have children as a single parent?



Case #2

- E.B. is a 32 year old female resident in General Surgery and R. G. is a 33 year old man in Family Medicine. They want to start trying to conceive – what should they do?
  - Start having intercourse every 2-3 days
  - E.B. should track her cycles, measure her LH and then plan intercourse during her fertile window
  - See a fertility physician for Fertility Testing
  - They're too old – they need IVF

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Where do they start?

75% chance of pregnancy within 6 months
85% chance of pregnancy within 1 year
95% chance of pregnancy within 2 years

- Trying to conceive can seem **daunting**
- It can be hard to plan when you may have a child
- Infertility is defined as trying to conceive without success for **12 months** (which is a long time!)
- If you are 35-40, we suggest testing for fertility issues after trying for 6 months with the goal to decrease time to treatment but you may still be successful

Optimizing Natural Conception

- Track menstrual cycle :
  - calendar or app to track your ovulation (i.e. Glow) - in general, you ovulate 2 weeks before your menstrual period
  - Measure ovulation with an LH testing strip (have intercourse if LH positive and next day)
- Intercourse every 1-2 days in the 6 days before ovulation with regular cycles, or every 2-3 days with irregular cycles

When should someone be referred to a fertility doctor?
Requires a referral

- Female < 35 and TTC x 1 year
- Female between 35-40 and TTC x 6 months
- Female > 40 and TTC
- Irregular menstrual cycles
- Fertility preservation (sperm/embryo/egg freezing)
- Known medical condition that may impact ability to conceive
- 2-3 pregnancy losses

Fertility Testing

- Surface level assessment of :
  - Number of eggs
  - Uterine cavity & uterine tubes
  - Sperm quantity & quality
- AMH – assessment of ovarian reserve
  - Does NOT predict spontaneous fertility
  - Cannot be predictable measured on birth control pills
  - Predicts response to ovarian stimulation for egg freezing/IVF
- Semen analysis fluctuate with illness, diet, exercise, time of day, abstinence length etc
- **Only true test of fertility is TRYING TO CONCEIVE**

Should I get a “fertility check”?

- PRO
  - Identifies any obvious issues
  - Early connection to care – especially if surgery would be beneficial

- CON
  - There is a LOT we do not know about spontaneous fertility
  - Someone with blocked tubes CAN get pregnant spontaneously
  - Someone with low sperm numbers and movement CAN get pregnant spontaneously
  - Someone with PCOS/no periods CAN get pregnant spontaneously

What types of fertility treatment may be offered to them?

- In general
  - Ovulation induction/Controlled ovarian hyperstimulation → cycle monitoring
  - Intrauterine Insemination
  - In vitro Fertilization/Intracytoplasmic Sperm Injection
- Each treatment takes one menstrual cycle
  - More time commitment depending on each treatment
  - Will likely need multiple cycles of treatment
- Costs are variable

Case #2

- E.B. is a 32 year old female resident in General Surgery and R. G. is a 33 year old male in Family Medicine. E.B. becomes pregnant. They both plan to take parental leave.

- What are some considerations as they plan their next few months together?

Pregnancy

- Nausea/vomiting in the first trimester
  - Distraction can be helpful
  - Medications/strategies to discuss with a physician
- Physical activity
  - Continue what you were able to do before
  - Avoid heavy lifting
  - Only very specific pregnancy indications for modified activity
- Attending medical appointments does NOT require vacation/professional day use
  - Arrange directly with supervisors for appropriate coverage
- Avoid unnecessary radiation and chemotherapeutic agents

Discussions with your Program Director

- Consider :
  - Length of leave
  - Waiver of training
  - lighter rotations both for during pregnancy (if female) or upon return to work as a parent
- Earlier notice may be better, though many residents choose to wait until 12 weeks GA (point at which pregnancy loss risk is lowest)
  - Only required to give 4 weeks notice
- If there are specific concerns during pregnancy (i.e.fluoroscopy), you can discuss with your program & occupational health what the lowest risk setting may be for you and whether another rotation could be considered

Explanation of EI Benefits

- You must have worked for **600 hours** in the 52 weeks prior to the claim
  - Determination of hours differs by provincial union
  - In Ontario - this includes **on-call hours, rounding hours and overnight shifts**;
  - Usually achieved by 4 months of residency
- The **birthing parent → maternity leave** for **17 weeks** AND **parental leave** for either **35 weeks** (standard) or **61 weeks** (extended)
- The **non-birthing parent → parental leave** for **37 week**s (standard) or **63 weeks** (extended)
- If both parents intend to claim benefits - either **40 weeks** (standard) or **69 weeks** (extended) are **divided between parents**

Other Leave Considerations

- Maximum benefit is **55% of a resident's average weekly earnings** to a max amount ($638 in 2022)
- Does not have to be consecutive, but must be within certain period of child's birth – standard leave (within 52 weeks), extended leave (within 78 weeks)
- Sick leave can be used during pregnancy
- Fellowship Programs may not included in PARO

PARO Supports :

- EI Top-ups :
  - For birthing parent – 84% of income for 27 weeks
  - For non-birthing parent – 84% of income for 12 weeks
- Overnight call to stop at 27 weeks GA
- Breast pump coverage ($300, need prescription)
- Fertility medication 100% coverage
- All benefits continue while on leave
- Vacation time accumulates and can be taken together at the end of leave
- Upon return to work – you must be accommodated to chest/breastfeed or express milk (private, protected space with a secure fridge to store milk safely)

Impact on Exams/Fellowship

- NO restriction on when the Royal College Exam can be taken in relation to the end of training
  - Resident/Fellows/Staff may recount that they only took 6 months so they could take their exam with their cohort
- Residency employment + exam timing
- Application cycles for fellowship → restrictions may exist

Case #2

- E.B. is a 32 year old female resident in General Surgery and R. G. is a 33 year old man in Family Medicine.
- They have a baby and E.B. takes off 9 months while R.G. takes off 3 months.
- E.G. returned to work.
- What are some considerations for them as they return to work ?

Childcare Considerations

Nanny vs. Daycare

- Support on Sick days
- Backup call systems
- Overnight call help
- Pick-up/Drop-off times

Early disclosure to clinical supervisors re: timing limitations

- Communicating at the beginning of the day when you have to leave
- Ensuring as much work as possible is completed before you leave – i.e. being mindful of dictations
- Longer phone handover later in the evening may be more feasible

Breast/Chestfeeding

- NOT EASY, fed is best!!!
- Now recommended for 2 years of a child's life
- Breast Pump is covered by PARO ($300)
- Generally need to feed/pump every 3-4 hours (timing depends on age of child)
- Upon return to work – you must be accommodated to chest/breastfeed or express milk (private, protected space with a secure fridge to store milk safely)
- Communicate early and clearly to your supervisors about your schedule

Case #3

- F.B. is a 32 year old female resident in General Surgery and S.G. is a 33 year old female resident in Family Medicine. They want to start trying to conceive – what should they do?
  - They need IVF
  - Adopt
  - See a fertility physician

Case #3

- F.B. is a 32 year old female resident in General Surgery and S.G. is a 33 year old female resident in Family Medicine. They want to start trying to conceive – what should they do?
  - They need IVF
  - Adopt
  - **See a fertility physician**

Questions to consider - 2SLGBTQI+

Am I able to provide eggs/sperm/uterus to support a pregnancy?

Will I have a partner who is able to provide eggs/sperm/uterus to support a pregnancy?

Is there someone in my life who can provide eggs/sperm/uterus to support a pregnancy?

Family Building Options

- Donor & Surrogacy
  - Options
    - Donor egg
    - Donor sperm
    - Donor embryo
    - Gestational Carrier
  - Directed (known) vs. non-identified
  - Fresh vs. Frozen
- Reciprocal IVF
- Adoption

Process of Family Building – 2SLGBTQI+

- Process takes time
  - Faster for non-identified frozen gametes (sperm, eggs)
- Some clinics will only use egg/sperm banks, while others will work with agencies & surrogacy
- Legal Agreements – will need a lawyer for fresh donation, known donation and/or surrogacy
- Genetic testing/counselling
- Counselling
  - Specific considerations for raising a child with donor gametes
  - Often a requirement of clinics

Case #4

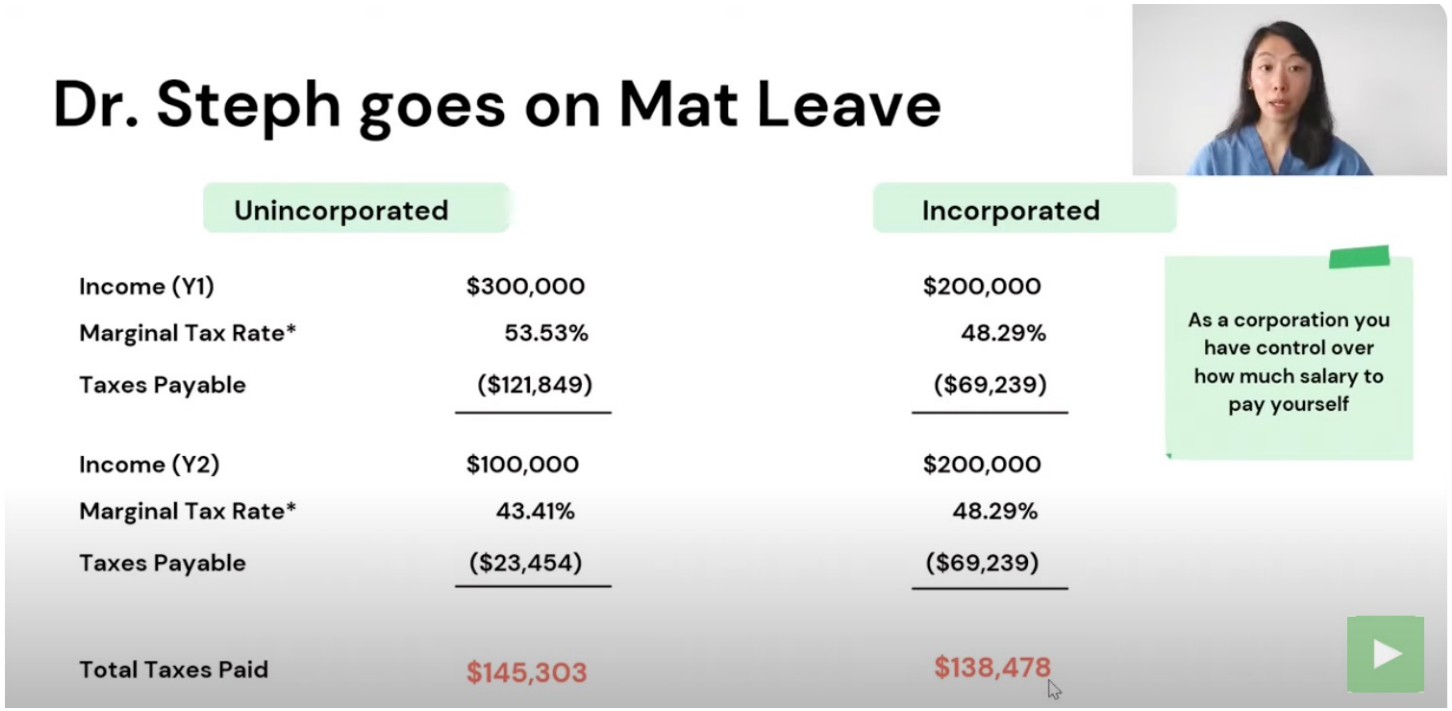
- F.B. is a 32-year-old family physician and Y.H. is a 35 year-old pediatrician who started their practice in the last 2 years
- They are now expecting their first child
- What are some considerations for them as they plan for their leave?

Parental Leave Support as a Staff (Ontario)

- Pregnancy and Parental Leave Benefit Policy (Ministry of Health)
  - Applies to practicing physicians for 26 weeks prior to leave
  - Must earn less than $2600 per week in gross income during leave
  - Applies to all parents and both can take 17 weeks
- 75% of income up to Weekly Maximum of $1300
- Can earn up to $1300 additional income per week on leave (any amount over this will be deducted from benefits)
- If eligible for EI, will receive top-ups to $1300 per week
- 17 weeks – does not have to be taken consecutively but must be taken 2 weeks at a time

Incorporation

- As a corporation, you have control over how much salary you pay yourself
- Income smoothing : deferring revenue earned in a good year to a lower income year



Parental Leave Negotiations

- Understand your contract
  - What are the terms of leave?
    - How long do you have to work before you are entitled to leave?
    - If you are salaried – will you receive a top-up payment?
  - How will this impact academic progress?
  - Do you find your own locum? Are there rules surrounding what locums can do within your group?
  - Does your group cover call for you?
  - Will you be responsible for overhead?
  - License fees/society charges?
  - What are the expected work hours?

OPIP

- $7000 in fertility medication coverage
- Lactation consultant for 2 hours, $125 per hour
- Birth coach/doula $1000

Steps to take before Leave

- Post a Locum Job
- Interview Locums
- Sign a Locum contract
- Plan your handoff
- Arrangements before you go on leave

What if you are Unable to Find Coverage

Practice Closure → OMA has a guide, CPSO, CMPA

Final Message

- Many physicians and medical trainees have children and “make it work”
- Consider when in your career you may want to have children as your age, career stage, personal goals may be important to you
- There are supports available for medical trainees and physicians who choose to pursue having children during training
- ***We have more work to do as a medical community to support each other and advocate for improved external supports***
- ***WE ARE ALL IN THIS TOGETHER!***

QUESTIONS ?

www.familyplanningfordocs.com

Thank you!
Email me anytime :
shirin.dason@mail.utoronto.ca

Questions to ask …

01

When did you choose to start a family and why?

02

What were some barriers that you faced?

03

What was something you wish you had known?

04

How do you achieve work-life balance?

Please fill out this online, anonymous post-survey

1. Ensure that you are connected to Wi-Fi or data.

2. On your phone, open the built-in camera app.

3. Point the camera at the QR code. Tap the banner that appears on your phone to open the link in your browser.