# Congress Interviews

EMJ had the pleasure of interviewing five leading members of the European Society of Human Reproduction and Embryology (ESHRE) Executive Committee and senior faculty. Chair-Elect Anis Feki discusses the Society's vision for equitable, evidence-based fertility care, while Immediate Past Chair Karen Sermon explores the future of reproductive genetics and the responsible integration of genomic technologies. Chair-Elect Borut Kovačič shares his perspective on innovation in embryology, AI, and quality assurance; Georg Griesinger examines the future of IVF, treatment add-ons, and emerging reproductive technologies; and Maribel Acién reflects on the evolving role of reproductive surgery, multidisciplinary care, and surgical education.

**Featuring:** Anis Feki, Karen Sermon, Borut Kovačič, Georg Griesinger, and Maribel Acién

**Anis Feki**

Professor and Head of the Department of Obstetrics and Gynaecology, Hôpital Fribourgeois, University of Fribourg, Switzerland; Chair-Elect, European Society of Human Reproduction and Embryology (ESHRE)

> **Policy and clinical standards are strongest when patients are part of the conversation**

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**Q1 Access to fertility care and clinical practice still varies considerably across Europe. In your view, what are the biggest challenges facing reproductive medicine today, and how is European Society of Human Reproduction and Embryology (ESHRE) helping to address them?**

The central challenge is inequity. Across Europe, access to fertility care still depends too heavily on where people live, on funding arrangements, legislation, geography, and, at times, whether they fit historical definitions of family. There are also important differences in workforce capacity, laboratory standards, data collection, and access to specialised care. At the same time, patients face an expanding market of tests and treatments, not all supported by robust evidence.

ESHRE cannot determine national reimbursement policies or legislation, but it can provide a common scientific and ethical reference point. We do this through evidence-based guidelines, education and certification, centre accreditation, European IVF Monitoring, and advocacy for equitable, safe, and effective care.

We work closely with Fertility Europe (Evere, Belgium) because policy and clinical standards are strongest when patients are part of the conversation. We also support clear public information, including through

the International Human Rights Commission (IHREC), so that people can make informed decisions before they reach the clinic.

This is particularly important where regulation does not prevent clinics from offering unproven add-ons. In many countries, clinics remain free to provide these interventions, so patients need clear, evidence-based information to distinguish established treatments from innovations that have not been shown to improve live birth rates.

The objective should not simply be access to a procedure. It should be timely access to an evidence-based pathway, delivered safely by a trained multidisciplinary team, and measured by outcomes that matter to patients.

> **Fertility is not a single-organ problem, and reproductive medicine cannot be delivered well by isolated specialists**

**Q2 Quality assurance has been a major focus throughout your career. What practical steps can fertility centres take to improve the quality, safety, and consistency of patient care?**

Quality is not a document on a shelf; it is a daily clinical culture.

Every centre should have a functioning quality-management system with clear standard operating procedures, robust patient identification and traceability, documented staff training and competency assessment, incident reporting without blame, regular internal audits, and a tested emergency plan, particularly for cryostorage and critical laboratory equipment.

Centres should monitor meaningful indicators rather than relying on headline pregnancy rates alone: cumulative live-birth outcomes, multiple-pregnancy rates, ovarian hyperstimulation, laboratory performance, treatment cancellations, complications, and patient-reported experience. Results must be interpreted in the context of the patients treated, not used as marketing material.

The same principles apply to communication. Informed consent must be a process, not a signature. Patients should understand benefits, limitations, risks, costs, and alternatives.

Specialist nurses, embryologists, and reproductive biologists are indispensable in delivering this continuity and clarity. ESHRE's laboratory guidance, performance indicators, accreditation programmes, and professional certification support precisely this kind of transparent, team-based quality system.

**Q3 You have led both academic and clinical departments. How can fertility specialists balance the rapid adoption of new technologies with the need for robust clinical evidence?**

Innovation is essential in reproductive medicine; many of today's standard treatments began as bold ideas. But innovation must not outrun evidence.

A plausible biological mechanism, an attractive technology, or an early observational study is not enough to justify routine use. I encourage centres to distinguish clearly between established care, promising innovation, and experimental practice.

New technologies should be evaluated for efficacy, safety, cost, equity, and their impact on the whole treatment pathway, not merely on an intermediate laboratory outcome. Whenever possible, this requires well-designed prospective studies, randomised trials, and meaningful long-term follow-up. Registries also have an important role when trials are not feasible.

This is particularly relevant for AI, genetic technologies, and IVF add-ons. AI may improve workflow and decision support, but algorithms must be validated, transparent, and monitored in real clinical populations. AI is already well established in areas such as laboratory diagnostics and cervical cytology screening, where its performance has been extensively validated. Reproductive medicine should follow the same principles.

In embryology, AI may support embryo assessment and clinical decision-making, but these systems require prospective validation, transparent algorithms, and independent evaluation before they can be adopted routinely. AI should support clinicians, not replace clinical judgement, and the final responsibility for patient care must always remain with healthcare professionals.

Transparency is equally important. If the underlying algorithm cannot be independently assessed or validated, clinicians should be cautious about adopting it into routine practice. Innovation is welcome, but without transparency and external validation, it cannot become evidence-based care.

The most responsible message to patients is not: "We have the newest technology." It is: "We will offer what is justified for you and explain honestly what remains uncertain."

**Q4 Reproductive medicine is becoming increasingly multidisciplinary. How important is collaboration between reproductive endocrinologists, surgeons, embryologists, geneticists, and other specialists in delivering the best outcomes for patients?**

It is fundamental. Fertility is not a single-organ problem, and reproductive medicine cannot be delivered well by isolated specialists.

The best outcomes come when reproductive endocrinologists, reproductive surgeons, embryologists, andrologists, geneticists, nurses, counsellors, psychologists and, when needed, oncologists or maternal–fetal medicine specialists work as one team.

This matters most in complex cases: severe endometriosis, adenomyosis, recurrent implantation failure, severe male infertility, fertility preservation, and genetic disease. The question should never be, "Which discipline owns this patient?" It should be, "What is the best pathway for this patient?"

Multidisciplinary boards can avoid unnecessary sequential referrals, reduce delays, and ensure that surgery, laboratory treatment, genetics, and counselling are coordinated from the beginning.

I would welcome a joint statement from the major scientific societies encouraging this model, particularly for complex fertility care. A patient should not have a different chance of pregnancy merely because she first saw a reproductive surgeon rather than a reproductive endocrinologist or vice versa.

This model also recognises the central contribution of embryologists, reproductive biologists, and nurses. Their expertise is not ancillary; it is part of the clinical decision-making process.

**Q5 ESHRE has played a leading role in education and guideline development. Which recent initiatives do you believe will have the greatest impact on everyday clinical practice?**

I would highlight four areas.

First, the 2025 update of the ovarian stimulation guideline brings the entire stimulation pathway together, from pre-treatment assessment to prevention of ovarian hyperstimulation syndrome. It helps clinicians personalise care without losing sight of safety.

Second, the good-practice recommendations on add-ons are particularly important because they address a real pressure point in daily practice: how to discuss optional interventions honestly when evidence is limited. Their value is not only in recommending or discouraging individual tests or treatments, but in setting a standard for transparent counselling.

Third, the embryo-transfer guideline reinforces the central objective of treatment: a healthy pregnancy and birth, rather than the highest possible number of embryos transferred. It gives practical support for safer decision-making and shared discussions with patients.

Finally, education must reach every member of the team. ESHRE certification for clinical embryologists, nurses and midwives, reproductive medicine specialists, and reproductive surgeons, together with centre accreditation, helps turn guidance into practice. Guidelines improve standards of care, but they translate into better outcomes only when implemented by trained professionals within well-organised teams.

We are also preparing to update the international guideline on polyendocrine metabolic ovarian syndrome in collaboration with partner societies. As with previous guideline projects, the aim is to ensure that evolving scientific understanding is translated into practical, evidence-based recommendations for clinicians.

**Q6 Looking ahead, what do you hope will be the defining advances in reproductive medicine over the next decade, and what role do you see ESHRE playing in shaping that future?**

I hope the next decade will be defined less by technology alone than by precision, responsibility, and equity.

We will see progress in AI-supported laboratory and clinical decision-making, fertility preservation, reproductive genetics, the management of endometriosis and adenomyosis, and possibly new approaches to ovarian function and gamete biology. But each advance must be assessed not only for what it can do, but for whom it helps, at what cost, and with what long-term consequences.

The greatest advance may also be organisational: better registries, harmonised outcome reporting, multidisciplinary care pathways, and earlier fertility education. We need to move from measuring isolated cycle results to understanding cumulative outcomes, safety, wellbeing, and the health of children born after treatment.

ESHRE's role is to be both a catalyst and a safeguard. We should bring clinicians, scientists, embryologists, nurses, patient organisations, regulators, and policy makers together; support high-quality research; translate evidence into guidelines; strengthen education; and make reliable information understandable to the public.

Our ambition must remain clear: a healthy child, safe treatment, informed patients, and fair access. Hope is essential in reproductive medicine, but it has to be shaped by science, honesty, and compassion.

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