A call to action to reproductive endocrinologists: we cannot avoid the culture wars

I began life as a Catholic; however, by the age of 15 years, my permanent lapse from the Catholic church began. The main reason for my abandonment of Catholicism was its hardline stance that life begins at the moment of conception and its resulting implications. This position seemed to be dismissive of the individual who had to carry the pregnancy and care for the child. It seemed unfair to women. Further, it was problematic to me that a zygote had rights, which competed with a fully formed adult.

As a 15-year-old, I had a lot of ambition and perceived many barriers to attaining my life goals. However, expectations for me were low. My parents' stated goal for me, communicated throughout childhood, was to complete high school without getting pregnant. I wanted more from my life. I decided to stage a coup: I applied to a 6-year BS-MD program at Rensselear Polytechnic Institute/Albany Medical College, and I got in. At the age of 17, I began my medical and scientific career. I was in the medical school by the age of 19, and by the age of 23 I was a fully minted physician. However, I never stopped pondering the concepts that led me away from Catholicism and led me toward a career in obstetrics and gynecology and then to a fellowship in reproductive endocrinology. I now deal with the very early stages of human life every day. It has been said that the 2 most desperate people in the world are women who are pregnant but do not wish to be pregnant and women who are not pregnant but who wish to be pregnant. This dictum has rung true certainly over my years of clinical experience.

Our culture wars on abortion all but ignore the woman who is pregnant without intending to become pregnant. This mindset allows us to make proclamations on the basis of religious theory when in fact the practical, life-altering consequences of carrying a pregnancy and possibly caring for a child and nurturing that child to adulthood—a lifelong commitment— is at best a very messy process and almost always falls to the pregnant person. Although some women find themselves unintentionally pregnant, there are many women or couples who wish to conceive but cannot do so. As reproductive endocrinologists, we spend most time with women and couples in the latter situation and often consider ourselves "exempt" from the culture wars on abortion. We tell ourselves that we are working on the other end of the fertility conundrum, and our work has nothing to do with abortion politics. We believe that we are above the fray.

This intellectual position is not only wrong but also harmful to women in several ways. First, reproductive endocrinologists are already victims of the culture wars. We relinquished the opportunity to acquire federal funding for embryo research in 1995 when the Dickey-Wicker Amendment was attached to the appropriation bill. Signed into law by the then president Bill Clinton, this amendment prohibits the Department of Health and Human Services from using National Institutes of Health funds for the creation of embryos for research. By making traditional funding opportunities unavailable for reproductive endocrinologists who wanted to study embryo biology, Dickey-Wicker effectively stifled a major line of inquiry in our field for a generation of potential physician-scientists. We do further harm by pretending that we are the "good guys" who help create families because this positioning ascribes value to women on the basis of their reproductive choices—the woman who chooses not to be a mother is cast as "bad," and the woman who will stop at nothing to become a mother is "good"—an age-old dichotomy that defines women through their reproductive potential and overlooks their nonreproductive contributions to the society. Such a position further erodes the self-esteem of the woman who wishes to become pregnant but cannot because her reproductive wishes cannot be fulfilled, and she views herself as deficient. Moreover, because she is defined as a reproductive creature, the loss of this core aspect of her existence is considered a devastating loss.

I would argue that avoiding the culture wars and stressing our "proreproduction" stance as reproductive endocrinologists is a naïve position, but regardless, that may be about to change. It is widely expected that the Supreme Court will rule in favor of a "states' rights" argument for reproductive legislation and will reverse *Roe v Wade (cf Dobbs vs Jackson Women's Health Orgnaization, 19-1392 [Mississippi 2018])*, the landmark decision that decriminalized pregnancy termination up to the gestational age of 23 weeks, which at the time of the ruling was considered the lower limit of viability. It is also widely expected that restrictive laws—many of which are already in the works—will limit or eliminate a woman's ability to terminate her pregnancy in the privacy and safety of her provider's office in many states. Bounties for reporting on women who have terminated a pregnancy, restrictions on prescribing of mifepristone to facilitate a safe and private home pregnancy termination, and even criminalizing across-state travel to obtain a pregnancy termination are all on the table. Personhood amendments, which assign rights to zygotes, embryos, and fetuses, are expected to be passed in several states, with potentially draconian consequences for women.

As reproductive endocrinologists, we stand a very good chance of getting caught in the crossfire of these new restrictions. As discussed in a recent Views and Reviews on this topic, frozen embryos that have "personhood" can complicate our current practices of embryo cryopreservation (1–4). Such legislation can result in catastrophic damages in the face of a freezer failure or laboratory error and will make it much less attractive to put embryos into long-term storage because of the fear of any unintentional mishap. Patients with missed

abortions will likely become collateral damage in the abortion wars, and we may be breaking the law by providing such patients with medications to complete the miscarriage or be prosecuted for performing a uterine evacuation. Patients with heartbreaking second trimester pregnancy losses after infertility can also face prosecution if their pregnancy loss is suspected to have been intentional (5).

We need to break the silence and stand with our family planning partners to protest the religious tyranny of the anti-choice doctrine. We need to further the ideal of a pluralistic society, one in which people believe in all kinds of different things and tolerate each other's beliefs. We need to stop casting women into categories on the basis of their sexual and reproductive experiences and choices. We must apply our knowledge of reproductive science to public policy. In other words, we need to create a world that an ambitious 15-year-old would want to inherit.

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REFERENCES

1. Santoro N. Whither cryopreservation? The landscape gets colder. Fertil Steril 2022;117:467–8.
2. Pomeroy KO, Comizzoli P, Rushing JS, Lersten IL, Nel-Themaat L. The ART of cryopreservation and its changing landscape. Fertil Steril 2022;117:469–76.
3. Letterie G. In re: the disposition of frozen embryos: 2022. Fertil Steril 2022;117:477–80.
4. Reich JA, Caplan A, Quinn GP, Blakemore JK. Counseling, risks, and ethical considerations of planned oocyte cryopreservation. Fertil Steril 2022;117:481–4.
5. Gilbert AC. After miscarriage, woman is convicted of manslaughter. The 'fetus was not viable,' advocates say. Available at: https://www.usatoday.com/story/news/nation/2021/10/21/oklahoma-woman-convicted-of-manslaughter-miscarriage/6104281001/. Accessed April 13, 2022.