**Episode 71: Fertility Equality**

Dr. Joe Chappelle: Hello everyone and welcome back. I’m Joe Chappelle and you’re listening to Episode 71 of the OB/GYN Podcast. Today, we’re going to continue our recent focus on infertility by discussing an article from the New York Times from July. To do that, I have Dr. Jillian Kurtz and Dr. Vai Umesh with me. Welcome both of you.

Dr. Jillian Kurtz: Hey, thanks for having us.

Dr. Vai Umesh: Hi. Nice to be back.

Dr. Joe Chappelle: Before I get started today, I want to talk about our community a little bit. A couple of years ago I tried to put together a Slack channel for listeners to get together and connect, and we’ll just say it didn’t really work out as planned. But since I’m never afraid of failing over, and over, and over again, I’m going to take another stab at it and try to get us all connected, because there are quite a number of listeners from all over the world and I do feel like there is an opportunity for us to connect and it might lead to opportunities for research or collaboration, which I think would be great. So, there’s a new technology, or it’s not really new, but new to me, it’s called Discord and people have been using it a lot to set these communities up, and so I’m going to try one for ourselves. It’s open to anyone. The link will be in the show notes. It’s also on the webpage at [www.obgyn.fm](http://www.obgyn.fm) right in the top of the page, it says join the Discord. It’s an app, it’s on the web, it’s on iOS, it’s on Android, whatever you want to use and it’s very simple to use. So, if you’re interested in that and connecting with other listeners, please check it out and join us and we’ll see if this takes off this time or if I fail again.

Alright, on to today’s topic. We’re discussing an article, or we’re using an article from The New York Times as a jumping off point for this conversation, and it’s called *The Fight for Fertility Equality* by David Kaufman, and it was in The New York Times in July, and the link will be in the show notes. The main focus on this is about fertility equality and I wanted to know what the definition of that was, and there is a nice little summation of it, which I liked, and it’s “the ability to create a family is no longer determined by one’s wealth, sexuality, gender or biology.” And I think on the face of it no one’s going to argue with that statement. That sounds like equality. We all want equality for everything. But I do think it gets complicated very quickly. And before we really dive into some of my questions about the article, I want to give you both the chance for a little opening statement on fertility equality and the… I guess maybe the lens through which you see it. Jillian, obviously you’re an REI doc, so I think that you’re going to have a certain particular lens, so I’ll start with you.

Dr. Jillian Kurtz: I think this article was really exciting, because as you mentioned, it’s focused on the LGBTQ community, but the ideas are broad and can be applied to opposite sex couples also who just have poor access to fertility services for whatever reason, most likely financial in nature. But the concept of fertility equality is an exciting one and something that we’re really far away from still. Even though it’s been understood for quite some time that infertility is in fact a disease, we still only have a handful of states that actually mandate insurance coverage for IVF services, and we’ll get into all of that in the future. But I do think it’s an exciting topic that we are still pretty far away from achieving here in the U.S.

Dr. Joe Chappelle: I know we will argue on that and we will get into some of those specifics when we get into it. Vai, how about you?

Dr. Vai Umesh: Actually, jumping off what you just said, I echo that sentiment. I think as a resident, you take care of Medicaid patients primarily in clinic, and we have several REI clinics that we attend and have Medicaid patients come to, and I can tell you it’s very frustrating to have a natural halt in what we’re able to do for them because we get them testing, we get them worked up, we even diagnose them, and then when it comes time for the actual plan and treatment, oftentimes there’s a natural barrier in terms of access, especially because of all of these procedures are not covered. And so, from a resident perspective it is hard, because patients know that there is more that they can’t get to and I have no means to be able to offer them any more. So, I definitely think what you said resonates with me a lot.

Dr. Joe Chappelle: Yeah. I had a similar experience. I went to the same REI clinic that you went to, and it’s probably the same as it was then, because there’s still nothing we can do for them because they don’t have the insurance coverage nor the financial means to undertake anything really except… Actually, I guess there’s apps now that can help you track your fertility, it’s probably the only thing that’s changed in the last 15 years.

Dr. Vai Umesh: Right.

Dr. Joe Chappelle: But it is very frustrating. So, with the two of you, I think I’m going to end up playing devil’s advocate a little bit here and pushing against both of you. So, for the listeners, please know that everything I say is not necessarily how I feel about it, but in order to make the conversation interesting and elucidate some of these points, I’m going to take the opposite stance on some things. So, please don’t kill me.

I want to start with fertility, and I think Jillian, you alluded to this, is fertility as a human right. And I think… You called fertility a disease, and I think in doing that the language then says, well if it’s a disease, then we should treat it. And if we should treat it, that means that we should cover it under health insurance, that’s what health insurance is there for, to treat a disease. But I do think that there is a difference between, let’s say… Only because we were talking about it before we started recording, let’s say renal disease that requires dialysis because your kidneys don’t work and if you don’t have that you’ll die, or hypertension, which is a longer time to death but will get there eventually if you don’t treat your hypertension, and something like infertility which won’t kill you. And so, what would you say about that?

Dr. Jillian Kurtz: Well, I think that what you’re getting at is that it’s indisputable that people have the right to life. That is indisputable. And if you have a life sustaining treatment, that is going to be covered under insurance. The question is, is the right to a family an inherent human right? And if it is, then sure it’s a no brainer that we should be helping our citizens achieve that, whether it be by financial support or otherwise. But I think that’s what’s up for debate. Is it a human right to have a family?

In 1948 – I did a little bit of research before we recorded this podcast – there was a United Nations Universal Declaration of Human Rights that said men are women of full age without any limitation due to race, nationality or religion have the right to marry and raise a family. So, according to the United Nations, it actually is a human right.

Dr. Joe Chappelle: Okay. And I think that you could interpret that in different ways. Obviously in 1948, I don’t think they were talking about IVF. But you could definitely extrapolate from that to incorporate modern techniques for fertility. I’ll buy that. How about you, Vai?

Dr. Vai Umesh: I guess one other way to look at it is defining treatment as how it improves people’s quality of life. I’m going to go with this and see if it ends up making sense. But for example, if you have somebody who has mobility issues, do they have a right to have access to PT? Do insurance companies cover PT and wheelchairs and things like that? They may not die from not being able to move, but perhaps that impacts their quality of life and their ability to function as a contributing member of society. And so, could we argue that a right to a family and people’s emotional wellbeing is all sort of wrapped up in that and could that be one way to justify saying people have a right to this because that is what they are looking for when they define what is meaningful to them and what gives them the drive to get up in the morning and what is going to allow them to continue doing what they’re doing. That kind of thing. I’m not sure. But I feel like there’s something there we can try.

Dr. Joe Chappelle: I think you’re right. We’re going to run into this issue a lot in this discussion, that you get into a slippery slope pretty quickly where it’s how far does that right to quality of life extrapolate out and where is the end of that? Something I was thinking about while the two of you were talking was about erectile dysfunction. And we cover erectile dysfunction treatment, at least most insurance companies do, and that’s not going to kill you. You could actually consider that a fertility thing I suppose as well, but we cover that. And so, again, we’ve already decided to cover some things for quality of life, so where do we draw that line?

And I think one of the major things that’s going to come into it is going to be cost. So, let’s step back for a second and talk about what reproductive assistance actually costs and then we can talk about how we incorporate that into… if we should or if we’re going to incorporate that into our decision making. So, how much does an IVF cycle cost? According to a few sites online I could find, the average cost per cycle is about $20,000 give or take $5,000 maybe depending on where you get it done. And there are some places, there’s a place upstate in New York in Albany that does it much cheaper than that. And there are some places you can go to, to do that but there’s only a few. But for most places it’s $20,000. And the median number of cycles that a couple needs to get pregnant is two cycles. So, per pregnancy you’re talking about $40,000. That’s not an insignificant amount of money and it’s probably a lot more expensive than the treatment for erectile dysfunction. And so, what do you guys think? Do you think that we should be incorporating the cost to society to cover this or not?

Dr. Vai Umesh: I guess my question is where do a lot of these costs come from? I actually don’t know this. I don't know if this is just based on… Is this market driven? So, based on demand and supply this is the cost that was deemed by certain private groups and that’s what we’re basing it on, or does it come from elsewhere? I guess that would be the first thing I’d want to know.

Dr. Joe Chappelle: Jillian, do you have any insight into that?

Dr. Jillian Kurtz: Generally, the bulk of the cost is the retrieval itself, the actual procedure where you undergo anesthesia and all that. That costs like maybe $9,000. Then, the embryo transfer itself costs about $4,000. And the additional tests that you can do, like preimplantation genetic testing and things like that, that’s an additional $4,000. All of these addons add up to be about $20,000 if you buy the full package. The drugs alone are about 5 to $6,000, so a lot of it is… When somebody does have insurance coverage for IVF it still won’t cover the cost of the medication. So, even if somebody has IVF coverage, sometimes just the cost of the medications is prohibitive.

Dr. Vai Umesh: I think a more conservative answer is yes, ideally if we could eat the cost of this and provide this, that would be the best-case scenario. But I get that that is the idealistic answer. I think a more practical one that would seem reasonable to me is do it in somewhat of a graded fashion, like we do have a little bit now. So, saying, almost like we requiring to say you need to try X, Y, Z before we get to this and if there was a way to do that without it becoming inefficient, perhaps that would be a more reasonable way to approach eating the cost of this to make sure that people are not jumping to the most expensive option without actually trying…

Dr. Jillian Kurtz: That already is in place, at least from my experience. Most insurance plans, if you’re less than 35, require you to go through six oral medicated cycles before they’ll even cover it.

Dr. Vai Umesh: Got it.

Dr. Jillian Kurtz: So, they do force you to do a conservative course before jumping right to it. If you’re greater than 35, they will cut it down to only three months. So, that is built into the system.

Dr. Joe Chappelle: And we’ll get into a little bit in a minute about the different insurance techniques that are used in these different states. Just to give us a couple of more numbers, in 2017, so that’s 3 years, data’s old a little bit, there were 284,000 cycles done in the U.S. in a year, of which there were 78,000 deliveries, so that’s actually about three cycles per baby there. But if you take 284 and you multiply it by 20,000, you’re talking about a lot of money and that adds up very, very quickly.

I guess that’s a good time. Why don’t we go over what the different states and how they do it? I’m not going to go through all of them, but I’ll go through a couple. Currently, I believe there are 17 states that have laws pertaining to infertility coverage and 9 of those states have laws that mandate IVF coverage in some form or another. Let’s talk about a couple of them.

So, here’s Connecticut. Connecticut law includes both individual and group health insurance policies and includes coverage for things like IUI and IVF. They do have some exclusions. You have to be under the age of 40 and they only pay for a lifetime maximum of two IVF cycles. I think the average couple was 2.7 IVF cycles per a live infant, so you’re already talking there that for a lot of women that may not cover the whole thing. Delaware includes up to six IVF retrievals and an illimited number of transfers from those retrievals. Retrievals must be completed before the age of 45 and transfers before the age of 50, and if the employer has less than 50 employees, they’re exempt from the requirements. I’ll give you one more, which is Maryland. Coverage in Maryland is limited to three IVF attempts per live birth and a lifetime maximum of $100,000.

Dr. Jillian Kurtz: Wow.

Dr. Vai Umesh: Wow.

Dr. Joe Chappelle: Yeah, so that’s pretty generous.

Dr. Jillian Kurtz: Yeah.

Dr. Joe Chappelle: Must be able to get pregnant via less expensive treatment options. So, I guess that I think they mean must not be able to get pregnant. Must have at least a two year history of infertility or have an infertility caused by endometriosis, blocked or surgically removed fallopian tubes (not voluntary), abnormal male factors or fetal exposure to DES, which is not that common anymore. And then there’s a couple of other things. For same sex couples, there must be six previously failed attempts of artificial insemination over the course of two years or have infertilities related to one of the conditions listed above.

Now, let’s take that opportunity, because that’s a nice segue into the article a little bit. Obviously, they’re talking about same sex female couples and the article really was from the point of gay men. I guess you can argue that a lot of the articles about this is that for gay men artificial insemination is not an option for obvious reasons, and so the only thing that you can really do to make that equal is to do surrogacy. Do you guys have any idea how much surrogacy costs?

Dr. Jillian Kurtz: It varies, I think, but it can be upwards of, all in all, $130,000 or something like that.

Dr. Vai Umesh: Oh my God.

Dr. Joe Chappelle Yeah. The conservative I got was like $90,000 and the highest I saw was $150,00. And it does depend on state. In some states, up in New York actually until recently, it was illegal to be a surrogate. It is now not illegal. That was passed during COVID and so basically everyone missed it. So, in some states it’s still not legal and it does cost a lot of money. So, you’re talking, let’s say it takes two cycles to get pregnant with IVF, you’re talking $40,000, but for surrogacy you’re talking to $100,000 to $150,000. So, it’s a big difference in cost.

So anyway. I guess there’s no right answer to any of this conversation. So, let’s say you guys are designing an insurance thing. You don’t want to bankrupt your insurance, but you do want to cover some of this like some of these states do. Where do you draw the line? Do you say three cycles? Do you say two cycles? Is there a lifetime maximum? Is there an age limit? I mean, one of them is under the age of 40, and Jillian I don't know if you can tell me, but how many of the women you take care of are over the age of 40?

Dr. Jillian Kurtz: Quite a few. But I understand. The success rates, once you’re over the age of 40, you’re in the single digits. So, I can understand why an insurance company would be hesitant to go down route unless you’re using donor egg.

Dr. Joe Chappelle: But is that fair?

Dr. Jillian Kurtz: I don't know. Of course, it’s not fair but it doesn’t make sense financially to pay for IVF for a woman that has dismal prognosis.

Dr. Joe Chappelle: Right. I think that’s where we get into the rub.

Dr. Jillian Kurtz: Well, I think as the physician, that’s when I would counsel and say, okay, say we have $15,000 insurance benefit. Is it to our benefit for you to stimulate using your own eggs or should we put this money towards donor egg and get you pregnant that way so that we don’t use up all of your benefit? I should be able to give the patient the option, but as the physician counsel them towards…

Dr. Vai Umesh: And so then maybe what you’re saying, maybe it would benefit more for a max in your lifetime kind of thing, where people can use money towards whatever intervention is better suited for them. So, perhaps you throw the 50 grand towards surrogacy if you are a gay couple and want to go that route. Or you try what you just suggested, try the donor egg versus cycles of IVF. I think this would give some element of being able to customize a treatment plan for the couple that you have but still be able to provide equal compensation for all scenarios.

Dr. Jillian Kurtz: Right. I also wonder if it would be cheaper. If part of the reason why having a surrogate is so expensive because once she’s pregnant you have to pay for all of her medical expenses out of your own pocket. If your insurance could cover her as if she was just another pregnant person on the street, maybe the cost would go down substantially.

Dr. Vai Umesh: I also don’t know, with regards of surrogacy, I know they mentioned there’s a lot of regulatory agencies and things like that. I actually don’t know how much money the actual surrogate takes home from this and how much of this is just eaten up in a lot of bureaucratic costs.

Dr. Jillian Kurtz: Right.

Dr. Vai Umesh: And so, if there’s ways to regulate that perhaps and say… I believe the majority of the money should be going towards the surrogate and the least should be going to all of these other fees.

Dr. Jillian Kurtz: Towards the agency.

Dr. Vai Umesh: Exactly. So, I mean, there’s some possibility there of trying to legislate and make sure that people aren’t getting exploited through those agencies.

Dr. Joe Chappelle: Right. I’m looking at the West Coast Surrogacy Agency and they say they’re very transparent about their fees, so I will take them at their word and at least it’s probably in the ballpark. An experienced surrogate, which I like the term experienced there, it carries a lot of water, gets 60 grand for the surrogacy, so that’s their money. An extra $5,000 if it’s a twin pregnancy. Extra $10,000 if it’s triplets.

Dr. Jillian Kurtz: Oh my God.

Dr. Joe Chappelle: Extra $3,000 if they have a caesarean or need a caesarean. And they can get paid $10,000 if it’s a cancelled cycle, if they need an amniocentesis, CVS, if there’s a fetal reduction, termination of pregnancy, loss of reproductive organs I guess if they have a hysterectomy, and ectopic pregnancy or other occurrences. And the rest of the $40,000 goes to screening costs, legal fees, mandatory psychological support for the surrogate and then other costs paid by the parents’ health insurance and things like that. But the surrogate herself is getting 60 grand. Which, what is carrying a human fetus to delivery worth? I don't know. I don't know how you put money on that. But $60,000 out of the $100,000 seems not that bad considering everything else that has to be paid for as well, including health insurance.

Dr. Vai Umesh: Yeah.

Dr. Joe Chappelle: But this place is very transparent, so therefore you can assume that they probably pay their people more than other surrogates get paid, so I’m not going to extrapolate that across the country.

So, let’s take that to this gay couple that’s in this article here. Do you guys think that insurance should cover $100,000… or let’s say you’re going to make your lifetime limit 50 grand or 60 grand or whatever it is, do you think that people should be able to use that for surrogacy? It sounds like, at least Vai you’re saying yes.

Dr. Vai Umesh: Yes. Sorry, can you repeat the question? I just…

Dr. Joe Chappelle: Yeah. We were talking about making a health insurance thing where you get a maximum lifetime benefit of… We’re designing our perfect instrument here, right?

Dr. Vai Umesh: Right, right, right. Yes.

Dr. Joe Chappelle: Do you think you should be able to use that for either IVF or donor egg or you can use that for surrogacy?

Dr. Vai Umesh: Yes. I mean I do, Apparently I’m not going to make the most money in this insurance practice that I’m building, but I think if it were up to me, that is absolutely the way I would design it, because I think that gives people like Jillian the ability to counsel their patients to best utilize their resources in the most appropriate way and it should be different for every couple, same sex, not same sex, every couple is going to have different needs and different issues. And I think this would be the best way to allow us to customize that treatment plan.

Dr. Joe Chappelle: Jillian, do you feel the same way?

Dr. Jillian Kurtz: I mean, I do. I think, like you said, it doesn’t make for the best conversation if we’re just agreeing with each other the whole time, but I actually agree. I agree.

Dr. Joe Chappelle: Alright, fair enough. The other angle we haven’t talked about yet, and Vai I think you sort of brought it up is, is there a way of making, especially… let’s leave surrogacy to the side for a second. Is there a way of making IVF cheaper?

Dr. Jillian Kurtz: Yes. Yes. And I think there is a push towards doing that, to improve access in lower income countries and things like that, there are trials underway, some of them being like more gentle stimulation, because a lot of the cost comes from these expensive injectable medications. So, if we can do combinations of orals with injectables, maybe that could make it cheaper. There’s also something called INVOcell, have you guys heard of that?

Dr. Joe Chappelle: Mm-hmm.

Dr. Jillian Kurtz: It’s a way to have the embryos be incubated inside of a capsule that’s held in the vagina for five days, as opposed to being in the lab. A lot of the cost of IVF also comes from paying for the embryologist to be babysitting your embryos and checking on them every day and giving them a graded score on day three and all that stuff, so this takes that cost out of it. You put the capsule in, combine it with the sperm and the eggs and then five days later you open it up and see what you have and you transfer whatever you have at that point. So, there is definitely stuff on the horizon to try and make IVF cheaper.

Dr. Joe Chappelle: Yeah. I think there are certainly, like you said, fixed costs. We recently built a new IVF lab. We took on an IVF group. I won’t tell you exactly what it cost, but I will tell you that it cost a lot of money and that they will be paying that off for a long time. And when you have something, a fixed cost like that, you have to price the treatment to cover that cost, and also your rent and all the other things that go into running a business. And of course, as… well, maybe not everyone knows, but REIs do tend to make a decent salary as well, so there is that component of it. But I would say, as in most things, although physicians do tend to make a lot of money, including Ob/Gyns make good money too, just regular generalist Ob/Gyns make good money. If you look at the percentage of the cost of anything, the physician salary part of it is usually not the driving component of it. In this case it’s certainly all the equipment and like you said, the embryologist and all the stuff that goes into it.

If we could make it cheaper. If we could… I don't know. Do you think there’s a role for… I think the answer to this is no, but I’ll let you guys tell me that too. Do you think there’s a role for a government run IVF center that can somehow maybe do it cheaper for these low income or people with less means? Do you think there’s a role for that? Would it actually make any difference?

Dr. Jillian Kurtz: I mean, that almost sounds like separate but equal that won’t be equal. I think anything that’s specifically targeted to serve the lower income may not be… I feel like that’s inherently unfair, that you would corral the lower income population to a specific clinic designed to provide cheaper care and may not be the best care. I feel like the better way to go about it is to bring them up to the level that they get to go to the place where the wealthy white people can afford to go. I don’t think it’s right to set up a government run facility, if that makes any sense.

Dr. Vai Umesh: And also, I guess the question would be, what is the government facility doing that allows them to operate at a lower cost? Is it as you said, picking treatments that may not be the best or doing treatment modalities that may not be state of the art? Or is it that they are subsidizing it in some way? Is it because they’re operating with lower overheads? I would imagine if there was a government center that was doing it more efficiently, there’s no reason why a private company could not try to mimic that model if indeed the treatments were equal.

Dr. Jillian Kurtz: Right. And that’s what I think is in my head, the treatments would not be equal.

Dr. Joe Chappelle: Yeah, that’s probably true. I also think I agree. I think there’s an ideal world which we are, the three of us, envisioning and trying to create in our podcast here, which I’m sure will go far. But there’s also the stark reality that we still have millions of people in this country that don’t have health insurance at all or have Obamacare of some sort, which is usually pretty terrible with high premiums, and so, they don’t have access at all. Again, we get into this question, this gray ground of is it worth giving them something that maybe is slightly inferior to what you can get if you’re a rich white couple? Versus having nothing at all. If we’re living in a not perfect world, which we are. And I’ll buy the answer no, by the way. I think no might be the answer to that. But I’m not 100%.

Dr. Vai Umesh: I mean, I guess yeah. As you rightly said, it depends on what our bar is. These patients I’m seeing in my REI clinic, I guarantee you they would all take something over nothing, because right now it’s nothing.

Dr. Joe Chappelle: Right. They can’t even get Clomid.

Dr. Vai Umesh: Exactly. Literally. So, for them, yeah. They are so desperate and want to make this work that the answer would be undeniably yes. So, yeah.

Dr. Jillian Kurtz: And I have to say, to do an IUI does not involve complex equipment or expensive supplies or anything like that. So, that would be an easy thing to be able to provide people at a pretty minimal cost.

Dr. Joe Chappelle: That’s a good point. I’m going to go off script here for a second, because I want to talk about IUI for a second, because this is something if you go back 20 years, maybe even longer, that all the private guys did IUI. They would say, we will bring it in, we’ll time it right, we’ll wash it out, we’ll inject it. And they would tell me all the time, “Oh, yeah we do IUI in the office.” We do not do IUI in the office at all. I’ve never done it. It’s never been done in our offices outside of REI. And I think Jillian you’re right. It’s not about the technology of it, because it’s relatively simple technology. I think it’s the system that goes around it as far as timing it correctly, making sure you ovulated, all that stuff. Maybe you could just take two minutes and walk me through, if you’re doing an IUI, what are the things that you do before you actually perform it?

Dr. Jillian Kurtz: Well, I have to say I think the biggest barrier for generalists to want to perform IUIs is that it really has to be targeted within 24 hours of your ovulation, and nobody wants to come in on a Sunday to do an IUI unless you have to.

Dr. Joe Chappelle: Right.

Dr. Jillian Kurtz: So, at the fertility practice, we’re open seven days a week, we’re only closed Christmas and New Year’s. So, we’re available Saturday, Sunday, for people’s IUIs, which is not going to be the case at a generalist practice. But like you said, it’s not complex. We collect the sample of sperm from the partner. Generally, we have them produce at home. It has a shelf life of about an hour, so from the time they produce to the time we need to process it, is about an hour. Most guys feel more comfortable just producing at home as opposed to doing it in the office. And then, it’s just a simple sperm wash that we suspend the sperm in and use a centrifuge to create a sperm pellet and resuspend it in a sperm wash. It’s really pretty simple. Like I said, it’s all about timing, so if you do the HCG trigger to mimic an ovulation, the HCG is structurally similar to LH and acts like an LH surge and then they ovulate 36 hours later.

Dr. Joe Chappelle: Okay. Alright, so that’s the main difference, I think. You’re actually triggering the ovulation.

Dr. Jillian Kurtz: Not necessarily. Some practitioners just detect an LH surge in the blood and then do the IUI the following day.

Dr. Joe Chappelle: Okay.

Dr. Jillian Kurtz: But yes, we do need to see them every other day around their time of ovulation to do it one way or the other.

Dr. Joe Chappelle: Right. I actually tell patients, I say I can even do Clomid. I can do Clomid, I can do IUI technically, but we’re not set up as an office to maximize your success. And so, I’ll often send to REI just because you guys have a system in place in order to make that happen and for me to do it would be a struggle.

Dr. Jillian Kurtz: Right. And that most recent practice bulletin on unexplained infertility basically says, in the setting of unexplained infertility, doing empiric Clomid is not giving them any advantage unless you’re combining it with an IUI.

Dr. Joe Chappelle: Correct. I read that as well. Let me take it a step further then, because we’re now reducing costs. We talked about overhead. You have your lab that you work in or your office has a lab, and you have fixed overhead for that lab. And so, every patient that you are seeing who’s not utilizing that lab is costing you money, because you’re paying for the embryologist, you’re paying for the electricity, the freezers, you’re paying for all that stuff regardless if the patient is using it or not.

Dr. Jillian Kurtz: Sure.

Dr. Joe Chappelle: Alright. So, if we could divorce IUI from an REI’s office who has to pay overhead, we might be able to reduce the cost of IUI.

Dr. Jillian Kurtz: Totally agree.

Dr. Joe Chappelle: Okay. Alright. Anyway, food for thought for another day.

Dr. Jillian Kurtz: Yeah.

Dr. Joe Chappelle: Alright. I know Jillian wanted to get to this, so let’s talk about… back to the article. The article went through this whole thing about equality based on gender, wealth, sexuality, biology. And again, they were saying, if you are a female couple, you can do IUI, artificial insemination. And if you’re a heterosexual couple you have lots of options. But if you’re a gay male couple, you can’t get pregnant, so what do you do? You can only do surrogacy, and so they spend some time talking about that in the paper. But then they get to the rebuttal to this from this feminist groups is that essentially using women as a surrogate is exploiting women and antifeminist. And we chatted a little bit before we started recording, so I kind of know what you’re going to say already, but I’ll start with Vai because I think that Jillian is more passionate and so we’ll save her for the big gun.

Dr. Vai Umesh: I was going to say, I honestly think that it’s empowering. I think I firmly believe that giving women the right to utilize their bodies in whatever method that they see fit, and if they get compensated for it, I think that’s empowering. I mean, yes, the natural argument is then what do you think about prostitution? Personally, without getting too much into that, I think it should be legalized. In the same way, I think that if you want to use your body and sell body products, as long as you are well counseled, you are of sound mind and you are not doing it under undue influence, which is where the slippery slope comes in, you should be allowed to do it. And I actually think women who opt to be surrogates, a lot of them enjoy doing it. They find their experience rewarding. And at the end of the day, even if they end up doing it for money, as long as, as I said, they have been counseled and they understand what they’re getting into, it is they’re right. And I firmly believe we should respect that.

Dr. Joe Chappelle: Jillian’s going to talk about women’s right to her body and then this so I’ll let Jillian talk about that and then I have some rebuttals for both. Go ahead.

Dr. Jillian Kurtz: Okay. I just think it’s a little bit contradictory that the women’s rights advocates have fought so hard to defend Roe v. Wade and defend a woman’s right to make decisions about her reproduction. So, it just seems condescending to say a woman has a right to choose to terminate her pregnancy, but she would be unfairly coerced if she were allowed to receive payment for being a gestational carrier. It’s like being compassionately prejudiced. It bothers me that they wouldn’t have enough faith in a woman to make decisions that she felt was right for her body and for her family and things like that. Yeah, it irritates me.

Dr. Joe Chappelle: Yeah. I agree with you, but I’m going to, again, be the devil’s advocate just for the point of the conversation. And I think this is what they’re getting at. I don’t think they truly believe that they should be able to tell people they can’t do this. I think what they’re really railing against is the inherent economic inequality in our society, around the world but also very much in the U.S., that forces people into a situation where they think that getting paid to be pregnant is a good thing. Because again, how many rich white women are going to be surrogates?

Dr. Jillian Kurtz: Very few.

Dr. Joe Chappelle: Very few. And so, we really have this economic inequality that forces people to be prostitutes, to sell their blood, to sell their sperm, to – if we allowed it – sell their organs, to rent their uterus out for nine months. Is that really something that we want as a society, to have people who are so destitute that they feel that the only way they can survive is by selling a portion of themselves to survive? I’m not sure that that’s… If we were all equal, I don't know how many people would be lining up to be surrogates.

Dr. Jillian Kurtz: Sure. Have you guys heard of the term repugnant transaction?

Dr. Joe Chappelle: No, but I like it already.

Dr. Jillian Kurtz: There’s this podcast, and I don’t want to plug anybody else’s podcast on your podcast.

Dr. Joe Chappelle: Oh, please do.

Dr. Jillian Kurtz: There’s an NPR podcast called Hidden Brain.

Dr. Vai Umesh: Oh, I love it.

Dr. Jillian Kurtz: Yeah, I love Hidden Brain. There was an episode about repugnant transaction and it’s an economics term, and it’s in reference to things like this that are legal financial agreements that make us a little sick to our stomach. It’s a little questionable on the ethics of it but I think that it’s providing a service for a fee and that women who put their body through that experience for a really good cause, they deserve to be compensated for it. Getting money for a service makes you feel appreciated and valued. And Dr. Chappelle, I know that you probably love delivering babies, but if you weren’t reimbursed for it, you’d probably a lot fewer babies than you do now, right?

Dr. Joe Chappelle: That’s 100% true.

Dr. Jillian Kurtz: So, it’s hard for me to say that it’s a bad thing to pay people for doing something that I think is an imperative.

Dr. Vai Umesh: Yeah. And I actually wonder is this that different than undesirable other jobs? I mean, there are jobs out there that we’re like, oh my god, I would never do that. And we have the luxury of saying this because we are not in that socioeconomic bracket where I have to do that, and I don’t have a choice. So, my question is, as long as you are… My issue is with lack of compensation. As long as people are being compensated, I would argue that that disparity already exists, but as long as people are making this choice and are being appropriately compensated, as opposed to now with thinks like prostitution for example, it’s not necessarily the case. What I mean by that is things like access to care and having people being in dangerous situations unnecessarily versus if you were to legalize transactions like such, then perhaps getting people to more access would allow them to do what they’re doing but in a safer manner? I don't know. I don't know that there’s a whole lot of difference between that and other undesirable jobs. I don't know if I want to clean up sewage every day. And someone has to do it.

Dr. Jillian Kurtz: Right. That’s a good point.

Dr. Vai Umesh: And I’m thankful that there are people doing it, but I don’t want to do it. And I’m sure those people doing it, I shouldn’t speak on their behalves, but I am sure that there are times where your job is unpleasant but you’re doing it because you have to do it. And so, how is this any different?

Dr. Jillian Kurtz: Right. I think that I hope the agencies are doing a really good job with their psychological screening and making sure that they’re choosing appropriate candidates and that this person doesn’t feel coerced unnecessarily. And hopefully, screening for some human trafficking…

Dr. Vai Umesh: Exactly.

Dr. Jillian Kurtz: Risk factors and things like that.

Dr. Joe Chappelle: Yeah. To bring it back around for me to say how I really feel is I am concerned about the economic inequalities in our society that do lead people or force people, depending how strong a language you want to use, to pursue any of these risky jobs. I mean, whether it be cleaning up sewage or prostitution or being a lumberjack, which are all dangerous jobs, I would like to make that more equal. However, I do not think that should be an excuse to rob people of their agency to be able to decide what to do with their body in a way that’s not harming other people. I mean, by being a surrogate there’s no harm to other people. It’s not like we have to police that in society and say, okay you can’t do that because it hurts the rest of the society, it’s really just their body. And I don’t feel like I should ever be in a position to tell someone what they can do with their body. As a women’s rights advocate in general but as a human’s rights advocate totally, I certainly shouldn’t get to tell people what to do. But I am concerned about the economic inequalities that there probably are a percentage of these people who are surrogates who do it for reasons that aren’t the good reasons.

Dr. Jillian Kurtz: Right. I think that’s probably true.

Dr. Vai Umesh: Yeah.

Dr. Jillian Kurtz: But it’s not as though the alternative, say they say we’ll all just adopt instead. It’s not like adopting is a lot easier or cheaper or quicker…

Dr. Joe Chappelle: Totally, yeah.

Dr. Jillian Kurtz: So. I think that’s a problem also. If we could fix our adoption system and make sure that it was more accessible, maybe there would be fewer gay couples who were looking for surrogates.

Dr. Joe Chappelle: I doubt it, because you could make the same argument about… I mean, we’ve seen this. We’ve seen couples come back five, six times for IVF.

Dr. Jillian Kurtz: Right, right, right.

Dr. Vai Umesh: It’s a biological need, right?

Dr. Joe Chappelle: Correct.

Dr. Vai Umesh: I think that’s what drives a lot of that decision making.

Dr. Joe Chappelle: And it’s always easy for me. I mean, first of all I’m not a woman, second of all I’m lucky enough that my wife and I had no fertility issues. So, I don’t really understand what it feels like to be in that situation. So, it’s easy for me to say why don’t you just adopt? You’ve done this six times, it’s not working.

Dr. Vai Umesh: Yeah.

Dr. Joe Chappelle: But I don’t have their lived experience, and so I’m not going to sit here and tell them that. Because if I was in that spot, I might feel the same way.

I think we pretty much covered the topic as well. I mean, again, we didn’t come to any conclusions tonight. Although I think that we did a little bit. I think we all agree that having some kind of insurance coverage for fertility, and we can quibble about is it $20,000, is it $50,000 maximal lifetime, is it $100,000? Whatever it may be. I think that we agree that there should be something. And I also think we agree that whatever money we put up for that should also be able to be applied for surrogacy, even though that’s not going to cover the whole cost of it, it does at least make it somewhat more equal. Is that a fair assessment of what we all think?

Dr. Jillian Kurtz: Yep.

Dr. Vai Umesh: Yes.

Dr. Joe Chappelle: Alright. But obviously we don’t get to control that, but hopefully some of our listeners may be in a situation where they are, in their community or nationally, can advocate for that, and we certainly will do that in our own communities.

Before we close up for tonight, Jillian, is there any other thoughts or comments you wanted to make about all of this?

Dr. Jillian Kurtz: No. I was excited to see they did a link to an article that showed all the companies that are improving access to fertility, I thought that was exciting to read. One of them was Starbucks, and they were saying that 85% of the workers at Starbucks make less than $40,000, so that’s exciting to think of corporations starting to include that as a benefit to maybe improve access to lower socioeconomic groups and things like that.

Dr. Joe Chappelle: I agree. I have mixed feelings about it. I guess you can live in the United States and not be a capitalist at heart, because I get there are plenty of people who are not, as evidenced by recent elections. But I am a capitalist, I believe in capitalism in general, but I am concerned when our social or societal benefits are being led by corporations, because corporations in general only do things out of their own self-interest. And even if it’s I’m doing this, it seems like it’s selfless, it’s not because it helps them retain employees and their public persona and PR. If there’s not some kind of incentive to them, they’re not going to do it. So, I’m nervous about that.

Dr. Jillian Kurtz: Whatever their intention might be, maybe it’s not super benevolent, but their employees benefit from that.

Dr. Joe Chappelle: I agree. My concern is that when it’s no longer beneficial they’ll stop doing it.

Dr. Jillian Kurtz: Yeah.

Dr. Joe Chappelle: And so, I hate to… Again, it’s not that I’m against it, I just hate to depend on it.

Dr. Jillian Kurtz: Sure, sure.

Dr. Joe Chappelle: We shouldn’t have to depend on our corporations to do the right thing.

Dr. Jillian Kurtz: Absolutely. I agree, I agree.

Dr. Joe Chappelle: But I still give them credit for it, because in the system we currently have, they’re doing a good thing whatever the reason is, and so I applaud that. Vai, any final things for you?

Dr. Vai Umesh: Yeah, I was going to say, we didn’t get into this too much, but the article did mention this segment about fertility equality overseas and I just wanted to say I recently did a short elective in India before the COVID pandemic, where I got...

Dr. Joe Chappelle: Just before.

Dr. Vai Umesh: Just before.

Dr. Joe Chappelle: You barely got back, yes.

Dr. Vai Umesh: But I actually was very taken aback at how much demand there is in terms of trying to provide access to IVF and things like that in a lot of India’s population. Without getting too much into it, there’s no real insurance coverage issues in India, a lot of it is just pay out of pocket. And so, a lot of families in the lower middle class cannot afford basic healthcare, let alone IVF. But a lot of your merit in society is dependent on your ability to procreate. It was just shocking to me. I thought these resources were not on people’s radars internationally, and my limited time in India definitely proved or showed me otherwise. So, I think there’s a lot of stuff happening abroad too, which would one day be very interesting to look into and get into. And maybe even mimic some of the models that have been well developed internationally, because they’re maybe even ahead of the U.S. in that regard.

Dr. Jillian Kurtz: Oh, definitely. The percentage of live births in Denmark that are attributable to IVF is like 6%. In the U.S. is like 1.6%. So, yeah, there’s definitely some of those Scandinavian countries that really have it figured out.

Dr. Joe Chappelle: Interesting. Do you think that has something to do with the relative education levels in those countries, where women are delaying child birth later and so more people are seeking IVF?

Dr. Jillian Kurtz: I don't know what it is. That could be though, that’s a good argument.

Dr. Joe Chappelle: Just a thought. I know especially in Norway, Oystein could probably tell us, but the rate of higher education in those Nordic countries is much higher than at least here in the U.S. But it wouldn’t surprise me also if they have a higher success rate with IVF just on the basic numbers.

I didn’t intend…. Well, I didn’t intend a lot this year, because COVID basically took half the year away. But I certainly didn’t intend to focus on fertility this year, but I think that we might make it a little bit of a focus this year, because I do think there are a lot of issues around it. I think it’s a very interesting subject and I do think that we probably have more topics to cover this year on fertility, from basic infertility work-up which Jillian did for us last month, to maybe some more advanced stuff about how IUI works about, about how IVF… how the actual egg retrieval works and the rates of success, because I think the better informed we are, even as general Ob/Gyns, the better we’re able to counsel our patients and direct people to right place. So, I think you’ll be hearing more about is as long as Jillian accepts that charge.

Dr. Jillian Kurtz: Yeah, you know I’m game.

Dr. Joe Chappelle: Okay. Alright. Well, I want to thank you both for this very interesting conversation. Like I said, I think we’re going to have more of it. If you’re a listener out there, please if you have comments about what we said, then please you can always reach us at feedback@obgyn.fm and I will send on if you have particular comments for either Dr. Kurtz or Dr. Umesh, I will certainly send them on to them as well, and we can respond in subsequent podcasts. But please, send me any questions or comments you have. Again, the Discord server is there for us to get together. Hopefully Vai and Jillian will join up as well so we can all be there and answer questions as well. Like I said, it’s very easy, it’s on the website at obgyn.fm or it’ll be in the show notes of the podcast.

Alright, thank you all and I look forward to talking to all again soon.