# ASRM TASK FORCE ON DIVERSITY, EQUITY AND INCLUSION

## STATEMENT OF INTEREST AND CONCERN

For just over 75 years, the American Society for Reproductive (ASRM) has been the global leader in multidisciplinary reproductive medicine research, ethical practice, and education. ASRM's approximately 8,000 distinguished members, which include obstetricians and gynecologists, urologists, embryologists, nurses, mental health professionals and others, represent more than 100 countries and impact and inform all aspects of reproductive care and science worldwide. In this role, our focus is on serving our members in optimization of their patients' reproductive health.

ASRM is passionately committed to promoting diversity within both our membership and leadership, as well as to promoting access to quality reproductive care for all patients without regard to marital status, gender identification, religious beliefs, or race/ethnicity. We are committed to addressing the factors that impact health disparities in our subspecialty and to addressing the ability of individuals to access proper and equal medical care, which is a pervasive barrier to educational, economic, and social success.

ASRM recognizes that there are economic and non-economic barriers, including cultural and societal factors (see **Appendix A**) that act as impediments to accessing infertility and reproductive care. To begin to address these impediments, ASRM established and charged a Diversity, Equity and Inclusion (DEI) Task Force, consisting of experts trained in diversity, reproductive endocrinology, nursing, mental health, and ART laboratory (see **Appendix B**), to evaluate and make recommendations on the following two key charges:

- **Charge I:** Enhancing opportunities to increase and support diversity and equity, and the inclusion of underrepresented minority populations, in the profession and leadership of reproductive medicine

- **Charge II:** Reducing and eventually eliminating health disparities in access and outcomes to reproductive care

The Task Force concluded that the lack of people of color in key positions in our profession, high price of treatment, inaccessibility of medical care, differences in success rates, lack of accessible patient education, and implicit biases and discrimination by some offices pose immense burdens to infertile individuals of diverse backgrounds, in same sex relationships or who are without a partner. The Task Force encourages all reproductive medicine stakeholders to establish a pipeline for people of color to consider reproductive health as a career option and to put into place opportunities to establish affordable, safe, effective infertility services and treatments for underserved populations, those in the United States who lack insurance coverage for needed treatment, and refine the definition of infertility for same sex couples and single women.

## SUMMARY TASK FORCE RECOMMENDATIONS

**Taskforce Charge I:** *Enhancing opportunities to increase and support diversity and equity, and the inclusion of underrepresented minority populations, in the profession and leadership of reproductive medicine*

1. **Perform an environmental scan**
2. **Expand and focus recruitment and retention of a diverse workforce**
3. **Increase outreach, education, and opportunities for diverse populations, including pipeline programs**
4. **Expand and enhance training to support a diverse and informed workforce**

**Task Force Charge II:** *Reducing and eventually eliminating health disparities in access and outcomes to reproductive care*

1. **Promote inclusive terminology and definitions**
2. **Reduce and address infertility related stigma in diverse populations**
3. **Advocate for and support inclusive education in reproductive health**
4. **Continue to support universal inclusive coverage for infertility care**
5. **Evaluate opportunities to enhance and provide low-cost and inclusive services**
6. **Continue and expand advocacy efforts for inclusive policies**
7. **Require transparency to promote accountability**
8. **Ensure ASRM publications prioritize diversity, equity, and inclusion**

## APPENDIX A - STATEMENT OF THE PROBLEM

According to the ASRM Ethics committee opinion document on access disparities, economic barriers are not the only impediments to accessing infertility care (1). Chief among non-economic barriers are cultural and societal factors. Researchers who have studied African American, Hispanic, Muslim, and Asian populations in the United States have noted that communication differences, cultural stigmas (including male and female aversion to being labeled infertile), cultural emphasis on privacy, and unfamiliarity or prior bad experiences with the U.S. medical system can dissuade members of certain racial, ethnic, or religious groups from seeking care for infertility (2-6). Language differences may also discourage non–English speaking patients from seeking care.

When it comes to people of color, single women, or same sex couples, physicians may consciously or unconsciously make assumptions or possess biases about who deserves to be a parent and who wants or deserves treatment (7-8). Women of color, for example, have reported that some physicians brush off their fertility concerns, make assumptions that they can get pregnant easily, emphasize birth control over procreation, and may dissuade them from having children (3).

Another obstacle is the burden of pursuing infertility treatment, particularly cycle-based therapies like in-vitro fertilization (IVF). In addition to cost barriers, infertility patients often must take substantial time away from work for repeated office visits and associated procedures, and must be able to travel to medical facilities, which are often geographically distant (9-11). Additionally, many treatments require repeated cycles and the ability to follow complex medical instructions (12).

Other patients may be denied access to effective care if the institution at which they seek treatment does not inform them of the availability of certain treatment options, such as IVF, because they conflict with the religious affiliation of the facility. Fair access also is impaired by providers who refuse to treat unpartnered individuals and same-sex couples, a practice that ASRM rejects (13).

Research on IVF outcomes and race/ethnicity, including three studies using data collected by the Society for Assisted Reproductive Technologies (SART) suggests that when African American, Asian, and Hispanic women attain access to ART they experience lower success rates compared with non-Hispanic white women (2). The findings include evidence of lower implantation and clinical pregnancy rates, as well as increased miscarriage rates among certain minority women. These differences in treatment success are concerning; they are poorly understood and insufficiently studied, with explanations ranging from biological factors to modifiable behavioral factors (14-16). Their rectification is critical to achieving reproductive health equity among women and men of different racial and ethnic backgrounds. More research is urgently needed to identify the causes and the remedies for these disparate outcomes.

Moreover, we are ever mindful of the unique and even heightened barriers to care faced by LBGTQI+ families and couples. These may include medical and legal barriers, for example, a

struggle to be recognized as intended parents or even to be treated. Moreover, the cost of services upon which they may rely to build their families, including surrogacy, can be overwhelming and even insurmountable (13). ASRM believes that the ethical duty to treat persons with equal respect requires that fertility programs treat single persons and LGBTQI+ couples equally to heterosexual married couples in determining which service to provide.

The diversity of reproductive care providers may also come into play. As of December 2018, there were 50 ACGME approved REI fellowship programs. Of 156 total reproductive endocrinology & infertility (REI) fellows in the programs at the time, just 11 (7%) identified as Black/African American, five as Hispanic/Latino (3.2%), 22 as Asian (14.1%), and six as Multiracial (17). Data on the racial/ethnic diversity of other reproductive care practitioners, including practicing REIs, reproductive care nurses, mental health professionals, laboratory personnel, or laboratory directors, could not be found. This gap in data merits mention; and enhanced research in this area should be prioritized.

**References**


1. Ethics Committee of the ASRM. Disparities in access to effective treatment for infertility in the United States: An Ethics Committee opinion, updated 2020 (in press).
2. Armstrong A, Plowden TC. Ethnicity and assisted reproductive technologies. Clin Pract (Lond). 2012;9:651-8.
3. Bell AV. Beyond (financial) accessibility: inequalities within the medicalisation of infertility. Sociol Health Illn. 2010;32:631-46.
4. Cordasco KM, Ponce NA, Gatchell MS, Escarce JJ. English language proficiency and geographical proximity to a safety net clinic as a predictor of health care access. J Immigrant Minor Health. 2011;13:260-7.
5. Inhorn MC, Fakih MH. Arab Americans, African Americans, and infertility: barriers to reproduction and medical care. Fertil Steril. 2006;85: 844-52.
6. McCarthy-Keith DM, Schisterman EF, Robinson RD, O'Leary K, Lucidi RS, Armstrong AY. Will decreasing assisted reproduction technology costs improve utilization and outcomes among minority women? Fertil Steril 2010;94:2587-9.
7. White L, McQuillan J, Greil AL. Explaining disparities in treatment seeking: the case of infertility. Fertil Steril. 2006;85:853-7.
8. Duke CC, Stanik, C. Overcoming lower-income patients' concerns about trust and respect from providers. Health Affairs 2016. Available at https://www.healthaffairs.org/do/10.1377/hblog20160811.056138/full/. Last accessed July 11, 2019.
9. Wu AK, Elliott P, Katz PP, Smith JF. Time costs of fertility care: the hidden hardship of building a family. Fertil Steril. 2013;99:2025-30.
10. Missmer 2011, Missmer SA, Seifer DB, Jain T. Cultural factors contributing to health care disparities among patients with infertility in Midwestern United States. Fertil Steril. 2011;95:1943–9.
11. Domar AD, Rooney K, Hacker MR, Sakkas D, Dodge LE. Burden of care is the primary reason why insured women terminate in vitro fertilization treatment. Fertil Steril. 2018;109:1121-26.
12. Nachtigall RD, Castrillo M, Shah N, Turner D, Harrington J, Jackson R. The challenge of providing infertility services to a low-income immigrant Latino population. Fertil Steril 2009;92:116-22.

13. ASRM Ethics Committee, Access to fertility treatment by gays, lesbians, and unmarried persons: a committee opinion, Fertil Steril. 2013;100:1524-7.
14. Humphries LA, Chang O, Humm K, Sakkas D, Hacker MR. Influence of race and ethnicity on in vitro fertilization outcomes: systematic review. Am J Obstet Gynecol. 2016;214:212.e1-212.e17.
15. McQueen DB, Schufrieder A, Lee SM, Feinberg EC, Uhler ML. Racial disparities in in vitro fertilization outcomes. Fertil Steril. 2015; 104:398-402.
16. Kelley AS, Qin Y, Marsh EE, Dupree JM. Disparities in accessing infertility care in the United States: results from the National; Health and Nutrition Examination Survey, 2013-2016. Fertil Steril. 2019; 112:562-68.
**17.** Brotherton SE, Etzel SI. Graduate Medical Education, 2018-2019. JAMA. 2019;322:996-1016

## APPENDIX B - ASRM DIVERSITY, EQUITY, AND INCLUSION TASK FORCE

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