Reproductive Rights in Neurology—The Supreme Court’s Impact on All of Us

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The overturning of Roe v Wade through the US Supreme Court’s official ruling in Dobbs v Jackson Women’s Health Organization is already having an undeniable ripple effect on health care delivery across the nation. How this may change clinical practice for both adult and child neurologists and management of neurologic diseases appears initially less relevant. Neurologists rarely prescribe contraception or menopausal hormone therapy and do not participate in fertility treatment procedures or terminations of pregnancy. Except for contraception, these topics are seldom included in training and neurologic practice, and only 2 fellowship programs specialize in sex- and gender-informed neurology nationally. However, bans on abortion will immediately affect the delivery of current standard neurologic care for many patients, specifically standards that depend on planning or preventing pregnancies using individual choice.

Limits on reproductive health affect a wide diversity of populations and could magnify racial, ethnic, and social inequities that can negatively affect health outcomes for people with neurological conditions. Elimination of abortion as a constitutional right will restrict its availability to as many as 58% of women of reproductive age in the US. Further, termination of pregnancy is not exclusively a women’s rights issue—those who do not identify as women, such as transgender men and nonbinary people, may also seek abortion. Abortion rates are higher in non-Hispanic Black women and Hispanic women compared with non-Hispanic White women, according to 2019 data published by the US Centers for Disease Control and Prevention. Abortions are also starkly higher in women whose incomes are below the federal poverty line relative to those 200% above the federal poverty line. Further, longitudinal studies suggest that being denied a wanted abortion is associated with higher odds of poverty and lower odds of employment long term, as well as increased odds of headache and perception of “fair or poor health.” Therefore, restrictions on reproductive rights may differentially affect the health of women according to their race, ethnicity, or income levels and could further entrench women in a cycle of poverty.

Many neurologic diseases disproportionately affect women during their reproductive years. This is relevant for common conditions such as migraine and for conditions such as epilepsy and multiple sclerosis that have had substantial improvements in disease control and quality of life associated with modern therapies. Known teratogenic medications (including valproic acid or teriflunomide) may be required to achieve optimal control of neurologic diseases that may be life threatening (such as status epilepticus) or result in accumulation of irreversible disability (such as multiple sclerosis). However, concerns about medication teratogenicity for those who are anticipating pregnancy or are pregnant may extend beyond medications with clearly established teratogenicity and include medications that lack evidence supporting their safety profiles. For instance, 1 review of 172 medications approved by the US Food and Drug Administration from 2000 to 2010 found “undetermined” human teratogenic risk profiles for 98% of these medications. In a climate of increased limitations on reproductive rights, whereby pregnancies cannot be reliably timed or prevented, neurologists might possibly restrict use of the effective medications that are standard care for other patient groups because of potential concerns about causing fetal harm. This could increase risk of morbidity, mortality, and irreversible disability accumulation for women with neurologic diseases.

However, unintended pregnancies occur, even among participants in clinical trials with protocols that strictly encourage or require use of effective contraception, and these pregnancies will continue to occur regardless of legislative constraints on reproductive health services. Teratogenic drugs are only prescribed when it is possible for women to plan pregnancies and prevent fetal exposure. However, controlling the timing of teratogenic medication use may not be feasible in the short-term treatment of certain disorders, such as medically refractory status epilepticus, infectious and autoimmune encephalitis, or vasculitis. Further, some neurologic conditions, such as eclampsia, may occur before fetal viability, increasing the risk of morbidity and mortality for the mother if the pregnancy cannot be terminated. There are also neurologic diseases, such as having a central nervous system neoplasm, that are not immediately life threatening, but where a delay in treatment due to pregnancy could put both the health and life of the mother at risk. Some bills, such as Oklahoma Senate Bill 612 signed into law in May 2022, restrict legal abortion only “to save the life of a pregnant woman in a medical emergency.” Tensions in clinical decision-making that exist when the health of the mother is in opposition to the health of the fetus will only intensify with additional constraints on reproductive rights.

Restricting personal decisions on childbirth will also change aspects of fetal neurologic care and counseling by child neurologists and maternal-fetal medicine specialists. The anatomic ultrasound at approximately 20 weeks’ gestation is common in obstetrical practice, with the goal of evaluating the growth and health of the fetus, placental position, and amniotic...
Fluid volume. In worst-case scenarios, fetal neurologic conditions that are not survivable or that could result in poor quality of life due to profound disability are identified with prenatal ultrasound, fetal brain magnetic resonance imaging, and/or genetic testing. The decision to carry or terminate a pregnancy with severe fetal anomalies (such as anencephaly) or genetic syndromes (such as trisomy 13 or 18) is highly complex and personal regardless of which decision each woman makes. If pregnancy termination is banned, then women may be forced against their wishes to deliver a newborn that may require prolonged intensive care and end-of-life care. The loss of bodily autonomy for pregnant women in such a scenario conscripts the dyad of mother and child to potential physical and psychological morbidity. Women and their partners will not have the right to self-determination, as well as the ability to make reasonable and informed decisions for the health and welfare of their child and family. Helping patients address these issues also may have psychological consequences for clinicians who provide care for these patients.

Neurologists should consider how legislating private health decisions between patients and clinicians might alter the landscape of neurologic practice across the patient’s life span. Equity in care depends on the unrestricted liberty to make personal decisions affecting bodily autonomy. This includes optimization of fertility windows, personal determination of pregnancy timing to limit disease progression or exacerbation, and pregnancy termination if necessary for the health of the mother, the fetus, or both. Now that Roe v Wade is overturned, abortion will be banned or severely restricted in as many as 28 states, compromising the care available to approximately 40 million women. Availability of reproductive health care is integral to equitable delivery of neurologic care. The Supreme Court’s decision will undoubtedly now have an impact on all of us in the field of neurology.

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REFERENCES