A day in the life of a reproductive endocrinologist and infertilty subspecialist—integration or dissolution?

I am worried. The scope of reproductive endocrine and infertility (REI) practice appears to be an ever-narrowing sliver of activity. Most of our efforts are directed toward preparing patients for in vitro fertilization (IVF), guiding them through the cycle of stimulation and hopefully referring them back to their obstetrician for prenatal care, or caretaking their frozen gametes. Although helping people create their families is one of the most rewarding things I have ever had the privilege to do, part of what drew me to this field was its breadth and ability to take a lifecourse view of our patients and to have patients of all ages.

As a junior faculty member, it was assumed that I would be the doctor who saw the "tough" patients—the ones with difficult diagnoses or who requested unusual management. I got the patients with amenorrhea who no one else could diagnose. The menopausal patient who could not take hormone therapy because of a prior venous thromboembolism and did not tolerate any alternatives to hormones. I got to have my own surgical loupes to do tubal surgery. We got to work with a suture material that was thinner than hair. Clinical practice was exhilarating, and my days were varied. I roamed from the operating room to the IVF suite to Labor and Delivery, clinic, and the laboratory. As an REI, I was a highly visible member of my department, on the main campus of our medical school's university hospital, and our practice was embedded within the hospital.

Politics and medical economics have brought us to a critical juncture. Unlike our colleagues in Europe, IVF centers in the United States did not remain embedded within hospitals and universities. Research in IVF from the traditional funding pathways was forever denied by the Dickey-Wicker Amendment, which considers IVF-related research to be "fetal research" and therefore ineligible for support from federal (National Institutes of Health) funding. Academic careers built on the National Institutes of Health's peer review system, a model that has led to some of the most impactful research in medical history, are not available to most REIs. This lack of academic support infrastructure for research was, in my opinion, a central driver of a process that is now coming full circle. REI practices became drawn to the private sector because it was a far more hospitable space in which to grow. Individual physicians who were sufficiently entrepreneurial were able to build IVF empires by scaling up their practices. Large fortunes were made in this first generation of IVF capitalists. Quality improvement became the driver for these practices along with market competition. This first generation of IVF practices has now evolved into a venture capital-driven model. Even more aggressive quality improvement measures are being applied by these entities, which come from a business perspective and now include the restructuring of REI practice to maximize its efficiency.

Do not get me wrong—teamwork and technical excellence are worthy goals. The job of fertilization and embryogenesis ex vivo requires an enormous effort, little room for error, and stiff competition. When it all works well, the team is poetry in motion. We help many patients. They send us cards and name their infants after us. There is honor and there is a good living to be made as a reproductive gamete manager. This should be a part of REI practice; however, it should not be the whole. It is simply not enough to sustain the intellectual curiosity of the physicians we are training.

There is now talk of changing fellowship training to 2 years instead of 3, to accommodate the increased need for assisted reproductive technology services to the population. This shortened training period will increase the pipeline for 1 year and will not result in the intended goal. Venture capital-driven practices are now "certifying" non–REI-trained physicians to perform egg retrievals and embryo transfers. This ultrashort training period will result in proceduralists who will operate within a very narrow scope of practice. Is this really the direction we want to take our field? As much as I want to see patients get the care they need, I also want to continue to train the best and brightest in our subspecialty and give them the wherewithal to integrate all of the aspects of our fascinating field into their daily lives.

Calling all REIs to step up and take control! We need to preserve the breadth of practice and knowledge that makes this the best and most satisfying career path in all of Obstetrics and Gynecology! We need to work within our profit-driven system to make REIs more than a commodity. We must not gut fellowships of their research "requirement" in the mistaken belief that research and clinical care are separable. Careers in assisted reproductive technology and competitively funded, hypothesis-driven, top-flight research need to be made possible. We need to repeal Dickey-Wicker or create alternative funding streams for promising research, or both. The American Society for Reproductive Medicine has stepped in to fill some of this critical gap, but should the need for peer-reviewed research really be solely up to our professional society? Our trainees need to be trained and engaged in full-scope REI practice and all of its offshoots, including genetics, which is becoming a larger and larger part of our daily lives. We need to learn from our counterparts in other countries who have made it all work and join with those who suffer from the same impending impoverishment of our specialty. We must correct our course. We are training people with the goal of providing them with long and satisfying careers. Abandoning them to the "invisible hand" of the market in the name of capitalism or an ever-narrowing sliver of clinical practice in the name of efficiency is not acceptable. REIs need to speak up in this conversation and create our own future.

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