



# Fertility, Pregnancy, and Postpartum: A Survey of Practicing Georgia Obstetrician Gynecologists

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## Abstract

**Purpose** OBGYNs help patients plan families, conceive, and deliver children, however the personal reproductive history and goals, infertility experiences, and birth outcomes of OBGYNs are not well studied. We aim to characterize female OBGYN reproductive experiences with a particular focus on infertility, reproductive life planning (methods of pregnancy prevention, reasons why pregnancy is/was delayed), birth outcomes (mode of delivery, delivery timing), and the postpartum period (breastfeeding, maternity leave, postpartum depression).

**Description** An anonymous email survey was distributed to female members of Georgia OBGYN Society and Emory University Department of Gynecology and Obstetrics. Descriptive statistics and bivariable analysis were performed using Microsoft Excel and OpenEpi.

**Assessment** Of 352 surveys, 204 of 269 women who opened the survey agreed to participate (75.8% per opened email, 58.0% per sent email). Mean age of first childbirth was 30.7 (SD  $\pm$  4.2) years. Most pregnancies were intended (77%). Fertility treatments were used in 13% of pregnancies. Resident mothers compared to mothers who gave birth before or after residency were more likely to report postpartum depression [26% vs. 16%, OR 1.8 (95% CI 0.93–3.58)] and shorter maternity leave < 6 weeks [57% vs. 29%, OR 2.57 (CI 1.56–5.00)]; exclusive breastfeeding rates  $\geq$  6 months were similar [38% residents vs. 41% non-residents, OR 0.80 (CI 0.44–1.43)]. Among those not finished with childbearing, 68% worried about infertility, 29% were considering oocyte/embryo cryopreservation, and 5% had already cryopreserved oocytes.

**Conclusion** Compared to the general population, the average age of first childbirth among Georgia OBGYNs was 4 years higher (30.7) with a greater proportion of pregnancies planned. Use of fertility services and obstetric course matched national rates, however postpartum depression was more prevalent among Georgia OBGYNs. Awareness of increased postpartum depression among residents may allow for improved counseling and treatment.

**Keywords** Delayed childbearing · Obstetrician gynecologist · Fertility · Postpartum depression

## Significance

Although the majority of pregnancy outcomes are similar to previously published national data, Georgia OBGYNs report several important differences, especially among postpartum women, that warrant additional study. In particular,

OBGYNs report delaying pregnancy and those who deliver during residency report higher rates of post partum depression. These findings have the potential to impact policy to promote maternal and child wellness. Perhaps changes can be made to improve mental health counseling, resident physician wellness, and improved accessibility to fertility counseling in order to improve postpartum health among those who deliver and reduce anxiety among OBGYNs who desire future childbearing.

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## Introduction

Obstetrician gynecologists (OBGYN) help their patients plan families, conceive, and deliver children, however there is often less focus on the reproductive health of the physicians themselves. While many studies focus on women's health, few specifically address female physician health (Phillips et al. 2014; Stentz et al. 2016). To our knowledge, the reproductive, fertility, and perinatal experiences of female OBGYN physicians have not been well characterized.

The average age of a woman delivering her first infant has increased from 21.4 years in 1970 to 26.3 years in 2014 in the United States (Mathews and Hamilton 2009, 2016). This increasing trend likely reflects a combination of factors including purposeful delay of childbearing, access to affordable effective contraception, and evolving female societal roles (Mills et al. 2011; Schmidt et al. 2011). Consistent with the national trend, the average female physician in the United States experiences her first pregnancy later in life (Stentz et al. 2016). Female medical trainees are typically at the prime of their childbearing years, but often delay pregnancy. Increasing age not only decreases the likelihood of conception, but also increases the likelihood of miscarriage and other adverse pregnancy outcomes such as premature birth, gestational diabetes, preeclampsia, and cesarean delivery (Joseph et al. 2005; Kenny et al. 2013).

As compared to a national sample, one study documented that female surgeons have their first pregnancy at a later age, have smaller families, report more infertility than the national population, and are more likely to use assisted reproductive technology (ART) (Phillips et al. 2014). OBGYNs comprised only 2% of that study population, thus limiting the ability to make generalizations to OBGYNs, who may have differing experiences and knowledge regarding age-associated fertility decline. Previous studies examining female OBGYN resident attitudes towards their own pregnancy and pregnancy outcomes during residency are over 30 years old (Phelan 1988a, b). Thirty years later, this topic needs to be reexamined; unlike the late 1980s, we now have access to effective fertility treatments such as in vitro fertilization (IVF) (Centers for Disease Control and Prevention 2016b) and there is a growing emphasis on work-life balance that may influence an individual's choice to delay childbearing (Daskivich et al. 2015; Stentz et al. 2016).

We aim to characterize female OBGYN reproductive experiences with a particular focus on infertility, reproductive life planning (methods of pregnancy prevention, reasons why pregnancy is/was delayed), birth outcomes (mode of delivery, delivery timing), and the postpartum

period (breastfeeding, maternity leave, postpartum depression). Additionally, we make comparisons between our population and published national data in order to highlight similarities and differences between our specialized cohort and the general population. We also make comparisons between those women who delivered during residency training compared to those outside residency training.

## Methods

This anonymous, cross sectional survey (full text included in the Online Appendix) was distributed between 11/15/16 and 12/21/16 via email to 352 female OBGYNs practicing in the state of Georgia. Email lists were obtained from Emory University and the Georgia Obstetrical and Gynecological Society (GOGS) and were edited to remove duplicates and male physicians. Regardless of participation, anyone who received the survey was eligible for one \$25 gift card, which was given to the winner from a computer-generated random number generator. Participant emails were collected in a separate database to maintain anonymity. The study was considered exempt from review by the Emory University Institutional Review Board (#00089368).

The survey was developed after reviewing prior studies that focused on reproductive health (Phillips et al. 2014; Yu et al. 2015). The survey was piloted on OBGYN residents and attending physicians to ascertain relevance and clarity. The survey domains included (1) participant demographics, (2) obstetric and fertility history including age at each pregnancy and pregnancy outcomes, (3) experience with achieving pregnancy including number of months attempting pregnancy, and, if applicable, number of months before seeking fertility evaluation and infertility diagnoses and treatment, (4) attitude toward family size, satisfaction with current size, reproductive life goals, and (5) postpartum experience (breastfeeding, postpartum depression (PPD), and maternity leave). When inquiring about PPD, participants were asked if they experienced feelings consistent with postpartum depression. PPD was self-reported and was not based on a clinical diagnosis.

## Data Analysis

The survey was created and data collection was performed using Survey Monkey. Data was analyzed using Microsoft Excel. Descriptive statistics were performed using Microsoft Excel for Mac 2011. OpenEpi was used to perform bivariate analysis using Pearson Chi square statistics and odds ratios. A *p* value of < 0.05 was considered significant.

## Results

### Characteristics

Of 352 surveys emailed, 269 women clicked on the survey link, and 204 agreed to participate resulting in a response rate of 75.8% for those who opened the survey and 58.0% for those who were sent the invitation. An initial invitation was sent with two reminder messages if the survey was not completed. To encourage completion of the survey, few questions were mandatory. The survey was also distributed to those who piloted the survey. More than half of the respondents (55%) were 40 years old or younger (Table 1). Median age at time of participation was 37 years. Approximately 72% percent of participants completed or will complete residency after the year 2000; 24% were currently resident physicians (Table 1). The majority of participants intends to or currently practices general obstetrics and gynecology (58%).

### Pregnancy and Family Planning

Most of the respondents reported having attempted pregnancy (68%). Only 3% of participants were attempting to become pregnant and 7% of participants were pregnant at time of survey completion. Seventy-three percent of OBGYNs reported intentionally delaying pregnancy at some point for a variety of reasons: 65% for career or educational reasons and 19% for financial reasons (Table 2).

OBGYNs reported using a variety of contraceptive methods during their reproductive years. When asked about contraceptive choices, participants were asked to select all methods that they had used before or were currently using. The most popular contraceptive choice was combined oral contraceptives (COCs 57%, Table 2). Long acting reversible contraceptive devices (LARCs, intrauterine device or implantable device) were used by 50% of participants. When stratified by age < 40 years (n = 110) compared to age ≥ 40 years (n = 78), younger participants were more likely to have used LARCs [OR 0.29 (95% CI 0.15–0.53), p < 0.001] and withdrawal method [OR 0.39 (0.16–0.98), p < 0.04] compared to older participants.

Half of participants reported they were finished with childbearing (Table 2). Of those who still desired children, 68% reported being worried about infertility, 27% reported not being concerned, and 4% reported being unsure. Of those worried about infertility, 29% reported considering oocyte/embryo cryopreservation, and 5% reported already using oocyte/embryo cryopreservation. The average age of the participant at the time that oocytes/embryos were cryopreserved was 34.

**Table 1** Demographics of respondent obstetrician gynecologists practicing in the state of Georgia

	n = 204	%
Current age (years)		
≤ 30	38	19
31–35	43	21
36–40	31	15
41–50	41	20
51–60	27	13
61–70	9	4
Unanswered	15	7
Year residency completed		
Before 1980	3	1
1981–1990	16	8
1991–2000	30	15
2001–2010	53	26
2011–2016	44	22
2017–2020 (current resident)	49	24
Unanswered	9	4
Region of training		
Northeast	31	15
Southeast	132	65
Midwest	19	9
Northwest	3	1
Southwest	11	5
Outside US	2	1
Unanswered	6	3
Race/ethnicity <sup>a</sup>		
Caucasian	140	69
African American	33	16
Asian/Pacific Islander	19	9
Hispanic	11	5
Other	5	3
Unanswered	6	3
Current relationship status		
Single	27	13
Partnered	17	8
Married	140	69
Divorced/separated	12	6
Unanswered	8	4
Field of work (intended or current)		
General OB/GYN	118	58
Maternal–fetal medicine	15	7
Obstetrics only	0	0
Gynecology only	26	13
Urogynecology	3	1
Gynecology oncology	3	1
Reproductive endocrinology and infertility	21	10
Family planning	9	4
Administrative	2	1
Undecided	10	5
Unanswered	7	3

**Table 1** (continued)<sup>a</sup>Indicates more than one answer could be chosen

## Pregnancy Outcomes

There were 300 pregnancies reported among 139 women, ranging from 1 to 7 pregnancies (Table 3). The mean age of first pregnancy was age 30.1 years ( $SD \pm 4.7$ ), second pregnancy 33.1 ( $SD \pm 4.1$ ), and third pregnancy 35.1 ( $SD \pm 4.2$ ). The mean age of first birth was 30.7 ( $SD \pm 4.2$ ) years. The average inter-pregnancy interval following a viable birth was 3.0 ( $SD \pm 1.7$ ) years. Of the pregnancies, 77% were intended. Of the planned pregnancies, it took participants a median of 2 months (IQR 1–6 months) to conceive, with a mean of 5.2 months ( $SD \pm 7.9$  months). Of the births, 73% delivered vaginally, and 90% delivered  $\geq 37$  weeks.

For the pregnancies, 13% reported use of one or more fertility treatment for conception (sometimes more than one treatment), including controlled ovarian stimulation ( $n=28$ ), intrauterine insemination ( $n=16$ ), in vitro fertilization ( $n=14$ ), oocyte/embryo donor ( $n=1$ ), or donor sperm ( $n=5$ ).

## Postpartum Depression and Breastfeeding

Among deliveries, 68 (28%) infants were delivered during residency and 170 (70%) before or after residency (2% did not report timing, Table 4). Exclusive breastfeeding for  $\geq 6$  months was reported by 35% of participants who delivered during residency and 41% of participants who delivered before or after residency. There was not a significant difference between exclusive breastfeeding for  $\geq 6$  months between the groups [OR 0.80 (0.44–1.43),  $p=0.45$ ]. Residents were more likely to report feelings of postpartum depression compared to the non-resident cohort [26% compared to 16%, OR 1.83 (0.93–3.58),  $p=0.078$ ]. Additionally, residents reported a maternity leave time of  $< 6$  weeks more frequently than non-residents [53% compared to 29%, OR 2.78 (1.56–5.00),  $p < 0.001$ ].

## Discussion

Our study describes reproductive history and goals, fertility experiences, and perinatal outcomes of practicing OBGYNs in the state of Georgia. We were able to include a wide breadth of women, with a range of ages and at various levels of training. In many ways Georgia OBGYN's reproductive experiences are similar to those of the national population; the use of fertility services, preterm delivery, and mode of delivery in our cohort matched nationally reported rates (Chandra et al. 2014; Martin et al. 2017; Committee on

Practice Bulletins—Obstetrics, The American College of Obstetricians and Gynecologists 2012). As a result of surveying women at different career stages, we were able to stratify the data by timing of pregnancy, during or before/following residency; this allowed for analysis of differences in breastfeeding, maternity leave, and postpartum depression. We estimate that we were able to survey approximately 45% of female OBGYNs practicing in the state of Georgia. Although data are not available to determine what percentage of practicing OBGYNs in Georgia are female, according to the American College of Obstetrician and Gynecologist's OBGYN workforce report, in 2017 there were 1110 practicing OBGYNs in the state of Georgia, of which 58.7% were female (Rayburn 2011); an estimated 80% are members of GOGS.

Half of the study participants were not yet finished with childbearing, and desired additional children, but were purposely delaying conception. Despite the planned delay, more than half of our cohort who desired future children reported being concerned about fertility and many considered embryo or oocyte cryopreservation. A recent study of female physicians who finished childbearing reported that 7% wished that they had used technology such as cryopreservation (Stentz et al. 2016). Perhaps the rates of cryopreservation will increase over time in our population with its more widespread use. Additionally, a recent study of OBGYN residents reported that approximately one-third of trainees overestimated the age at which fertility declined (Yu et al. 2015). It is possible that the group of physicians most likely to have information regarding age's effect on fertility is not acting on this knowledge; most of this cohort reported wanting to have a child after age 30 (Dunson et al. 2002).

Reported use of infertility services in our study population was similar to nationally reported rates. Based on a study of female surgeons, we expected Georgia OBGYNs to have higher use of infertility services than the national population (Phillips et al. 2014). However, only 13% of pregnancies ( $n=40$ ) reported use of infertility services, which is similar to the national rate of 12% (Chandra et al. 2014). Because Georgia is not a state with mandated fertility insurance coverage, use of infertility services may be lower than the need for such services. Despite delaying child bearing, the vast majority of Georgia OBGYNs, like most of the national population, conceive without medical assistance.

With regards to timing of first pregnancy, the average age of first live birth among Georgia OBGYNs is 4 years higher than that of the general United States' population (as reported by the office of National Vital Statistics) (30.7 vs. 26.3 years) (Hamilton et al. 2015). Most participants reported purposefully delaying pregnancy. The most common reason was for a career or educational reason, which is consistent with previous reports among female physicians practicing in the United States (Stentz

**Table 2** Family planning and fertility among obstetrician gynecologists practicing in the state of Georgia

	n = 204	%
Ever or currently delaying pregnancy <sup>a</sup>		
Yes	148	73
No partner	33	16
Career/education	132	65
Financial reasons	39	19
Partner preference	9	4
Health reasons	4	2
Other	21	10
No	49	24
Unanswered	7	3
Ever-use of contraceptive method <sup>a</sup>		
Long acting reversible contraception (ex. IUD, implantable)	102	50
Oral contraceptive (combined)	116	57
Oral contraceptive (progesterone only)	10	5
Permanent sterilization (male or female)	17	8
Condoms	72	35
Rhythm method/natural family planning	19	9
Withdrawal	29	14
Vaginal ring	49	24
Transdermal patch	10	5
Depo provera	3	1
No method	21	10
Unanswered	7	3
Satisfaction with family size		
Yes, I'm finished with child bearing	101	50
Yes, I don't wish to have children	11	5
No, I wish I had more children, but have not been able to conceive	6	3
No, I'm not yet done with child bearing and plan to have more children	31	15
No, I haven't started child bearing	48	24
Unanswered	7	3
	n = 92	%
If not finished with child bearing, number of planned children <sup>b</sup>		
0	5	5
1	5	5
2	45	49
3	28	30
4	5	5
Unanswered	4	4
	n = 55	%
Age planning to have first child <sup>b</sup>		
≤ 30	14	25
31–32	18	33
33–34	10	18
35–36	6	11
≥ 37	3	5
Unanswered	4	7

<sup>a</sup>Participants could choose more than one option

<sup>b</sup>Denominator obtained by sum of those who answered that they were not finished with child bearing and unanswered

**Table 3** Pregnancy outcomes among obstetrician gynecologists practicing in the state of Georgia

	n = 300	%
<b>Outcomes of all pregnancies</b>		
Currently pregnant	13	4
Vaginal delivery	178	59
Cesarean section	65	22
Miscarriage	16	5
Termination	15	5
Unanswered	14	5
<b>Planned or unplanned</b>		
Unplanned	52	17
Planned	232	77
Unanswered	0	0
<b>Infertility evaluation</b>		
Not necessary	250	83
Yes, with a general OBGYN	2	1
Yes, with an REI	30	10
Yes, with both	4	1
Unanswered	14	5
<b>Underlying infertility diagnosis<sup>a,b</sup></b>		
None	243	81
Endometriosis	2	1
Tubal factor	0	0
Uterine abnormality	0	0
Male factor	9	3
Polycystic ovarian syndrome	6	2
Advanced age	8	3
Diminished ovarian reserve	7	2
Anovulation	3	1
Same sex relationship	4	1
Unexplained	15	5
Unanswered	17	6
<b>Infertility treatment<sup>a,b</sup></b>		
None	244	81
Oocyte/embryo freezing	6	2
Controlled ovarian stimulation (e.g. Clomiphene, Letrozole, Injectable gonadotropins)	28	9
IUI	16	6
IVF	14	5
Oocyte/embryo donor	1	0
Donor sperm	5	2
Unanswered	14	6
<b>Obtaining fertility medications</b>		
None	210	70
From provider	31	10
Self prescribed	3	1
From friend	4	1
Unanswered	26	9
<b>Timing of pregnancy</b>		
Before medical school	20	7
Medical school	11	4

**Table 3** (continued)

	n = 300	%
Residency	75	27
Fellowship	21	7
Post training	156	52
Unanswered	18	6
<b>Work status at time of pregnancy</b>		
Academic	104	35
Community	51	17
Full time	210	70
Part time	17	6
Stay-at-home	2	1
Other	13	4
Unanswered	15	5
<b>Partner's work status at time of pregnancy</b>		
Full time	256	85
Part time	11	4
Stay-at-home	16	4
Other	11	4
Unanswered	11	4

<sup>a</sup>Participants could choose more than one option

<sup>b</sup>The denominator for this table (n=300) was derived from the reported pregnancies in the “planned or unplanned” question, which was the highest number reported

et al. 2016; Willett et al. 2010). Perhaps if new policies were implemented allowing for more schedule flexibility and longer maternity leave time, less trainees would delay child bearing; European Society of Human Reproduction and Embryology recently published a paper suggesting that changes in policy may decrease purposeful delay in childbearing (Mills et al. 2011). Delaying pregnancy increases age at time of conception, which decreases the likelihood of conception and also increases the likelihood of miscarriage and other adverse pregnancy outcomes such as premature birth, gestational diabetes, preeclampsia, and cesarean delivery (Joseph et al. 2005; Kenny et al. 2013).

Although many OBGYNs may delay pregnancy until finishing residency, over a quarter of our sample who conceived reported pregnancies during residency. We had previously hypothesized that resident mothers would be less likely to breastfeed exclusively through 6 months due to their demanding schedules. Surprisingly, the rates of exclusive breastfeeding in both resident and non-resident physicians were not significantly different (35% compared to 41%). Although these rates were higher than the reported national rate of exclusive breastfeeding (22.3%) (Centers for Disease Control and Prevention 2016a), it was lower than anticipated as OBGYNs spend much time during antenatal and immediate postpartum care discussing the benefits of breastfeeding.

**Table 4** Postpartum outcomes among obstetrician gynecologists practicing in the state of Georgia who delivered pregnancies during residency versus before or after residency

	Pregnancies during residency		Pregnancies before or after residency	
	n=68	%	n=170	%
<b>Feeding pattern<sup>a</sup></b>				
Formula fed only	9	13	17	10
Breast fed exclusively for 6 weeks	4	6	13	8
Breast fed exclusively for 3 months	9	13	19	11
Breast fed exclusively for 6 months	14	21	24	14
Breast fed exclusively for 1 year	10	15	45	26
Breast and formula fed for 6 weeks	6	9	8	5
Breast and formula fed for 3 months	6	9	5	3
Breast and formula fed for 6 months	4	6	16	9
Breast and formula fed for 1 year	6	9	21	12
Unanswered	0	0	2	1
<b>Post partum depression<sup>b</sup></b>				
Yes	18	26	28	16
No	50	74	142	84
Unanswered	0	0	0	0
<b>Length of maternity leave<sup>c</sup></b>				
<6 week maternity	36	53	49	29
6–12 week	29	43	108	64
12–36 week	2	3	12	7
>36 week	1	1	1	1
Unanswered	0	0	0	0

<sup>a</sup>Comparison between rates of exclusive breast feeding for  $\geq 6$  months between groups [OR 0.80 (0.44–1.43)  $p=0.45$ , not significant]

<sup>b</sup>Comparison between rates of post partum depression between groups [OR 1.83 (0.93–3.58),  $p=0.078$ , not significant]

<sup>c</sup>Comparison between rates of maternity leave <6 weeks [OR 2.78 (1.56–5.00),  $p<0.001$ ]

As expected, resident mothers were much more likely to report a maternity leave <6 weeks compared to non-resident mothers. Options for maternity leave and amount of paid/unpaid maternity leave vary by program and have changed over time, sometimes requiring extension of residency beyond 4 years. Recently, both the American Academy of Pediatrics and the American College of Obstetrician Gynecologists released policy statements supporting at least 6 weeks of paid parental leave (Section on Medical Students, Residents, and Fellowship Trainees; Committee on Early Childhood 2013; The American College of Obstetricians and Gynecologists 2016). These positive changes supporting new mothers and their families will hopefully be incorporated nationally into policies of residency programs. Longer maternity leaves have been associated with decreased infant morbidity, mortality, and overall health, as well as decreased rates of hospital readmission for mother

and baby, improved breastfeeding rates and overall maternal mental health (Andres et al. 2016; Jou et al. 2018; Rossin 2011; Ruhm 2000).

Most concerning in our study were the high rates of postpartum depression. Twenty-six percent of resident mothers reported feelings consistent with postpartum depression compared to 16% of non-resident mothers. According to the Centers for Disease Control and Prevention (CDC), in 2012 the reported national rate of postpartum depression was 11.5% and the rate in Georgia was 8.0% based on data from the Pregnancy Risk Assessment Monitoring System (PRAMS) (Ko et al. 2017). Both the rates reported by CDC and those in our survey are self-reported; the true prevalence may actually be higher. Self-reported data may be subject to recall bias. However, the Edinburgh Postnatal Depression Scale is a screening test commonly used in the postpartum period that has a high sensitivity for detecting depression and is a self-report questionnaire (Eberhard-Gran et al. 2001). Our findings in the postpartum population are similar to rates of depression among male and female resident physicians of 28.8% (Mata et al. 2015). It is possible that medical trainees are more vulnerable to postpartum depression than the general population, just as trainees have higher rates of depression than the general population. It has been suggested that program culture and resident schedules may contribute to increased rates of depression, which has been linked to poor patient outcomes (Mata et al. 2015). Residents may benefit from more focused care, screening, and counseling. It also may be especially challenging when residents resume work after a short maternity leave; studies have reported that residents may have increased call shifts and may have to make-up time post maternity leave (Davis et al. 2001; Gabbe et al. 2003). Additionally, in a learning environment where minimum requirements are necessary for graduation, residents may choose to take a shorter maternity leave in order to avoid missing cases or learning opportunities. There have been efforts made nationwide to promote resident wellness and reduce resident burnout (Busireddy et al. 2017), however to our knowledge there are no published papers regarding wellness promotion for residents who are also new to motherhood; this may be another area to focus resident wellness promotion.

Admittedly, the study has several limitations. The study population does not represent the entire female OBGYN population in the state of Georgia and the Georgia OBGYN population may not be generalizable to the national population of OBGYNs. Approximately one-third of our cohort was academic clinicians, which is higher than the approximate 12% reported by ACOG. Our cohort was, however, primarily composed of generalists, which is similar to the national OBGYN population (Rayburn 2011). Although the survey was anonymous, as with all survey studies, our results may be influenced by response bias, self-report and

missing data. We also did not ask questions regarding gender-identity, sexual orientation or adoption, which will be important to address in future studies.

Our paper has several strengths. By sending individual emails to participants, we were able to calculate an accurate response rate, ensuring a representative sample. To our knowledge, our survey may be the first to report on OBGYNs' personal experience with reproductive life planning, contraceptive choices, consideration of cryopreservation, pregnancy rates and outcomes, and rates of breastfeeding and postpartum depression. This study offers a rare view into an OBGYN's experience as it relates to personal fertility and pregnancy-related issues.

Although the majority of pregnancy outcomes are similar to the previously published data, Georgia OBGYNs report several important differences, especially among postpartum women, that warrant additional study. These findings have the potential to impact policy to promote maternal and child wellness. Perhaps increased mental health counseling, purposeful attention to physician wellness, and improved accessibility to fertility counseling during residency may improve postpartum health among those who deliver and reduce anxiety among OBGYNs who desire children in the future.

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