

EMBRYOS ARE NOT PEOPLE, BUT DISABILITY IS DIFFERENCE: TOWARD AN ANTIDISCRIMINATION THEORY FOR REPRODUCTIVE SERVICES

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Women are becoming increasingly disempowered in reproductive choice just as new technologies offer scientists and clinicians more power and discretion in selecting the types of children to bring into the world. As these phenomena converge, a gap in antidiscrimination law has emerged. Fertility clinic practitioners are free to refuse the transfer of embryos based on disability-related animus. Mothers unable to prove coverage under the Americans with Disabilities Act (ADA) have no apparent legal remedy.

Parallel to other civil rights statutes, the ADA covers people, and primarily people with disabilities. The 2008 Amendments clarified that disability definitions should be construed broadly, favoring coverage to the maximum extent possible under the terms of the ADA. Yet the statute has never been interpreted to afford broad coverage to those with unexpressed genetic indicators for disability. The ADA and its Amendments provide little recourse, then, for women with genetic indicators for disease who are denied assisted reproductive technology services on that basis.

The resurgence of the fetal personhood movement further complicates this picture. Its advocates could seize this opportunity to supplant narratives around an emerging form of disability discrimination with arguments for further constraining women's autonomy. Solutions that bridge antidiscrimination principles and women's autonomy are therefore urgent and imperative. This Note introduces theoretical frameworks for extending disability antidiscrimination law toward expanding reproductive autonomy.

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I will never forget the day my mother found out she was the source of my HLA-B27 positivity and told me: “I am sorry.” It was several years after my diagnosis with a chronic illness that has and would cause me suffering. My mother was made to feel that by having a disabled child, she did something wrong. This Note is about the systems that instilled in my mother the need to say sorry.¹

It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind.

— Oliver Wendell Holmes, *Buck v. Bell*.²

INTRODUCTION

Developments in reproductive technology are introducing new possibilities for reproductive health, genetic testing, and disease eradication. Simultaneously, legislators and the judiciary have decreased autonomy in reproductive choices. This pernicious combination presents challenges for many women³ seeking reproductive care and protection from federal antidiscrimination laws when healthcare providers make decisions based on unsubstantiated and even intolerant preconceptions about the quality of disabled life.

1. This use of first person is a deliberate choice by the author to foreground narratives about disability identity and interpret the law through a disabled person’s lens. Disability theorists have highlighted the importance of disability narratives in illuminating the constitutive outside and “inserting persons into the social world.” See Tobin Siebers, *Disability as Masquerade*, 23 *Literature & Med.* 1, 8 (2004) (“Narratives about disability identity . . . are political because they offer a basis for identity politics, allowing people with different disabilities to tell a story about their common cause.”).

2. 274 U.S. 200, 207 (1927).

3. This Note generally favors the use of “women” over “pregnant people” despite acknowledging the mosaic of identities associated with pregnancy. “Unsexing pregnancy” using gender-inclusive terminology and the recognition of pregnancy discrimination’s unique effect on the LGBTQ community is an ontological project that expands perceived possibilities for transgender men and nonbinary people. See Jessica Clarke, *Pregnant People?*, 119 *Colum. L. Rev. Forum* 173, 173–76 (2019), https://columbialawreview.org/wp-content/uploads/2019/10/Clarke-Pregnant_People-1.pdf [<https://perma.cc/GQS3-UJQ3>] (“The law could see pregnancy not only as something that happens to women’s bodies, but also as a bodily condition experienced by people who do not identify as women.”). This Note nonetheless retains some reference to “women” in part because transgender people may qualify for ADA coverage under the theory that a “gender dysphoria diagnosis” enables transgender plaintiffs to invoke the ADA’s protections. See Namrata Verghese, *The Promise of Disability Rights Protections for Trans Prisoners*, 21 *Dukeminier Awards J.* 291, 293 (2022). In June 2023, the Supreme Court denied a petition for certiorari in *Kincaid v. Williams*, 143 S. Ct. 2414 (2023), after a Fourth Circuit panel ruled the ADA does not exclude coverage for people who are “transgender” or have “gender dysphoria.” See *Williams v. Kincaid*, 45 F.4th 759, 773 (4th Cir. 2022); Arthur S. Leonard, *Supreme Court Declines to Review 4th Circuit Ruling that Gender Dysphoria Is a “Disability” Under the Americans With Disabilities Act*, *LGBT L. Notes*, July 2023, at 6, 6.

Parallel to other civil rights statutes, the Americans with Disabilities Act (ADA) covers *people*, and primarily people with disabilities. Under Title III of the ADA, “[n]o individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation.”⁴ The 2008 Amendments (ADAAA) clarified that disability definitions should be construed broadly, favoring coverage to the maximum extent possible under the terms of the ADA.⁵ Yet the ADA has not been interpreted to afford broad coverage to those with unexpressed genetic indicators for disability.⁶ The ADA and its Amendments provide little recourse, then, for women with genetic indicators for disease who are denied assisted reproductive technology (ART) services on that basis.

Fertility clinics have the discretion to refuse these women equal access to healthcare services based on disability-related animus, and the law provides no remedy. In fact, the United States’ weak regulatory framework on ART⁷ and the American Society for Reproductive Medicine’s (ASRM) recommendation that physicians consider “the well-being of offspring” in determining whether to deny services⁸ encourages such preconceptions to drive reproductive healthcare. At present, antidiscrimination law affords few protections for individuals with genetic conditions,⁹ just as technology renders genetic conditions easier to detect and weed out.¹⁰

Published studies and reporting mechanisms documenting fertility clinic practitioner refusals to transfer embryos are lacking.¹¹ Nonetheless,

4. ADA Amendments Act (ADAAA) of 2008, 42 U.S.C. § 12182(a) (2018).

5. Section 2(b) of the ADAAA states that it was enacted “to carry out the ADA’s objectives of providing ‘a clear and comprehensive national mandate for the elimination of discrimination’ and ‘clear, strong, consistent, enforceable standards addressing discrimination’ by reinstating a broad scope of protection to be available under the ADA.” ADA Amendments Act (ADAAA) of 2008, Pub. L. No. 110-325, § 2(b)(1), 122 Stat. 3553, 3553 (quoting 42 U.S.C. § 12101(b)) (codified in scattered sections of Title 42 of the U.S.C.).

6. This Note sometimes refers to individuals with genetic conditions as “genetic carriers” or individuals with “unexpressed genetic indicators for disability,” as here. These terms are used interchangeably to describe individuals likely to pass on certain genomic variants associated with an impairment in reproduction, but who do not show symptoms of the impairment themselves. Research compiling data of carrier screening across numerous healthcare practices found approximately twenty-four percent of individuals were carriers for at least one of 108 disorders. Gabriel A. Lazarin et al., An Empirical Estimate of Carrier Frequencies for 400+ Causal Mendelian Variants: Results From an Ethnically Diverse Clinical Sample of 23,453 Individuals, 15 *Genetics Med.* 178, 179 (2013).

7. See *infra* section I.A.

8. Ethics Comm. of the Am. Soc. for Reprod. Med., *Child-Rearing Ability and the Provision of Fertility Services*, 100 *Fertil. Steril.* 864, 865 (2009), [https://www.fertstert.org/article/S0015-0282\(09\)02474-1/pdf](https://www.fertstert.org/article/S0015-0282(09)02474-1/pdf) [<https://perma.cc/4HH3-NR77>] [hereinafter ASRM Ethics Committee, *Child-Rearing Ability*].

9. See *infra* section I.B.

10. See *infra* notes 146–148 and accompanying text.

11. See Judith Daar, *A Clash at the Petri Dish: Transferring Embryos With Known Genetic Anomalies*, 5 *J.L. & Bioscis.* 219, 246 (2018) [hereinafter Daar, *A Clash at the Petri*].

fertility clinic policies and patient anecdotes confirm the regularity of the practice.¹² Popular media has amplified anecdotes of disabled people seeking in-vitro fertilization (IVF) to intentionally select for disabled embryos, such as a deaf lesbian couple seeking a deaf sperm donor.¹³ In general, fertility clinic physicians have refused these types of requests, with one Maryland-based physician telling the *New York Times*, “In general, one of the prime dictates of parenting is to make a better world for our children . . . Dwarfism and deafness are not the norm.”¹⁴

In one infamous case, a deaf lesbian couple from Maryland employed sperm from a deaf male friend because they sought a deaf baby,¹⁵ and conservative commentators decried the act as creating “victims from birth.”¹⁶ Some couples, on the other hand, use genetic testing to

Dish] (“The absence of published studies or other formal reporting on the frequency and motivation for physician refusals to transfer embryos on the basis of anticipated offspring health poses challenges to an empirical analysis of this clinical scenario, but sufficient anecdotal and ancillary data exist to permit a reasonable discussion.”).

12. See, e.g., Iris G. Insogna & Elizabeth Ginsburg, Transferring Embryos With Indeterminate PGD Results: The Ethical Implications, 2 *Fertility Rsch. & Prac.* Feb. 1, 2016, at 1, 2 (describing the case of a woman seeking the transfer of an embryo with BRCA-1 mutation and the clinic denied implantation).

13. See, e.g., Richard Gray, Couples Could Win Right to Select Deaf Baby, *The Telegraph* (Apr. 13, 2008), <http://www.telegraph.co.uk/news/uknews/1584948/Couples-could-win-right-to-select-deaf-baby.html> (on file with the *Columbia Law Review*); Liza Mundy, A World of Their Own, *Wash. Post* (Mar. 31, 2002), <https://www.washingtonpost.com/archive/lifestyle/magazine/2002/03/31/a-world-of-their-own/abba2bbf-af01-4b55-912c-85aa46e98c6b/> (on file with the *Columbia Law Review*) (recounting the story of a couple that sought out a deaf sperm donor); Darshak M. Sanghavi, Wanting Babies Like Themselves, Some Parents Choose Genetic Defects, *N.Y. Times* (Dec. 5, 2006), <https://www.nytimes.com/2006/12/05/health/05essa.html> (on file with the *Columbia Law Review*); see also Sarah Aviles, Note, Do You Hear What I Hear?: The Right of Prospective Parents to Use PGD to Intentionally Implant an Embryo Containing the Gene for Deafness, 19 *Wm. & Mary J. Women & L.* 137, 139 (2012) (comparing the lack of media attention when preimplantation genetic diagnosis (PGD) is used to screen out disabilities compared to the “public outcry” associated with designing babies with certain characteristics).

14. Sanghavi, *supra* note 13 (internal quotation marks omitted) (quoting Dr. Robert J. Stillman). Another physician interviewed from the Chicago area echoed the sentiment, stating, “If we make a diagnostic tool, the purpose is to avoid disease.” *Id.* (internal quotation marks omitted) (quoting Dr. Yury Verlinsky).

15. See Mundy, *supra* note 13. There is no national regulation prohibiting selection for traits like deafness. In the United Kingdom, on the other hand, the 2008 Human Fertilisation and Embryology Act prohibited the selection and implantation of embryos known to have a genetic abnormality resulting in the birth of a child with a “serious physical or mental disability” or a “serious illness.” Human Fertilisation and Embryology Act 1990 § 14(4)(9) (UK); see also Gerard Porter & Malcolm K. Smith, Preventing the Selection of “Deaf Embryos” Under the Human Fertilisation and Embryology Act 2008: Problematizing Disability?, 32 *New Genetics & Soc’y* 171, 173 (2013) (scrutinizing the legislative review process prior to the Act’s passage).

16. Wendy McElroy, Victims From Birth: Engineering Defects in Helpless Children Crosses the Line, *Fox News* (Jan. 13, 2015), <https://www.foxnews.com/story/victims-from-birth-engineering-defects-in-helpless-children-crosses-the-line> [<https://perma.cc/FJP3-3U9H>].

determine whether their embryos carry genes for certain impairments—even with the initial aim of selecting against disability¹⁷—but seek implantation of some genetically anomalous embryos notwithstanding the test’s results. Selecting for traits raises numerous ethical questions;¹⁸ at present, the arbiters of these ethical debates are clinics¹⁹ rather than the individuals producing these embryos. Policies prohibiting implantation of genetically anomalous embryos not only screen out prospective parents seeking disabled children but also refuse service to those for whom

17. For examples of individuals with disabilities using IVF to select against a trait leading to a disability, see Sonja Sharp, *How Modern Medicine Neglects Mothers-to-Be With Disabilities*, L.A. Times (Nov. 17, 2021), <https://www.disabilitycoop.com/2021/11/17/how-modern-medicine-neglects-mothers-to-be-with-disabilities/29600/> (on file with the *Columbia Law Review*) (“Even Flores, who decided to screen out embryos with her condition when she and her husband began IVF, bristled at the implication that she should have to, or that she was selfish for wanting an experience that close to 90% of American women will have in their lifetimes.”). For a reproductive medicine case study involving individuals who were unknowing carriers of a genetic disorder nevertheless seeking implantation of genetically affected embryos, see Sigal Klipstein, *Transfer of Embryos Affected by Genetic Disease*, in *Case Studies in the Ethics of Assisted Reproduction* 37, 37–42 (Louise P. King & Isabelle C. Band eds., 2023).

18. See, e.g., Rosamund Scott, *Choosing Between Possible Lives: Legal and Ethical Issues in Preimplantation Genetic Diagnosis*, 26 *Oxford J. Legal Stud.* 153, 161 (2000) (exploring implications for the widespread use of PGD without serious justifications); Rachel E. Remaley, Note, “The Original Sexist Sin”: Regulating Preconception Sex Selection Technology, 10 *Health Matrix: J.L.–Med.* 249, 250–51 (2000) (reviewing the “unique legal and ethical dilemmas” associated with sex selection); Karen E. Schiavone, Comment, *Playing the Odds or Playing God? Limiting Parental Ability to Create Disabled Children Through Preimplantation Genetic Diagnosis*, 73 *Alb. L. Rev.* 283, 294–302 (2009) (considering moral arguments that weigh a parent’s autonomy to create disabled life against a child’s future autonomy); Lindsey A. Vacco, Comment, *Preimplantation Genetic Diagnosis: From Preventing Genetic Disease to Customizing Children. Can the Technology Be Regulated Based on the Parents’ Intent?*, 49 *St. Louis L.J.* 1181, 1218–20 (2005) (explaining how the value of procreative liberty has led to a lack of regulation on ART); see also *infra* notes 144, 148. A body of scholarship on “intentional diminishment” considers the ethical permissibility and potential liability of parents’ selection of disabled children. See, e.g., Taylor Irene Dudley, Comment, *A Fair Hearing for Children*, 9 *Whittier J. Child & Fam. Advoc.* 341, 343 (2010) (contending intentional selection of a child with deafness is a form of child abuse).

19. Some clinics use ethics committees to respond to complicated ethical questions that arise in embryology. In 1992, the Joint Commission on Accreditation of Healthcare Organizations mandated that hospitals have a mechanism for resolving ethical questions, recommending a multidisciplinary ethics committee. Anne-Marie Slowther & Tony Hope, *Clinical Ethics Committees*, 321 *Brit. Med. J.* 649, 649–50 (2000) (referencing the 1992 Accreditation Manual for Hospitals). Nonetheless, a 2009 analysis estimated 73.5% of U.S. clinics are not university or hospital affiliated, meaning they may not have ethics committees. Robert Klitzman, Beata Zolovska, William Folberth, Mark V. Sauer, Wendy Chung & Paul Appelbaum, *Preimplantation Genetic Diagnosis on In-Vitro Fertilization Websites: Presentations of Risks, Benefits and Other Information*, 92 *Fertility & Sterility* 1276, 1281 (2009).

selection of viable genetically anomalous embryos represents their only opportunity at biological parenthood.²⁰

Women predisposed to having disabled children face compounded constraints on reproductive autonomy. A woman who is an asymptomatic genetic carrier for Duchenne Muscular Dystrophy (DMD) can be denied services by a fertility clinic because any son she conceives has a fifty percent chance of developing DMD.²¹ A mother to two deaf sons can be denied reproductive care after her embryos test positive for a gene associated with hearing impairment.²² An aspiring mother who can only afford one round of IVF can be denied the implantation of any of her embryos because they carry a genetic indicator for autoimmune diseases.²³ While federal law prohibits genetic discrimination in employment and health insurance,²⁴ and disallows service denials based on disability,²⁵ fertility clinics' refusals to provide reproductive services on the basis of genetic conditions go largely unchecked. In many cases, women are not presently disabled enough to qualify for the ADA's protections, but nevertheless become victims of discrimination in reproductive services based on stereotypes about disabled people. Permitting this gap in antidiscrimination law to persist legitimizes the devaluation of disabled lives, prevents some women with genetic conditions from becoming mothers, and kindles the fire igniting current debates surrounding fetal personhood legislation.²⁶

20. Transferring Embryos With Genetic Anomalies Detected in Preimplantation Testing: An Ethics Committee Opinion, 107 Am. Soc'y for Reprod. Med. 1130, 1131 (2017) [hereinafter ASRM Ethics Committee, Transferring Embryos With Genetic Anomalies] (“[R]equests may be the result of prospective parents actively seeking to birth a child with a condition that one or both of the intended parents express, or it may be that all the viable embryos produced are genetically anomalous and thus represent the patient’s only opportunity for biologic parenthood.”).

21. See *infra* section II.B.1 (“Cam”).

22. See *infra* section II.B.2 (“Lia”).

23. See *infra* section II.B.3 (“Judy”).

24. See *infra* section I.C (describing the Genetic Information Nondiscrimination Act (GINA)).

25. See *infra* section I.B (outlining the ADA’s multiple theories of coverage).

26. Without addressing the regulatory gap that enables healthcare professionals to discriminate based on antidisability animus in a way that maximizes, rather than further contracts, women’s autonomy, abortion opponents may deploy personhood laws to do the same. See *infra* section I.A.2 (reviewing the rise of fetal personhood laws in the United States). Some predict the battleground over reproductive rights will turn to state limitations on women’s autonomy in using in-vitro fertilization and preimplantation genetic diagnosis. See Christian J. Sorensen, Thinking Outside the Box: Preimplantation Genetic Diagnosis, In Vitro Fertilization, and Disability Screening in the Wake of *Box v. Planned Parenthood*, 31 Wm. & Mary Bill Rts. J. 149, 152 (2022) (concluding “the next logical step for states concerned with parents committing reproductive discrimination in the wake of advancements in genetic screening is to target PGD and IVF, just as they have targeted trait selection in the abortion context”); see also Judith Daar, Emerging Reproductive Technologies: Regulating Into the Void, *in* Case Studies in the Ethics of Assisted Reproduction, *supra* note 17, at 13, 19–20 (“Routine aspect[s] of IVF, including preimplantation genetic testing and embryo cryopreservation may be subject to restriction

This Note highlights the risks of allowing unchecked fertility clinic discretion in assisted reproductive technology to persist and proposes several possible solutions that bridge antidiscrimination principles and women's autonomy.

I. THE LANDSCAPE OF REPRODUCTIVE TECHNOLOGY REGULATIONS AND ANTIDISCRIMINATION LAW'S COVERAGE OF GENETIC ANOMALIES

Women are becoming increasingly disempowered in reproductive choice just as new technologies offer fertility clinics greater power and discretion in selecting the characteristics of children brought into the world. When such selection reflects discriminatory animus against people with disabilities—or stereotypes about the quality of life with a disability—prospective mothers have no legal recourse. This Part explores why theories of antidiscrimination coverage for women with expressed or unexpressed genetic indicators for disability are, at best, incomplete. To better understand the current legal protections for women carrying genetic disorders seeking implantation of genetically anomalous embryos,²⁷ the following sections summarize (A) the degree of discretion afforded to fertility clinics in the law; (B) current theories of coverage under the ADA; and (C) current applications of the Genetic Information Nondiscrimination Act (GINA).

A. *Fertility Clinic Discretion in the Law*

At present, regulations of fertility clinics and assisted reproductive technology are lacking. While states have medical licensing requirements and disciplinary regimes for physician misconduct, comprehensive federal laws are nonexistent,²⁸ and states have largely failed to regulate in the

in a post-*Roe* world as the balance of state interests shifts from protecting patient choice and autonomy to favoring unborn human life over any other interests.”).

27. In this Note, reference to “genetically anomalous embryos” refers to a widely accepted scientific term for embryos that have undergone genetic testing and revealed genetic anomalies, providing a “near certainty that a child . . . will manifest certain health-affecting symptoms.” Daar, *A Clash at the Petri Dish*, supra note 11, at 221. This term is used interchangeably with “genetically affected,” sometimes used in this context. See, e.g., Lacey Brennan & Louise King, *Transferring Genetically Affected Embryos in IVF*, Harv. Med. Sch. Ctr. for Bioethics (June 1, 2019), <https://bioethics.hms.harvard.edu/journal/ivf-affected-embryos> [<https://perma.cc/FMP2-K6AB>].

28. See *Assisted Reproductive Technologies*, 24 *Geo. J. Gender & L.* 337, 338 n.3 (Leanne Aban, Jenna Pickering, Kira Eidson, Reema Holz, Chunhui Li & Olivia Luongo eds., 2023) (“While the federal government did enact the Fertility Clinic Success Rate and Certification Act, which does address the industry, the Act explicitly bars federal regulation of the ‘practice of medicine in assisted reproductive technology programs.’” (quoting Delores V. Chichi, Note, *In Vitro Fertilization, Fertility Frustrations, and the Lack of Regulation*, 49 *Hofstra L. Rev.* 535, 545 (2021))). The federal government passed the Fertility Clinic Success Rate and Certification Act of 1992 to address the reproductive healthcare industry, but the Act prohibits federal legislation regulating the “practice of

absence of federal action.²⁹ With the extraordinary discretion wielded by fertility clinics, critics accuse clinical practitioners of “playing God” in the face of power over procreation.³⁰

Preimplantation genetic diagnosis (PGD) enables patients to test embryos for genes that cause disease.³¹ For some, this technology has prevented the transfer of serious inherited genetic conditions from parent to child.³² In the early 1990s, when the technology was introduced, the innovation was hailed for its prospect of preventing the inheritance of genetic disorders.³³ For others, PGD presents a threat to respect for disabled lives.³⁴

medicine in assisted reproductive technology programs.” Fertility Clinic Success Rate and Certification Act of 1992, Pub L. No. 102-493, 106 Stat. 3146, 3149.

29. See Delores V. Chichi, Note, *In Vitro Fertilization, Fertility Frustrations, and the Lack of Regulation*, 49 Hofstra L. Rev. 535, 554 (2021) (observing “state lawmakers’ hesitation in attempting to regulate the industry”).

30. See Kimberly M. Mutcherson, *Disabling Dreams of Parenthood: The Fertility Industry, Anti-Discrimination, and Parents With Disabilities*, 27 Law & Ineq. 311, 311 (2009) (“Critics of the fertility industry frequently lament that those working in the field of reproductive technology are playing God, as they manipulate embryos, create and sustain pregnancies that could not exist or continue without their aid, and bring the gift of biological parenthood to those longing for it.”). Religious communities have also wielded this language to warn against the unchecked development of this technology. See generally Ariana Eunjung Cha, *Gifts From God*, Wash. Post (Apr. 27, 2018), <https://www.washingtonpost.com/graphics/2018/national/how-religion-is-coming-to-terms-with-modern-fertility-methods/> (on file with the *Columbia Law Review*) (“Some religious leaders have objected to using gene editing on embryos or in ways that could affect future generations, arguing the human genome is sacred and editing it violates God’s plan for humanity.”).

31. Harvey J. Stern, *Preimplantation Genetic Diagnosis: Prenatal Testing for Embryos Finally Reaching Its Potential*, 3 J. Clinical Med. 280, 281 (2014).

32. See Michelle J. Bayefsky, *Comparative Preimplantation Genetic Diagnosis Policy in Europe and the USA and Its Implications for Reproductive Tourism*, 3 *Reprod. BioMed. & Soc. Online* 41, 42 (2016) (“The technique is primarily used to detect serious heritable disorders, such as Tay-Sachs or cystic fibrosis, which the parents wish to avoid passing on to their children.”).

33. See *Bergero v. Univ. S. Cal. Keck School of Med.*, No. B200595, 2009 WL 946874, at *2 (Cal. Ct. App. Apr. 9, 2009) (“[PGD] is intended to allow parents to avoid conceiving a child that will be born with a particular genetic disorder.”); see also Karen Sermon, André Van Steirteghem & Inge Liebaers, *Preimplantation Genetic Diagnosis*, 363 *Lancet* 1633, 1638 (2004) (“New methods for diagnosis of monogenic diseases are being developed at a rapid rate . . .”).

34. See Adrienne Asch & Eric Parens, *The Disability Rights Critique of Prenatal Genetic Testing* 14, in *Prenatal Testing and Disability Rights* (Erik Parens & Adrienne Asch eds., 2000) (“Indeed, many people with disabilities, who daily experience being seen past because of some single trait they bear, worry that prenatal testing repeats and reinforces that same tendency toward letting the part stand in for the whole.”); Jeanne Salmon Freeman, *Arguing Along the Slippery Slope of Human Embryo Research*, 21 *J. Med. & Phil.* 61, 73 (1996) (presenting the full slippery slope argument that funding embryo research could promote eugenic practices).

In the United States, there are no formal laws regulating the selection and transfer of genetically anomalous embryos.³⁵ The United States stands apart from Europe in this regard. In Italy, a 2004 law restricted the use of PGD to individuals diagnosed as infertile to prevent the deployment of reproductive technology to select against inheritable traits.³⁶ Patient advocates challenged the law's constitutionality and prevailed in 2008.³⁷ Now, Italians can use PGD to maximize the embryo's health and development, but the law still bans "any form of eugenic selection" or "breeding techniques . . . intended to alter the genetic heritage of the embryo or gamete or to predetermine genetic characteristics, except interventions with diagnostic or therapeutic purposes."³⁸ Switzerland similarly permits PGD for serious heritable disorders, without clarity on the exact disorders that qualify.³⁹ France limits PGD services to only some certified fertility specialists allowing selection against only serious, incurable diseases.⁴⁰ A 2004 law vested the Agence de la Biomédecine

35. ASRM Ethics Committee, *Transferring Embryos With Genetic Anomalies*, supra note 20, at 1131.

36. Luca Gianaroli, Anna Maria Crivello, Ilaria Stanghellini, Anna Pia Ferraretti, Carla Tabanelli & Maria Cristina Magli, *Reiterative Changes in the Italian Regulation on IVF: The Effect on PGD Patients' Reproductive Decisions*, 28 *Reprod. BioMed. Online* 125, 126 (2014).

37. *Id.*

38. Norme in materia di procreazione medicalmente assistita [Rules Regarding Medically Assisted Procreation], Legge 19 febbraio 2004, n.40, art. 13, para. 3, G.U. Feb. 24, 2004, n.45 (It.) (author's translation). For more regarding this decision confirming the law's constitutionality, see Mirzia Bianca, *Il best interest of the child nel dialogo tra le Corti* [The Best Interest of the Child in the Dialogue Between the Courts], in *The Best Interest of the Child* 669, 669–70 (Mirzia Bianca ed., 2021).

39. See Christian De Geyter, *Assisted Reproductive Medicine in Switzerland*, *Swiss Med. Wkly.*, May 2, 2012, at 1, 5 (explaining the legislative history of PGD in Switzerland). After historically restrictive laws prohibiting PGD, the Swiss voted in 2015 to modify the Constitution to allow PGD. See *Constitution fédérale [Cst] [Constitution]* Apr. 18, 1999, RO 101, art. 119 para. 2 (Switz.) (amended on June 14, 2015, to legalize PGD); see also *Loi fédérale sur la procréation médicalement assistée [Federal Act on Medically Assisted Reproduction]*, Dec. 18, 1998, SR 810.11 art. 5a (Switz.) ("L'analyse du patrimoine génétique de gamètes et leur sélection . . . ne sont autorisées que pour détecter des caractéristiques chromosomiques susceptibles d'entraver la capacité de se développer du futur embryon ou si le risque de transmission d'une prédisposition à une maladie grave ne peut être écarté d'une autre manière." ["The analysis of the genetic material of reproductive cells and their selection . . . are only permitted in order to identify chromosomal properties that may inhibit the development capacity of the embryo to be created, or if there is no other way of avoiding the risk of transmitting a predisposition for a serious disease."]).

40. *Loi no. 2011-814 du 7 juillet 2011 relative à la bioéthique* [Law No. 2011-814 of July 7, 2011 Relating to Bioethics] *Journal Officiel de la République Française [J.O.]* [Official Gazette of France], July 8, 2011, art. 33. ("L'assistance médicale à la procréation a pour objet de remédier à l'infertilité d'un couple ou d'éviter la transmission à l'enfant ou à un membre du couple d'une maladie d'une particulière gravité. Le caractère pathologique de l'infertilité doit être médicalement diagnostiqué." ["The purpose of medically assisted procreation is to remedy the infertility of a couple or to prevent the transmission of a

(Agency of Biomedicine) with the power to regulate the uses of PGD.⁴¹ Now, requests for PGD are reviewed by a Centre Pluridisciplinaire de Diagnostic Prénatal (CPDPN), a group of physicians, biologists, and others who evaluate whether the conditions are sufficiently severe and the genetic information sufficiently prognostic.⁴² The United Kingdom's legislation, on the other hand, lists disorders for which PGD is permitted.⁴³ Fertility clinics can apply to add new conditions to the list.⁴⁴

In the United States, there is no list of permissible conditions to evaluate using PGD, nor are there state or federal laws regulating the acceptable use of the technology.⁴⁵ The Center for Human Reproduction estimates over half of IVF cycles in the United States involve preimplantation genetic testing (PGT).⁴⁶ Some clinics explicitly state that they will not implant embryos that are genetically affected by diseases like Down syndrome and Turner syndrome.⁴⁷ A 1987 survey found that 79% of ART practitioners would deny ART to patients at risk of transmitting a serious genetic disorder to their offspring.⁴⁸

The ASRM states that ART providers in the United States have traditionally not engaged in any “systematic screening of [a prospective

particularly serious illness to the child or a member of the couple. The pathological nature of infertility must be medically diagnosed.”]).

41. Loi no. 2004-800 du 6 août 2004 relative à la bioéthique [Law 2004-800 of August 6, 2004, Relating to Bioethics] Journal Officiel de la République Française [J.O.] [Official Gazette of France], Aug. 6, 2004, art. 2 (“L’Agence de la biomédecine se substitue à l’Etablissement français des greffes pour l’ensemble des missions dévolues à cet établissement public administratif.” [“The Agency of Biomedicine replaces the French Registry Establishment for all the missions assigned to this public administrative establishment.”])).

42. Rep. Agence de la Biomédecine, *Le diagnostic préimplantatoire et vous* [Preimplantation Diagnostics and You] 6 (2022), https://www.agence-biomedecine.fr/IMG/pdf/agencebiomedecine_ledpi_vous.pdf [https://perma.cc/2NLS-AHTN] (“Le CPDPN doit valider, après étude du dossier, le principe de recourir au DPI pour la maladie que vous êtes susceptible de transmettre.” [“The CPDPN must validate, after studying the file, the objective of using PGD for the disease that you are likely to transmit.”])).

43. PGT-M Conditions, Hum. Fertilisation & Embryology Auth., <https://www.hfea.gov.uk/pgt-m-conditions/> [https://perma.cc/WG82-CMKQ] (last visited Jan. 5, 2024).

44. Human Fertilisation and Embryology Act 1990, c. 37, § 10 (U.K.) (introducing the licensing procedure for clinics to perform PGD for a certain condition).

45. Bayefsky, *supra* note 32, at 43.

46. Norbert Gleicher, *CHR Reports Excellent Rates From “Chromosomal Abnormal” Embryos*, Ctr. for Hum. Reprod., <https://www.centerforhumanreprod.com/blog/chr-reports-excellent-rates-from-chromosomal-abnormal-embryos> [https://perma.cc/V3C3-HZU2] (last visited Jan. 7, 2024).

47. ASRM Ethics Committee, *Transferring Embryos With Genetic Anomalies*, *supra* note 20, at 1132.

48. U.S. Cong. Off. of Tech. Assessment, *Artificial Insemination: Practice in the United States: Summary of a 1987 Survey 29–30* (1988), <https://ota.fas.org/reports/8804.pdf> [https://perma.cc/58A9-6DYM].

patient's] ability or competency in rearing children"; however, ASRM also provides that physicians may "withhold services from prospective patients on the basis of well-substantiated judgments that those patients will be unable to provide or have others provide adequate child-rearing for offspring."⁴⁹ While the ASRM does not elaborate on its definition of a "well-substantiated judgment," an ASRM Ethics Opinion clarifies practitioners "may take the welfare of resulting children into account in deciding whether to provide services."⁵⁰ There is no existing regulatory body that reviews physician decisions for suitable substantiation or disciplines physicians whose decisions are motivated principally by presumptions about disability.⁵¹

Prior scholarship has identified the effect these practices have on screening out mothers with disabilities, whom medical practitioners regard as less suited to parent a child based on ableist assumptions about a disabled individual's capacity for parenthood.⁵² Authors like Judith Daar characterize ART as legitimizing a "stratification of reproductive freedom" and serving as a "commentary on the social worth of certain prospective parents."⁵³ Disabled women, long subject to a history of forced sterilization,⁵⁴ report being regarded as unfit mothers.⁵⁵

Scholarship has not yet addressed concerns that these policies screen out individuals who are denied the implantation of genetically anomalous embryos, based less on ableist assumptions about a parent's life than on

49. ASRM Ethics Committee, *Child-Rearing Ability*, supra note 8, at 864.

50. *Id.* at 866.

51. See Mutcherson, supra note 30, at 319–20 ("There is no overarching regulatory body like the HFEA [Human Fertilisation and Embryology Authority] to subject them to fines or the loss of a license, which could help to compel conformance to any particular set of non-discrimination practices.").

52. *Id.*; see also U.S. Cong. Off. of Tech. Assessment, supra note 48, at 33; Dave Shade, *Empowerment for the Pursuit of Happiness: Parents With Disabilities and the Americans With Disabilities Act*, 16 *Minn. J.L. & Ineq.* 153, 171–72 (1998) (analyzing an August 1987 Office of Technology Assessment survey revealing fertility provider biases in selection of patients for artificial insemination). A 1987 survey of 1,213 fertility physicians by the Office of Technology Assessment revealed one in five patients seeking artificial insemination are denied. U.S. Cong. Off. of Tech. Assessment, supra note 48, at 27. Around 52% of physician participants reported performing a personality assessment, which included screening of genetic diseases. *Id.* at 29. Asked "[h]ave you ever rejected or would you be likely to reject a request for artificial insemination for a potential recipient because she was/has: ___," 79% of participants reported they would reject a woman with a serious genetic disorder and 32% would reject a woman with less than average intelligence. *Id.*

53. Judith F. Daar, *Accessing Reproductive Technologies: Invisible Barriers, Indelible Harms*, 23 *Berkeley J. Gender, L. & Just.* 18, 49 (2008).

54. See, e.g., *Buck v. Bell* 274 U.S. 200, 208 (1927) (upholding a Virginia law authorizing the forced sterilization of individuals with mental disabilities).

55. A personal account by a mother with multiple sclerosis elaborates: "Whether a woman is born with a disability or acquires it later in life, the message she gets from the medical system and society is that she is ineligible for normal societal female roles of lover, wife, or mother." Carrie Killoran, *Women With Disabilities Having Children: It's Our Right Too*, 12 *Sexuality & Disability* 121, 122 (1994).

assumptions about the value of prospective disabled lives. The law currently affords fertility clinics and healthcare providers ample discretion to discriminate on the basis of the protected identities of parents as well as the propensity those parents have to produce disabled embryos. This Note is the first to address autonomy-maximizing legal recourses available for prospective parents denied services based not on their capacity as parents but on their likelihood to bring disabled children into the world.

1. *Unchecked Discretion Is Pitting the Marginalized Against One Another: The Disability and Reproductive Health Debate.* — Despite disability’s positionality as a feminist issue,⁵⁶ disability rights and women’s reproductive rights have long been pitted against each other. Abortion opponents have connected abortion to eugenics.⁵⁷ After *Roe*,⁵⁸ antiabortion activists wielded disability issues as a slippery slope argument against women’s reproductive autonomy.⁵⁹ Beginning in 2015, legislators in states like Indiana, Ohio, and Texas began considering bills banning abortions on the basis of disabilities like Down Syndrome.⁶⁰ Some scholars have framed the assisted reproduction industry as a “primary site of eugenic practices”

56. Disability studies drew influence from feminist theory, and numerous early works focused on the lives of disabled women. See generally Michelle Fine & Adrienne Asch, *Women With Disabilities: Essays in Psychology, Culture, and Politics* (1988) (describing disabled women’s lives across many dimensions); Jenny Morris, *Able Lives: Women’s Experience of Paralysis* (1989) (publishing the results of questionnaires completed by 205 women with spinal cord injuries); Harilyn Rousso, Susan Gushee O’Malley & Mary Severance, *Disabled, Female, and Proud! Stories of Ten Women with Disabilities* (1988) (detailing the lives of ten women with the goals of destigmatizing the barriers associated with disabled life). Rosemarie Garland-Thomson introduced the field of feminist disability studies in 1994. See Rosemarie Garland Thomson, *Redrawing the Boundaries of Feminist Disability Studies*, 20 *Feminist Stud.* 583, 592 (1994) (reviewing work that “participates in the discourse of feminist disability studies without even announcing itself as such”). Recent contributions have criticized the field for its exclusion of disabled women of color. Sami Schalk & Jina B. Kim, *Integrating Race, Transforming Feminist Disability Studies*, 46 *J. Women Culture & Soc’y* 31, 32 (2020) (arguing “the insights of feminists of color on disability have largely been excluded as intellectual contributions to feminist disability studies”).

57. See, e.g., Sarah St. Onge, *Aborting Disabled Babies Is Genocide, So Why Is It Legal?*, *The Federalist* (June 9, 2021), <https://thefederalist.com/2021/06/09/aborting-disabled-babies-is-genocide-so-why-is-it-legal/> [<https://perma.cc/ME8R-4JMK>] (arguing “[u]nborn babies who face complicated medical diagnoses are living human children”). In his opinions, Justice Clarence Thomas has also frequently directed his anti-abortion arguments at protecting disability rights. See, e.g., *Box v. Planned Parenthood of Ind. & Ky., Inc.*, 139 S. Ct. 1780, 1784 (2019) (Thomas, J., concurring) (“Technological advances have only heightened the eugenic potential for abortion, as abortion can now be used to eliminate children with unwanted characteristics, such as a particular sex or disability.”).

58. *Roe v. Wade*, 410 U.S. 113 (1973).

59. See Mary Ziegler, *The Disability Politics of Abortion*, 2017 *Utah L. Rev.* 587, 600 (“As the decade progressed, however, pro-lifers took up the issue of disability, using it to argue for the reversal of *Roe* and the importance of the right to life.”).

60. *Id.* at 613.

as women use PGT to select against certain genes.⁶¹ Given disability's inextricable ties to a history of eugenics,⁶² abortion opponents often claim protections for hypothetical disabled fetuses and overlook pregnant persons with disabilities who become what some scholars have termed "collateral damage in the war against reproductive justice."⁶³

Scholars and disability activists have begun pushing back against the deployment of disabled stories to justify limiting abortion access. Recent studies challenge the antieugenicist promise of disability-based abortion bans, finding states with these bans do not tend to implement other antieugenicist measures.⁶⁴ Disability activist Kendall Ciesemier describes the destructive consequences of this divide by stating:

Despite the fact that abortion opponents would champion my disabled "life" in my mom's womb, the laws they've levied across the country now put my life and that of other disabled and chronically ill people in danger by potentially forcing us to carry a pregnancy to term even in the face of serious health consequences.⁶⁵

According to many, abortion opponents' wielding of disability rights to limit reproductive autonomy has proven detrimental to people with disabilities. People with disabilities are disproportionately exposed to the risks of sexual violence, unwanted pregnancy, and maternal and infant mortality.⁶⁶ For individuals with chronic health conditions, pregnancy's physiological effects can "severely compromise health or even cause death."⁶⁷ Legislation imposing burdensome regulations on abortion

61. Suzanne Holland, *Selecting Against Difference: Assisted Reproduction, Disability and Regulation*, 30 Fla. St. U. L. Rev. 401, 402 (2003).

62. See *Buck v. Bell*, 274 U.S. 200, 207 (1927) (upholding a Virginia law authorizing the forced sterilization of individuals with mental disabilities); see also Robyn M. Powell, *Confronting Eugenics Means Finally Confronting Its Ableist Roots*, 27 Wm. & Mary J. Race, Gender & Soc. Just. 607, 620 (2021) (discussing eugenics' roots in antidisability animus and termination of parental rights on grounds of disability).

63. Allison M. Whelan & Michele Goodwin, *Abortion Rights and Disability Equality: A New Constitutional Battleground*, 79 Wash. & Lee L. Rev. 965, 996 (2022).

64. See Sonia M. Suter, *Why Reason-Based Abortion Bans Are Not a Remedy Against Eugenics: An Empirical Study*, 10 J.L. & Bioscis., 2023, at 1, 32 [hereinafter Suter, *Reason-Based Abortion Bans*] (comparing the presence of antieugenicist legislation in states with reason-based abortion bans).

65. Kendall Ciesemier, *Opinion, Leave My Disability Out of Your Anti-Abortion Propaganda*, N.Y. Times (July 31, 2022), <https://www.nytimes.com/2022/07/31/opinion/disability-rights-anti-abortion.html> (on file with the *Columbia Law Review*).

66. Asha Hassan, Lindsey Yates, Anna K. Hing, Alanna E. Hirz & Rachel Hardeman, *Dobbs and Disability: Implications of Abortion Restrictions for People With Chronic Health Conditions*, 58 Health Serv. Rsch. 197, 199 (2022); see also Whelan et al., *supra* note 63, at 999 ("Finally, persons with disabilities are more likely to be victims of intimate partner violence and violent crimes like rape and sexual assault. Persons with disabilities make up approximately 12% of the population, but 26.5% of rape/sexual assault victims." (footnote omitted)).

67. Hassan et al., *supra* note 66, at 198 (internal quotation marks omitted) (quoting *Abortion Can Be Medically Necessary*, Am. Coll. Obstetricians & Gynecologists (Sept. 25,

providers after *Dobbs* has resulted in clinic closures that restrain access to nonabortion healthcare services.⁶⁸ Restricting abortion access nationally has also created barriers for individuals with disabilities for whom travel is physically and administratively challenging.⁶⁹ These harms faced by disabled individuals are compounded for disabled people of color, who are more likely to be unemployed and live in poverty,⁷⁰ and for Black women, who face a higher risk of pregnancy-related complications.⁷¹

2019), <https://www.acog.org/news/news-releases/2019/09/abortion-can-be-medically-necessary> [<https://perma.cc/9BEE-RDFN>]). See generally Jessica L. Gleason, Jagteshwar Grewal, Zhen Chen, Alison N. Cernich & Katherine L. Grantz, Risk of Adverse Outcomes in Pregnant Women With Disabilities, 4 JAMA Network Open, e2138414, Dec. 1, 2021, at 1, 4 (finding in a study that women with disabilities were at higher risk of adverse maternal outcomes); Meena Venkataramanan, Their Medications Cause Pregnancy Issues. Post-*Roe*, That Could Be Dangerous., Wash. Post (July 25, 2022), <https://www.washingtonpost.com/health/2022/07/25/disabled-people-abortion-restrictions/> (on file with the *Columbia Law Review*) (“Studies have found that those with disabilities experience higher rates of sexual violence—which can lead to abortions—in addition to higher rates of unplanned pregnancies and a higher risk of death during pregnancy than people without disabilities.”); Suzanne C. Smeltzer, Bette Mariani & Colleen Meakim, Pregnancy in Women With Disabilities, Nat’l League for Nursing, Vill. Univ. Coll. of Nursing (2017), <https://www.nln.org/education/teaching-resources/professional-development-programsteaching-resourcesace-all/ace-d/additional-resources/pregnancy-in-women-with-disabilities-a830c45c-7836-6c70-9642-ff00005f0421> (on file with the *Columbia Law Review*) (“During the prenatal period, women with disabilities that affect their mobility are at higher risk than women without disabilities for several health issues.”).

68. Whelan et al., *supra* note 63, at 979–80 (noting “when [trigger] laws result in clinic closures, they inhibit access to essential non-abortion healthcare services, such as contraception, cancer screenings, prenatal care, gender-affirming care, and more”).

69. See *id.* at 996 (“Laws that require medically unnecessary clinic trips, prohibit the use of telemedicine, or prohibit the use of local retail or mail pharmacies to obtain medication abortion create significant and sometimes insurmountable barriers for persons with disabilities for whom travel may be physically or logistically difficult.”). For more on the outsized burden faced by disabled people when deciding to or planning travel, see Kristen L. Popham, Elizabeth F. Emens & Jasmine E. Harris, Disabling Travel: Quantifying the Harm of Inaccessible Hotels to Disabled People, 55 Colum. Hum. Rts. L. Rev. Forum 1, 16–34 (2023), https://hrlr.law.columbia.edu/files/2023/08/Popham-Emens-and-Harris_Disabling-Travel_20230809_Final-Upload.pdf [<https://perma.cc/86K7-MN6X>] (detailing the main barriers to hotel access for individuals with disabilities).

70. See, e.g., Employment Status of the Civilian Noninstitutional Population by Disability Status and Selected Characteristics, 2022 Annual Averages, U.S. Bureau Lab. Stats. (last modified Feb. 23, 2023), <https://www.bls.gov/news.release/disabl.t01.htm> [<https://perma.cc/6WKW-TRSH>] (showing Black people with disabilities had an unemployment rate of 10.2% compared to a rate of 6.7% for white people with disabilities); see also Nanette Goodman, Michael Morris, Kelvin Boston & Donna Walton, Financial Inequality: Disability, Race, and Poverty in America, Nat’l Disability Inst. 12 (2019), <https://www.nationaldisabilityinstitute.org/wp-content/uploads/2019/02/disability-race-poverty-in-america.pdf> [<https://perma.cc/J36SNL85>] (“The poverty rate varies by color for people with and without disabilities. Almost 40 percent of African Americans with disabilities live in poverty, compared with 24 percent of Non-Hispanic Whites, 29 percent of Latinos and 19 percent of Asians.” (citation omitted)).

71. See Donna L. Hoyert, Nat’l Ctr. for Health Stats., Maternal Mortality Rates in the United States 1 (2021), <https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.pdf> [<https://perma.cc/X5TK-5JKV>] (“In 2021, the maternal

Despite the unique and augmented harms abortion restrictions place on the disabled community, disabled advocates like Ciesemier have observed that “[a]bortion opponents like to use disabled fetuses as pawns to support their politics.”⁷²

The disability rights problems explored in this Note are likewise susceptible to being deployed to justify further minimizing women’s autonomy. Post-*Dobbs*, developing a statutory framework that centers both women’s autonomy and disability rights in reproductive healthcare services is urgent.

2. *Situating This Debate in a Post-Roe World: The Rise of Fetal Personhood Laws.* — Many of the states that once implemented disability-based abortion bans enacted trigger laws generally banning abortion after *Dobbs*.⁷³ In 2021, states like Montana and Arizona sought to pass laws criminalizing abortion and PGT/IVF based on a fetus’s personhood.⁷⁴ Louisiana currently has a law designating IVF fetuses as juridical persons, limiting the destruction of viable embryos and the use of embryos for research and commercial purposes.⁷⁵ Since *Dobbs*, legislators have proposed thirty-six fetal personhood bills, twenty-three of which were introduced in 2024.⁷⁶

Since *Dobbs*, state courts have also increasingly validated fetal personhood theories. In February 2024, the Alabama Constitution’s fetal personhood clause gained national attention after the Alabama Supreme Court ruled frozen embryos created through IVF are children and individuals disposing of the embryos could be subject to liability.⁷⁷ The

mortality rate for non-Hispanic Black (subsequently, Black) women was 69.9 deaths per 100,000 live births, 2.6 times the rate for non-Hispanic White (subsequently, White) women (26.6).” (citation omitted)).

72. Ciesemier, *supra* note 65.

73. See Suter, Reason-Based Abortion Bans, *supra* note 64, at 4 (“Just five months after *Roe* was overturned, 14 of the 17 states with [reason-based abortion] bans had enacted or already had trigger laws with complete bans . . .”).

74. Press Release, Democratic Legis. Campaign Comm., Arizona Legislature Passes Fetal Personhood Bill (Apr. 23, 2021), <https://dlcc.org/press/arizona-legislature-passes-fetal-personhood-bill/> [<https://perma.cc/8PGG-UVSA>]; Iris Samuels, Montana House Advances ‘Personhood’ Bill to Limit Abortions, AP News (Mar. 18, 2021), <https://apnews.com/article/bills-montana-810bee54e0b6b6fd5795414a00e10c9e> [<https://perma.cc/27EC-TZL3>].

75. La. Stat. Ann. §§ 9:121–9:133 (2020). By recognizing an embryo as a “juridical person,” the Louisiana law confers certain legal rights on to the embryo, including the ability “to sue or be sued.” *Id.* § 9:124. Its existence as a “juridical person” is recognized “until such time as the in vitro fertilized ovum is implanted in the womb.” *Id.* § 9:123.

76. State Legislation Tracker: Major Developments in Sexual & Reproductive Health, Guttmacher Inst., <https://www.gutmacher.org/state-legislation-tracker> [<https://perma.cc/VSZ2-CDRP>] (last updated Sept. 1, 2024).

77. See *LePage v. Ctr. for Reprod. Med.*, No. SC-2022-0515 & SC-2022-0579, 2024 WL 656591, at *5–6 (Ala. Feb. 16, 2024) (holding that the meaning of “child” in Alabama’s Wrongful Death of a Minor Act encompasses “unborn children,” including IVF embryos that have not been implanted).

decision sparked confusion and fear for reproductive healthcare providers with IVF clinics across the state temporarily pausing services.⁷⁸ While fetal personhood laws exhibited the initial aim of constraining abortion access, states are now leveraging the movement to constrain access to reproductive healthcare more generally.⁷⁹

The moral panic animating the fetal personhood movement has roots predating *Dobbs*. Proponents of the personhood movement have long employed Justice Harry Blackmun's language in *Roe* suggesting Fourteenth Amendment protections for fetal persons to justify a narrowing of women's right to reproductive autonomy.⁸⁰ *Dobbs* "breathes new life" into this argument.⁸¹ In his opinion for the Court, Justice Samuel Alito did not address the issue of fetal personhood head-on. But just two months after the *Dobbs* decision, the Supreme Court received and ultimately declined a petition for writ of certiorari filed by two pregnant women and Catholics for Life presenting the issue of whether "unborn" fetuses are persons entitled to Fourteenth Amendment rights.⁸² At least six states currently have fetal personhood provisions on the books,⁸³ indicating cases invoking this argument are likely to persist.⁸⁴ Justice Alito's decision has empowered states to draw lines on when "the rights of personhood begin."⁸⁵ Some commentators assert originalism compels

78. See Joshua Sharfstein, *The Alabama Supreme Court's Ruling on Frozen Embryos*, Johns Hopkins Bloomberg Sch. Pub. Health (Feb. 27, 2024), <https://publichealth.jhu.edu/2024/the-alabama-supreme-courts-ruling-on-frozen-embryos> [https://perma.cc/S5RE-HRDU] ("Several of the state's IVF clinics have since paused services, and lawmakers, doctors, and patients are raising concerns about the far-ranging impacts of the ruling on health care, including reproductive technology.").

79. Monika Jordan, *Comment, The Post-Dobbs World: How the Implementation of Fetal Personhood Laws Will Affect In Vitro Fertilization*, 57 U. Ill. Chi. L. Rev. 249, 272 (2024).

80. Jonathan F. Will, *Beyond Abortion: Why the Personhood Movement Implicates Reproductive Choice*, 39 Am. J.L. & Med. 573, 578 (2013). In *Roe*, Justice Harry Blackmun argued, "If this suggestion of [fetal] personhood is established, the appellant's case, of course, collapses, for the fetus' right to life would then be guaranteed specifically by the [Fourteenth] Amendment." See *Roe v. Wade*, 410 U.S. 113, 157 (1973).

81. Cynthia Soohoo, *An Embryo Is Not a Person: Rejecting Prenatal Personhood for a More Complex View of Prenatal Life*, 14 ConLawNOW 81, 82 (2023).

82. *Petition for Writ of Certiorari at i, Doe as Next Friend Doe v. McKee*, 143 S. Ct. 309 (2022) (No. 22-201), 2022 WL 4096782.

83. See, e.g., Ariz. Rev. Stat. Ann. § 1-219 (2024); Ga. Code Ann. § 1-2-1 (2024); Kan. Stat. Ann. § 65-6732 (West 2024); Ky. Rev. Stat. Ann. § 311.720 (West 2024); Mo. Ann. Stat. § 1.205 (2024); 18 Pa. Stat. and Cons. Stat. Ann. § 3202 (2024).

84. See Soohoo, *supra* note 81, at 82 ("Prenatal Personhood claims are unlikely to go away.").

85. See *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228, 2261 (2022). Conservative scholars have argued that states should have this power. See, e.g., Brief for Professors Mary Ann Glendon and Carter Snead as Amici Curie in Support of Petitioners at 8, *Dobbs*, 142 S. Ct. 2228 (No. 19-1392), 2021 WL 3375877 (criticizing *Roe* for keeping states from "treating the unborn as persons"); see also Soohoo, *supra* note 81, at 114 ("Essentially the state's police power is repackaged as a rights claim that the zygote-embryo-fetus does not

fetal personhood,⁸⁶ and others repackage personhood arguments in scientific terms.⁸⁷

Already, states are assigning personhood status to embryos in ways that limit access to lifesaving reproductive medicine and access to technologies that expand the reproductive possibilities for many women with disabilities.⁸⁸ Applying antidiscrimination law to fertility clinics denying women the choice to implant genetically affected embryos aims at expanding women's autonomy, offering one avenue to challenge the values underlying discretionary medical judgments. Even so, abortion opponents risk usurping these principles to constrain autonomy. If current antidiscrimination law continues to provide little recourse for genetic carriers, a void expands for abortion opponents to reinforce the need to assign personhood status to embryos as a theory of ADA disability coverage.

B. *Americans With Disabilities Act Title III Coverage for People With Expressed and Unexpressed Genetic Disorders*

The ADA does not create a positive right to medical care but mandates individuals with disabilities receive equal access to medical care compared to individuals without disabilities.⁸⁹ The ADA also provides

(and cannot) assert on its own behalf that is used to override the decisions of a pregnant person about their body and the prenatal life inside them.”).

86. See, e.g., Joshua Craddock, *Protecting Prenatal Persons: Does the Fourteenth Amendment Prohibit Abortion?*, 40 *Harv. J.L. & Pub. Pol'y* 539, 547–48 (2017) (arguing that whether states asserted that fetuses were members of the human species at the time the Fourteenth Amendment was ratified did not matter if states asserted all human beings were persons).

87. See, e.g., Reva Siegel, *Reasoning From the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 *Stan. L. Rev.* 261, 325 (1992) (“The science of human development now provides a coherent framework for reasoning about the morality of abortion, one so compelling that it is possible to make claims about abortion that seem to have no roots in matters of religious faith or judgments about family life.”); see also Brief for Illinois Right to Life as Amici Curiae & Dr. Steve Jacobs, J.D., Ph.D., in Support of Petitioners at 24, *Dobbs*, 142 S. Ct. 2228 (No. 19-1932), 2021 WL 3375894 (“[T]he scientific consensus on the fertilization view on when a human’s life begins is as clear and convincing as visual observations of fetal development.” (footnote omitted)); Gregory J. Roben, *Unborn Children as Constitutional Persons*, 25 *Issues L. & Med.* 185, 250–55 (2010) (arguing that the Equal Protection Clause of the Fourteenth Amendment compels federal protection of “unborn persons”).

88. See Adam Edelman, *An Uptick in State Personhood Bills Fuels Growing Fears Over IVF Restrictions*, NBC News (Feb. 23, 2024), <https://www.nbcnews.com/politics/personhood-bills-ivf-restrictions-alabama-rcna140228> [<https://perma.cc/65KW-XDTL>] (last updated Feb. 26, 2024) (explaining that “[f]our states have enacted laws granting personhood rights to fertilized embryos, and one dozen more have introduced similar legislation in 2024”).

89. *Access to Medical Care for Individuals With Mobility Disabilities*, U.S. DOJ C.R. Div., <https://www.ada.gov/resources/medical-care-mobility/> [<https://perma.cc/9PLW-7XBX>] (last updated June 26, 2020) (“Both Title II and Title III of the ADA and Section

protection for individuals who were denied services because they are associated with an individual with a disability or because they are regarded as disabled.⁹⁰ This section explores the case law surrounding disability coverage⁹¹ and considers why protection under the ADA has not yet proved sufficient for women with genetically anomalous embryos seeking equal access to reproductive technology.

1. *Genetic Anomaly as Disability.* — The ADA defines disability as “a physical or mental impairment that substantially limits one or more major life activities.”⁹² Genetic conditions, when expressed, can result in disabilities that fall clearly within the scope of the ADA. Disability coverage is not designed to be a demanding standard under the ADA.⁹³ Courts have generally favored a broad construction of the substantial limitation requirement. In *Darby*, the Sixth Circuit held that a plaintiff with genetic mutation BRCA1—which limited her normal cell growth and warranted a double mastectomy, despite not yet being cancerous—plausibly alleged a disability under the ADA.⁹⁴ The Sixth Circuit cited the gene’s present

504 require that medical care providers provide individuals with disabilities . . . full and equal access to their health care services and facilities . . .”).

90. 42 U.S.C. § 12182(a) (2018).

91. This section focuses primarily on the status of people who are genetic carriers of disease as disabled or regarded as disabled. The third prong of coverage, associational discrimination, receives little consideration due to its reliance on the personhood status of an embryo. Titles I and III forbid discrimination “because of the known disability of an individual with whom the qualified individual is known to have a relationship or association.” *Id.* § 12112(b)(4) (Title I); see also *id.* § 12182(b)(1)(E) (Title III, using similar language). By referencing an “individual,” associational discrimination under the ADA still imposes a personhood requirement on the individual with which one is associated. While this represents one possible route to ADA coverage, this path would risk further retracting women’s autonomy and disability rights if applied to association with an embryo. Individuals could apply this theory of coverage to instances where fertility clinics deny services based on the disability status of one’s partner or the disability status of family members. Courts have found cognizable associational discrimination claims in cases where insurance companies deny coverage to an individual because their partner is HIV-positive. See, e.g., *Cloutier v. Prudential Ins. Co. of America*, 964 F. Supp. 299, 304 n.4 (N.D. Cal. 1997) (stating that “virtually any association or relationship requires conduct of some kind” and that “characterizing plaintiff’s relationship with his mate as ‘conduct’ does not remove him from protected status under the ADA”); *Kotev v. First Colony Life Ins. Co.*, 927 F. Supp. 1316, 1323 (C.D. Cal. 1996) (holding that a plaintiff who was denied insurance coverage because he had an HIV-positive wife “is entitled to bring a claim under Title III for the discriminatory denial of insurance coverage”). Nonetheless, these theories have gone untested in the context of reproductive health and risk bolstering claims for fetal personhood that could ultimately constrain women’s reproductive choice.

92. 42 U.S.C. § 12102(1)(A).

93. See 29 C.F.R. pt. 1630, App. § 1630.2(j)(1)(iv) (2024) (“[T]he term ‘substantially limits’ shall be interpreted and applied to require a degree of functional limitation that is lower than the standard for ‘substantially limits’ applied prior to the ADAAA.”).

94. See *Darby v. Childvine, Inc.*, 964 F.3d 440, 445 (6th Cir. 2020) (“*Darby* alleges both a genetic mutation that limits normal cell growth and the growth of abnormal cells. . . . [H]er condition was serious enough to warrant an invasive corrective procedure. Taking all

effects on the plaintiff's body as warranting this classification, rather than the possibility of future disability development.⁹⁵ While the ADA has not yet been leveraged to this effect, a couple pursuing IVF with one or more genetic indicators of disability that *presently* limit a major life activity may qualify for ADA coverage if denied reproductive services on that basis. Even so, this leaves many individuals who are genetic carriers for disabilities without present, discernible physiological effects uncovered by the ADA's protections and leaves fertility clinic discretion and discrimination largely unchecked.

Infertility itself can qualify as a disability under the ADA, which could cover at least some women who are also genetic carriers. The ADA of 2008 expanded the definition of a "major life activity" to include "major bodily functions," including "reproductive functions."⁹⁶ Even before the amendments, in 1998, *Bragdon v. Abbott* seemed to settle the question of whether infertility was a major life activity within the meaning of the ADA.⁹⁷ *Bragdon* involved a dentist's denial of services to a woman who tested positive for HIV.⁹⁸ Even though the plaintiff's HIV had not yet reached a symptomatic stage, the Supreme Court ruled she qualified for ADA coverage because her HIV infection substantially limited her ability to reproduce.⁹⁹ The Court reasoned that individuals with HIV risk passing on the disease to a partner and child, which represents a substantial limitation to the major life activity of reproduction.¹⁰⁰ While infertility constitutes a protected disability under *Bragdon's* reasoning,¹⁰¹ *Bragdon* has

of that together, it is at least plausible that Darby is substantially limited in normal cell growth . . .").

95. *Id.* at 446–47 ("We agree that a genetic mutation that merely predisposes an individual to other conditions, such as cancer, is not itself a disability under the ADA."). Insofar as a gene merely predisposes an individual to the development of a future disability, the court clarified, "the terms of the [ADA] do not reach that far." *Id.* at 466. The *Darby* court distinguished the plaintiff's disability from that at issue in *Shell*, where the Seventh Circuit denied disability coverage based on conditions that plaintiff feared would develop as a result of his obesity. See *Shell v. Burlington N. Santa Fe Ry. Co.*, 941 F.3d 331, 335–36 (7th Cir. 2019) (finding no ADA disability where plaintiff based his claim on conditions he feared he would develop as a result of obesity).

96. ADA Amendments Act (ADAAA) of 2008, Pub. L. No. 110-325, § 4(a)(2)(B), 122 Stat. 3553, 3555 (codified in scattered sections of Title 42 of the U.S.C.).

97. See 524 U.S. 624, 638 (1998) ("We have little difficulty concluding that [reproduction] is [a major life activity].").

98. *Id.* at 628–29.

99. *Id.* at 641.

100. See *id.* at 639–40 ("[R]espondent's infection substantially limited [a major life activity because] a woman infected with HIV . . . imposes on the man a significant risk . . . and risks infecting her child during gestation and childbirth . . .").

101. Some may argue the ADA could be deployed to cover women with genetic anomalies who are pursuing ART due to infertility, under the theory that their infertility constitutes a disability under the ADA. This theory of coverage would be unlikely to prevail. A patient's infertility is not the basis for discrimination when clinics decline the implantation of embryos that are genetically affected by disability; policies that limit implantation of genetically-affected embryos tend to "screen out" not infertile people but individuals with

never been extended to cover all individuals with unexpressed genetic indicators.

2. *Genetic Anomaly as Regarded-As Disabled.* — The ADA also protects individuals from discrimination when an entity denying services regards an individual as disabled, discriminating on the basis of perceived disability rather than actual disability.¹⁰² The statute finds “[a]n individual meets the requirement of ‘being regarded as having such an impairment’ if the individual establishes that he or she has been subjected to an action prohibited under [the ADA] because of an actual or perceived physical or mental impairment whether or not the impairment limits or is perceived to limit a major life activity.”¹⁰³ This provision does not apply to “impairments that are transitory and minor.”¹⁰⁴

This prong of ADA coverage, developed from 1974 Amendments to the Rehabilitation Act,¹⁰⁵ reflects Congress’s intent to strike down overly restrictive interpretations of ADA coverage by removing any requirement to show substantial limitation in major life activities.¹⁰⁶ As the Court

genetic indicators for disability. Courts have used *Bragdon*’s reasoning to recognize infertility as a per se disability under the ADA. See, e.g., *Saks v. Franklin Covey Co.*, 117 F. Supp. 2d 318, 324–26 (S.D.N.Y. 2000) (holding that infertility is a disability under the ADA, but insurance excluding medically necessary treatments for infertility from insurance coverage does not discriminate against infertile individuals). Nonetheless, this theory of ADA coverage may not resolve claims of discrimination brought by genetic carriers in the context of fertility treatments. In prior cases, ADA discrimination claims by infertile people denied health insurance coverage for infertility treatments have not succeeded when policies applied uniformly to disabled and nondisabled employees. See *id.* (holding infertility treatment insurance exclusions did not violate the ADA because the policies applied equally to disabled and nondisabled employees); see also *Doe v. Mut. of Omaha Ins. Co.*, 179 F.3d 557, 563 (7th Cir. 1999) (holding health plans capping AIDS treatment costs did not violate the ADA as long as disabled and nondisabled employees received the same benefits). Fertility clinic policies prohibiting implantation of genetically anomalous embryos likewise apply uniformly to infertile and non-infertile patients. In another case, a woman claiming disability discrimination for a Catholic school’s decision to fire her after receiving IVF treatments lost her case on summary judgment because “the evidence in the record indicates that the Diocese acted . . . not on any animus against infertility.” *Herx v. Diocese of Ft. Wayne-S. Bend Inc.*, 48 F. Supp. 3d 1168, 1180 (N.D. Ind. 2014) (holding “a religious organization can require its employees to conform to the organization’s religious tenets” (citing 42 U.S.C. § 12113(d)(2) (2012))). Infertility alone is an unsteady basis of coverage for individuals with genetic indicators for disease denied on the basis of those genetic indicators, rather than on the basis of their infertility.

102. 42 U.S.C. § 12102(1)(C) (2018).

103. *Id.* § 12102(3)(A).

104. *Id.* § 12102(3)(B).

105. Pub. L. No. 93-516, § 111, 88 Stat. 1617, 1619 (1974) (codified as amended at 29 U.S.C. § 706(8)(B) (1994)).

106. With the regarded-as prong, Congress aimed to reject the Supreme Court’s reasoning in *Sutton v. United Air Lines*, 527 U.S. 471, 475 (1999) (holding individuals whose eyesight was corrected with glasses were not disabled under the ADA because their condition could be mitigated), toward the broader coverage envisioned in *School Board of Nassau County v. Arline*, 480 U.S. 273, 284–86 (1987) (holding an individual is regarded-as disabled

acknowledged, legislators developed the regarded-as prong to counter “archaic attitudes” and stereotypes about the capacity of individuals with disabilities.¹⁰⁷ The Senate Committee Report reflected concerns related to negative attitudes and misconceptions that perpetuate discrimination and exclusion.¹⁰⁸ Some scholars draw connections between this theory of disability coverage and the social model of disability,¹⁰⁹ where societal stigmas—including, in some cases, myths about demonic possession¹¹⁰—can subject individuals to discrimination whether or not their condition substantially limits a major life activity.¹¹¹

The Fifth Circuit held there was sufficient evidence for a jury to conclude an individual with reported chest pains was regarded as disabled by their employer when their employer collected documentation from supervisors tying complaints to the individual’s asserted medical needs.¹¹² A subsequent Fifth Circuit case lifted the requirement that an employee show their employer regarded them as substantially limited in a major life activity, stating, “The amended ‘regarded as’ provision reflects the view that ‘unfounded concerns, mistaken beliefs, fears, myths, or prejudice about disabilities are just as disabling as actual impairments.’”¹¹³

when adversely treated on the basis of their impairment, notwithstanding an employer’s subjective beliefs about their limitations).

107. See *Nassau County*, 480 U.S. at 278–79 (internal quotation marks omitted) (quoting S. Rep. No. 93-1297, at 50 (1974)).

108. S. Rep. No. 101-116, at 105 (1989) (“Discrimination also includes harms affecting individuals . . . based on false presumptions, generalizations, misperceptions, patronizing attitudes, ignorance, irrational fears, and pernicious mythologies.”).

109. The social model of disability developed in England in the 1970s to distinguish the discriminatory and inaccessible social environment as a cause of disability from the medicalized conditions of impairment. One union of disabled veterans, thought to have originated the concept, released a 1976 statement writing, “In our view, it is society which disables physically impaired people.” Union of the Physically Impaired Against Segregation & the Disability Alliance Discuss Fundamental Principles of Disability 3 (1976), <https://disability-studies.leeds.ac.uk/wp-content/uploads/sites/40/library/UPIAS-fundamental-principles.pdf> [<https://perma.cc/EFA6-7K8M>]. Early academic articulations of the social model can be found in the work of Michael Oliver. See Mike Oliver, Social Policy and Disability: Some Theoretical Issues, *in* *Overcoming Disabling Barriers: 18 Years of Disability and Society* 7, 8 (Len Burton ed., 2006) (proposing a departure from the personal tragedy theory of disability dominating disability thought).

110. E.g., Isaac T. Soon, A Disabled Apostle: Impairment and Disability in the Letters of Paul 54–67 (2023) (describing biblical analysis mythologizing demons as impairment).

111. See Samuel R. Bagenstos, Subordination, Stigma, and “Disability”, 86 Va. L. Rev. 397, 501 (2000) (concluding individuals with a seizure disorder qualify for protections under the “social-stigma ‘regarded as’ analysis” because generations have developed elaborate, demeaning myths about people with epilepsy).

112. *Burton v. Freescale Semiconductor, Inc.*, 798 F.3d 222, 230–31 (5th Cir. 2015).

113. *Cannon v. Jacobs Field Servs. N. Am., Inc.*, 813 F.3d 586, 591 (5th Cir. 2016) (quoting 29 C.F.R. Pt. 1630.2(i) (2016)).

The Eleventh Circuit has held that this designation does not apply to those with the potential to become ill.¹¹⁴ The court clarified, “Even construing the disability definition broadly in favor of coverage, we still conclude that the terms of the ADA protect anyone who experiences discrimination because of a current, past, or perceived disability—not a potential future disability.”¹¹⁵ For the purposes of this provision, unexpressed genetic conditions without sufficient physiological effects could be interpreted as potential future disabilities.

C. *GINA’s Promise*

The Genetic Information Nondiscrimination Act, which prohibits discrimination on the basis of genetic information,¹¹⁶ applies uniquely to health insurance and employment.¹¹⁷ GINA applies its protections to the genetic tests of individuals or family members and to manifestation of a disease or disorder in family members of an individual.¹¹⁸ State laws prohibiting genetic discrimination in insurance predated GINA,¹¹⁹ and the “patchwork” of differing laws on the state and federal level was one motivation for GINA’s passage.¹²⁰

Scholars lauded GINA as a form of preemptive legislation, anticipating discrimination “that may pose a future threat.”¹²¹ In contrast with the ADA, GINA “*only* applies to future impairments.”¹²² Some argue this ADA–GINA divide has led to inconsistent policymaking and

114. See *Equal Emp. Opportunity Comm’n v. STME, LLC*, 938 F.3d 1305, 1315 (11th Cir. 2019) (“[W]e must conclude that the disability definition in the ADA does not cover this case where an employer perceives a person to be presently healthy with only a potential to become ill and disabled in the future due to the voluntary conduct of overseas travel.”).

115. *Id.* at 1316.

116. 42 U.S.C. §§ 2000ff to 2000ff-11 (2018).

117. See Yann Joly, Charles Dupras, Miriam Pinkesz, Stacey A. Tovino & Mark A. Rothstein, *Looking Beyond GINA: Policy Approaches to Address Genetic Discrimination*, 21 *Ann. Rev. Genomics & Hum. Genetics* 491, 494 (2020) (clarifying the scope of GINA as to “discrimination based on ‘genetic information’ in employment and health insurance”).

118. 42 U.S.C. § 2000ff(4)(A).

119. See, e.g., *Miss. Code R. § 3-10-24(A), (C), (G)* (LexisNexis 2024); 31 Pa. Stat. and Const. Stat. Ann. § 89.791(c)–(d) (2024); see also Joly et al., *supra* note 117, at 494–96 (“State insurance laws prohibiting [genetic discrimination] based on certain genetic conditions in specific types of insurance (e.g., health insurance) date back to the 1970s.”).

120. Genetic Information Nondiscrimination Act of 2008, Pub. L. No. 110-233, § 2(5), 122 Stat. 881, 882 (codified at 42 U.S.C. §§ 2000ff to 2000ff-11) (“Congress has collected substantial evidence that the American public and the medical community find the existing patchwork of State and Federal laws to be confusing and inadequate to protect them from discrimination.”).

121. Jessica L. Roberts, *Preempting Discrimination: Lessons From the Genetic Information Nondiscrimination Act*, 63 *Vand. L. Rev.* 439, 441 (2010).

122. See Mark A. Rothstein, *Predictive Health Information and Employment Discrimination Under the ADA and GINA*, 48 *J.L. Med. & Ethics* 595, 598 (2020) (“GINA prohibits discrimination based on information about future impairments, precisely the kind of discrimination that the ADA has been held not to cover for non-genetic impairments.”).

inadequate coverage.¹²³ GINA case law primarily addresses employment discrimination, in part because the Affordable Care Act's health insurance reforms "overlap" with important GINA protections.¹²⁴ Even in employment, courts are at odds over the breadth of the meaning of "genetic information" under GINA.¹²⁵ Under even the most demanding constructions of GINA, individuals with genetic anomalies could recover where facts suggest employment and insurance discrimination. This Note addresses whether expanding GINA's antidiscrimination protections to places of public accommodations would remedy unchecked fertility clinic discretion.

II. DENYING REPRODUCTIVE CARE BASED ON DISCRIMINATORY DISABILITY ANIMUS UNDERMINES DISABILITY AS DIFFERENCE

A. *Disability as Difference*

Disability carries different symbolic meanings for different societies and individuals, particularly when compounded by the oppression associated with other identities.¹²⁶ Despite this range of experiences, certain narratives around physical disability predominate. The radical and deviant existence of disabled people signals a failure of Western science to achieve desired control over the body.¹²⁷

123. See *id.* at 598–601 (“GINA applies only to discrimination based on genetic information about a condition that has not yet manifested. By contrast, the ADA applies only to symptomatic individuals who have an impairment that constitutes a substantial limitation of a major life activity. Two gaps in coverage remain.”).

124. Sonia M. Suter, *GINA at 10 Years: The Battle Over ‘Genetic Information’ Continues in Court*, 5 *J.L. & Biosciences* 495, 505 (2019).

125. Courts vary in how demanding a standard they place on plaintiffs claiming genetic discrimination; some assert plaintiffs must show another individual's diagnosis would affect the plaintiff's ability to develop a genetic disease. One view, introduced in *Poore v. Peterbilt of Bristol, L.L.C.*, is that GINA does not protect an individual against discrimination based on a family member's diagnosis with a genetic disorder when the diagnosis does not affect “an individual's propensity to get an inheritable genetic disease.” 852 F. Supp. 2d 727, 730 (W.D. Va. 2012) (internal quotation marks omitted) (quoting H.R. Rep. No. 110–28, pt. 3, at 70 (2007), as reprinted in 2008 U.S.C.C.A.N. 112, 141). Other courts present a broader construction, and in cases like *Jackson v. Regal Beloit America, Inc.*, they have ruled that unlawful requests of genetic information are not subject to added scrutiny based on whether they actually affect the plaintiff's propensity to develop disease. No. 16-134-DLB-CJS, 2018 WL 3078760, at *15 (E.D. Ky. June 21, 2018).

126. See Susan Wendell, *The Rejected Body: Feminist Philosophical Reflections on Disability* 62–63 (1996) [hereinafter *Wendell, Rejected Body*] (“[D]ifferent disabilities and illnesses can have different meanings within a society . . . and the same disability or illness may have different meanings in different societies or in the same society at different times Moreover . . . race, age, gender, class, or sexual identity[] may alter the meaning of . . . disability.”).

127. See *id.* (“In the societies where Western science and medicine are powerful culturally, and where their promise to control nature is still widely believed, people with disabilities are constant reminders of the failures of that promise, and of the inability of science and medicine to protect . . . from illness, disability, and death.”).

Among scholars, disagreement persists around the framing of physical disability as a condition of an oppressive society¹²⁸ or of a medical nature in need of a cure.¹²⁹ A new wave of scholarship rejects the medicalized view of disability and embraces the social model, whereby the source of a disabled person's disadvantage can be found not in physical impairment but in social barriers.¹³⁰ Critics of the social model posit that viewing disability as merely a social condition erases individuals with chronic illnesses from the disability community.¹³¹ To create space for a vision of chronic illness as difference, scholars like Alison Kafer have proposed a "political/relational model" of disability.¹³² In this model, Kafer interrogates inaccessibility and discrimination as political efforts to reinforce a constitutive normalcy and deconstructs the marginalizing effect of social limitations; at once, Kafer's model "neither opposes nor valorizes medical intervention."¹³³ This Note likewise adopts a political/relational model, neither opposing nor valorizing a woman's choice to select against disability in the face of intricate social and medical realities, whilst resisting the social barriers to selecting *for* disability.

The notion of eradicating and preventing disability is a complicated one, even in the disability community. Some deaf individuals oppose the use of cochlear implants because of the intrinsic value members of the community place on deafness as "entry into a rich culture, ripe with

128. See Alison Kafer, *Feminist, Queer, Crip* 5–7 (2013) (arguing the social model posits "impairments aren't disabling, social and architectural barriers are"); see also Liz Crow, *Including All of Our Lives: Renewing the Social Model of Disability*, in *Encounters With Strangers: Feminism and Disability* 206, 208 (Jenny Morris ed., 1996) (criticizing the medical model's necessity of "the removal or 'overcoming' of impairment" through "cure or fortitude").

129. See Kafer, *supra* note 128, at 5 (arguing that the medical model frames "atypical bodies and minds as deviant, pathological, and defective," addresses disability in "medical terms," and suggests the "proper approach to disability is to 'treat the condition and the person with the condition'" (quoting Simi Linton, *Claiming Disability: Knowledge and Identity* 11 (1998))).

130. See Rabia Belt & Doron Dorfman, *Disability, Law, and the Humanities: The Rise of Disability Legal Studies*, in *The Oxford Handbook of Law and Humanities* 145, 147 (Simon Stern, Maksymilian Del Mar & Bernadette Meyler eds., 2020) (discussing the rise and content of the social model of disability); Adi Goldiner, *Understanding "Disability" as a Cluster of Disability Models*, 2 *J. Phil. Disability* 28, 31 (2022) (characterizing the social model's perception of "disability as the social disadvantage and exclusion that some people face due to their surrounding environment"); see also Jamelia N. Morgan, *Policing Under Disability Law*, 73 *Stan. L. Rev.* 1401, 1406 (2021) (noting "the ADA embodies a social model of disability").

131. People with chronic illnesses face the disabling effects of social barriers, structural inaccessibility, and also their own bodies. See Kafer, *supra* note 128, at 7 (claiming "the social model with its impairment/disability distinction erases the lived realities of impairment; in its well-intentioned focus on the disabling effects of society, it overlooks the often-disabling effects of our bodies").

132. *Id.* at 6.

133. *Id.*

language, arts, and tradition.”¹³⁴ Others favor the use of cochlear implants to lessen the social barriers faced by a child with a disability.¹³⁵ Notwithstanding these seemingly incompatible approaches, bioethicists and disability experts alike generally support parental choice.¹³⁶ Parental choice, however, is absent from the conversation surrounding prenatal testing and reproductive care.

Among “unhealthy disabled” people,¹³⁷ the calculus surrounding disease prevention is not without complexities. Some chronically ill people, like Kafer, embrace a “personal, embodied truth,” whereby they do not oppose the choice to prevent disability or impairment.¹³⁸ Others, like Susan Wendell, cite “the history of eugenics” as enlivening “skeptic[ism] about whether prevention and cure are intended primarily to prevent suffering or to eliminate ‘abnormalities’ and ‘abnormal’ people.”¹³⁹

Wendell, in her framework departing from “disability as ‘the Other’” toward “disability as difference,” acknowledges the “devastating social consequences” of navigating life with a disability.¹⁴⁰ But, as she points out, socially created obstacles are never cited as reasons to exclude children of

134. Alicia Ouellette, *Hearing the Deaf: Cochlear Implants, the Deaf Community, and Bioethical Analysis*, 45 Val. U. L. Rev. 1247, 1257–58 (2011).

135. See *id.* at 1266–69 (explaining that some favor cochlear implants so that children are not confined “forever to a narrow group of people and a limited choice of careers” (internal quotation marks omitted) (quoting Dena S. Davis, *Genetic Dilemmas* 82 (2nd ed. 2010))).

136. See *id.* at 1268 (“The one issue about which bioethicists appear to have reached a consensus is that a parental choice to use cochlear implants is ethically and morally defensible.” (emphasis omitted)).

137. See Susan Wendell, *Unhealthy Disabled: Treating Chronic Illnesses as Disabilities*, *Hypatia*, Fall 2001, at 17, 18–19 [hereinafter Wendell, *Unhealthy Disabled*] (defining “healthy disabled” as “people whose physical conditions and functional limitations are relatively stable and predictable for the foreseeable future,” distinct from those with chronic diseases, who require medical treatment and experience “no reasonable expectation of cure”).

138. See Kafer, *supra* note 128, at 4 (“As much joy as I find in communities of disabled people, and as much as I value my experiences as a disabled person, I am not interested in becoming more disabled than I already am. I realize that position is itself marked by an ableist failure of imagination, but I can’t deny holding it.”).

139. Wendell, *Unhealthy Disabled*, *supra* note 137, at 31.

140. Wendell, *Rejected Body*, *supra* note 126, at 82; see also *id.* at 57–84 (describing how disability can be viewed as “Otherness” or as “difference”). This Note adopts Susan Wendell’s framework of “disability as difference” over other theoretical frames, such as anti-eliminationism which advocates for “the preservation of, and resources for, disabled lives.” Katherine L. Moore, *Disabled Autonomy*, 22 *J. Health Care L. & Pol’y* 245, 246 (2019) (“Anti-eliminationism inherently challenges the notion that getting rid of disability is a good thing.”). Some scholars advancing an anti-eliminationist lens for disability rights are critics of disability-selective abortion and argue “a resolution that is satisfactory to both abortion rights and disability rights may be . . . elusive.” *Id.* at 278. This Note, by contrast, advances a model that explicitly rectifies the abortion rights and disability rights divide.

color from coming into the world.¹⁴¹ What distinguishes these cases from disability is, in part, the perception of disability as “abnormality” and “pathology.”¹⁴² Likewise, contrary to other identity groups, children with disabilities are rarely born into families or communities of people with disabilities “committed to valuing their differences and fighting for their rights.”¹⁴³ These obstacles to disability as diversity are ever-present in the context of reproductive healthcare.

This Note does not posit that selecting for disability is the ethically, politically, medically, or socially superior choice. Rather, it raises questions about why these deeply personal choices—about which disability activists are divided¹⁴⁴—rest in the hands of medical professionals rather than individuals. A uniform policy of physician discretion in rejecting reproductive care centers one vision of disability over other, valid perceptions of disability as a fundamental form of diversity.

As Wendell notes,

People who take it for granted that it would be a good thing to wipe out all biological causes of disability (as opposed to social causes) are far more confident that they know how to perfect nature and humanity than I am. Even supposing that everyone

141. See Wendell, *Rejected Body*, *supra* note 126, at 82 (“The fact is that a child born with spina bifida or Down’s syndrome will face many socially created obstacles to living well. . . . [T]he same thing is true for children-of-colour in white-dominated societies, but few people-of-colour would argue that it is a sufficient reason not to bring a child-of-colour into the world.”).

142. *Id.*

143. *Id.*

144. For an overview of competing moral conceptions of using PGD to select for disabled traits, see I. Glenn Cohen, *Intentional Diminishment, the Non-Identity Problem, and Legal Liability*, 60 *Hastings L.J.* 347, 350–59 (2008) (arguing the non-identity problem applies in cases of creating disabled children through either selection or genetic manipulation); Alexander D. Wolfe, *Wrongful Selection: Assisted Reproductive Technologies, Intentional Diminishment, and the Procreative Right*, 25 *T.M. Cooley L. Rev.* 475, 484–95 (2008) (discussing arguments for and against legal regulation of using PGD to select for disabled traits). For the debate surrounding disability-selective abortion in the disability rights movement, see, e.g., Adrienne Asch & David Wasserman, *Where Is the Sin in Synecdoche? Prenatal Testing and the Parent-Child Relationship*, in *Quality of Life and Human Difference: Genetic Testing, Health Care, and Disability* 172, 209–11 (David Wasserman, Jerome Bickenbach & Robert Wachbroit eds., 2005) (“[M]ost decisions to abort for, or select against, impairment are misguided—based on harmful stereotypes, unreasonable expectations, or relentless institutional pressures.”); Marsha Saxton, *Disability Rights and Selection Abortion*, in *Abortion Wars: A Half Century of Struggle, 1950–2000*, at 374, 381–84 (Rickie Solinger ed., 1998) (reviewing how attitudes about disabilities affect women’s choices around PGD and abortion); Claire McKinney, *Selective Abortion as Moral Failure? Reevaluation of the Feminist Case for Reproductive Rights in a Disability Context*, *Disability Stud. Q.*, Winter 2016, <https://dsq-sds.org/index.php/dsq/article/view/3885/4213> [<https://perma.cc/ESH9-L46B>] (“[W]hile it may be the case that many women could cope with the additional time, stress, and money necessary to raise a child with a disability, to universalize from this perspective without empirical support ensures that we ignore the lived reality of women for whom such additional costs and burdens could be unbearable.”).

involved in such an effort were motivated entirely by a desire to prevent and alleviate suffering, what else besides suffering might we lose in the process? And would they know where to stop?¹⁴⁵

B. *“Would They Know Where to Stop?” Three Scenarios in Which Fertility Clinic Discretion Undermines Women’s Autonomy to Bring a Disabled Child Into the World*

Fertility clinic practices of refusing to implant genetically anomalous embryos allow fertility clinic practitioners to discriminate based on a patient’s genetic qualities. Unchecked discretion limits reproductive autonomy such that individuals with disabilities or with a propensity to develop disabilities are siloed from equal access to new reproductive technologies.

Innovations like PGT and CRISPR increase the level of knowledge practitioners and patients can gain about embryos. These technologies open up possibilities for preventing the transfer of certain conditions¹⁴⁶ and could do away with some disabilities altogether.¹⁴⁷ This raises important political questions about the value of disabled life and perceptions of disability as diversity. It also raises deeply personal, ethical questions around the knowing transfer of disease on to offspring.¹⁴⁸ While

145. Wendell, *Rejected Body*, supra note 126, at 84.

146. See Firuza Rajesh Parikh, Arundhati Sitaram Athalye, Nandkishor Jagannath Naik, Dattatray Jayaram Naik, Rupesh Ramesh Sanap & Prochi Fali Madon, *Preimplantation Genetic Testing: Its Evolution, Where Are We Today?*, 11 *J. Hum. Reprod. Sci.* 306, 311–12 (2018) (explaining PGT’s development as a “diagnostic tool to prevent transmission of any known genetic disorder”).

147. See Ruiting Li, Qin Wang, Kaiqin She, Fang Lu & Yang Yang, *CRISPR/Cas Systems Usher in a New Era of Disease Treatment and Diagnosis*, *Molecular Biomed.*, no. 31, Oct. 2022, at 1, 2 (observing “CRISPR-based genome editing technology has created immense therapeutic potential” to remove defective genes).

148. See Shawna Benston, *CRISPR, a Crossroads in Genetic Intervention: Pitting the Right to Health Against the Right to Disability*, *Laws*, no. 5, Mar. 2016, at 1, 2 (“With the emergence and refinement of reproductive genetic technologies (RGTs), especially gene-editing technologies like CRISPR/Cas9, potential parents must decide whether—and if so, how—to utilize the technologies available to them, and genetics scientists and legislatures must determine how best to regulate the technologies.”). CRISPR’s development has provoked ethical critiques related to the devaluation of disability. See, e.g., Katie Hafner, *Once Science Fiction, Gene Editing Is Now a Looming Reality*, *N.Y. Times* (July 22, 2020), <https://www.nytimes.com/2020/07/22/style/crispr-gene-editing-ethics.html> (on file with the *Columbia Law Review*) (“While still highly theoretical when it comes to eliminating disabilities, gene editing has drawn the attention of the disability community. The prospect of erasing some disabilities and perceived deficiencies hovers at the margins of what people consider ethically acceptable.”); see also Sandy Sufian & Rosemarie Garland-Thomson, *Opinion, The Dark Side of CRISPR*, *Sci. Am.* (Feb. 16, 2021), <https://www.scientificamerican.com/article/the-dark-side-of-crispr/> [<https://perma.cc/T8DV-T38N>] (“But CRISPR’s tantalizing offer to achieve the supposedly ‘best’ kind of people at the genetic level is an uneasy alert to those who are often judged to be biologically inferior People like us whose being is inseparable from our genetic condition would be the first to go.”).

this Note does not delve into the ethical implications underlying the development and use of gene-editing tools, it posits that protecting reproductive choice will become increasingly critical in the wake of these debates.

Perhaps most critical is the threat unchecked discretion in the use of these emerging technologies will have on reproductive autonomy. Failure to develop an antidiscrimination principle that centers women's reproductive choice will risk further disempowerment. The post-*Dobbs* reinvigoration of the fetal personhood movement¹⁴⁹ has narrowed reproductive freedom, using disability rights as its talking point. Indeed, fetal personhood proponents will doubtless leverage reproductive technology's implications on disability rights to justify limiting women's choice, particularly if antidiscrimination law continues to provide little recourse.

This section explores three hypothetical scenarios in which the rights of individuals with genetic conditions to equal access to reproductive services are implicated when denied service due to their propensity to pass disability on to their embryos. The first two examples pull from issues that have not been presented in public cases, in part because cases have not been cognizable under current antidiscrimination laws. The third example draws from the author's own family experience carrying a gene that predisposes children to inflammatory disabilities. This Part aims to showcase the toll of denying reproductive services based on their transmission of disability to offspring.

1. *Cam*. — Cam and her partner, Maddy, wish to have a child. Cam is excited about conceiving her own biological child and opts for IVF. Cam is a known carrier for DMD, a rare disease resulting in muscular degeneration and shortened life span.¹⁵⁰ In consultation with a genetic counselor, Cam learned that because she has a dystrophin mutation on one of her two X chromosomes, every son she conceives has a fifty-percent chance of inheriting the gene and having DMD, and every daughter she

149. See *supra* section I.A.2.

150. DMD is a rare muscular degeneration disease almost exclusively affecting children assigned male at birth. Recent studies report a life expectancy of 31.7 years. Mary Wang, David J. Birnkrant, Dennis M. Super, Irwin B. Jacobs, & Robert C. Bahler, Progressive Left Ventricular Dysfunction and Long-Term Outcomes in Patients With Duchenne Muscular Dystrophy Receiving Cardiopulmonary Therapies, *Open Heart*, e000783, Jan. 2018, at 1, 6. Children typically develop symptoms at ages two or three, and use wheelchairs around age ten to twelve. Dongsheng Duan, Nathalie Goemans, Shin'ichi Takeda, Eugenio Mercuri & Annemieke Aartsma-Rus, Duchenne Muscular Dystrophy, *Nature Revs. Disease Primers*, no. 13, 2021, at 1, 1. Studies on caregiver outcomes report some DMD caregivers of teenage children experience constraints on life choices and compromised mental health. Carolyn E. Schwartz, Roland B. Stark, Ivana F. Audhya & Katherine L. Gooch, Characterizing the Quality-of-Life Impact of Duchenne Muscular Dystrophy on Caregivers: A Case-Control Investigation, 5 *J. Patient-Reported Outcomes*, no. 124, Nov. 2021, at 1, 1–2.

conceives has a fifty-percent chance of inheriting the mutation and being a carrier.¹⁵¹

Cam has a nephew with DMD who she has known to live a rich adolescence,¹⁵² and Cam has been careful to educate herself on raising a child with DMD. She decides she will proceed with fertility treatments and does not want to use PGT on her embryos, leaving the status of her prospective children as carriers unknown.

She calls the clinic to schedule her next appointment and learns the clinic will no longer treat her. The fertility clinic staff explain that the clinic team reviewed her case and concluded providing Cam fertility services would contravene ASRM recommendations. They point Cam to the ASRM Ethics Committee decision, counseling:

In circumstances in which a child is highly likely to be born with a life-threatening condition that causes severe and early debility with no possibility of reasonable function, it is ethically acceptable for a provider to decline a patient's request to transfer such embryos. Physician assistance in the transfer of embryos in this category is ethically problematic and therefore highly discouraged.¹⁵³

2. *Lia*. — Lia and her husband, Dani, are the parents of two young boys, both of whom the couple conceived naturally. Lia and Dani have not experienced hearing loss, but Lia grew up in a family in which her parents and siblings were all deaf; Dani became fluent in American Sign Language (ASL) as soon as he met Lia to communicate more effectively with her family.

151. See Duchenne Muscular Dystrophy (DMD), Muscular Dystrophy Assoc. <https://www.mda.org/disease/duchenne-muscular-dystrophy/causes-inheritance> [<https://perma.cc/5MWR-E5JY>] (last visited Jan. 9, 2024) (“Each son born to a woman with a dystrophin mutation on one of her two X chromosomes has a 50 percent chance of . . . having DMD. Each of her daughters has a 50 percent chance of inheriting the mutation and being a *carrier*.”). Carriers can pass on the mutation without displaying any disease symptoms. *Id.*

152. The notion that individuals with DMD contribute meaningfully to society and live rich adolescences is not and should not be a radical one. Studies show boys with DMD “engage[] with their finitude head-on.” Thomas Abrams, David Abbott & Bhavnita Mistry, *Ableist Constructions of Time? Boys and Men With Duchenne Muscular Dystrophy Managing the Uncertainty of a Shorter Life*, 22 *Scandinavian J. Disability Rsch.* 48, 55 (2020). One study has found health-related quality of life in children with DMD is similar to healthy children and is unaffected by disease progression. See S.L.S. Houwen-van Opstal, M. Jansen, N. van Alfen & I.J.M. de Groot, *Health-Related Quality of Life and Its Relation to Disease Severity in Boys With Duchenne Muscular Dystrophy: Satisfied Boys, Worrying Parents—A Case-Control Study*, 29 *J. Child Neurology* 1486, 1489–93 (2014) (“[E]xcept for the physical domain, the health-related quality of life is similar to their healthy peers and is not influenced by disease progression in boys with Duchenne muscular dystrophy in contrast to previous studies . . .”).

153. ASRM Ethics Committee, *Transferring Embryos With Genetic Anomalies*, *supra* note 20, at 1130.

When both of their sons were born deaf, Lia and Dani underwent genetic testing and learned they are both carriers for a genetic mutation, GJB2, that can lead to hearing loss.¹⁵⁴ While neither member of the couple experienced hearing loss to date, they were excited that their children shared an element of their extended family's identity. The family communicated exclusively using ASL, and the sons attended a school catered to deaf students.

The couple decided to have a third child but was experiencing fertility challenges and thus pursued IVF at a university hospital's fertility clinic. Lia and Dani requested PGT to determine whether the embryos inherited the gene for deafness. The couple did not communicate to physicians whether they sought this information to select *for* or *against* deafness, or to merely acquire information. The PGT results indicated all three embryos developed after one round of IVF were dominant carriers for deafness. Lia and Dani enthusiastically requested the implantation of the embryos. The clinic staff, citing their policy prohibiting implantation of genetically anomalous embryos, refused implantation. The clinic noted implantation of embryos with genetic abnormalities, such as deafness, violated a physician's duty to "do no harm."

3. *Judy*. — Judy grew up working as a nanny and had always dreamed of being a mother to her own children.¹⁵⁵ After trying unsuccessfully to conceive naturally for several years, she learned IVF was an option for her. Judy grew up in a family with relatively low medical literacy. She had long heard stories about her maternal grandmother, who died during childbirth after experiencing what her family recounted as "fused hips." Judy long suspected there were undiagnosed medical complexities that contributed to her grandmother's death. Judy also knew that her grandmother's sister had lupus and experienced pain and limited mobility throughout her lifetime. Recently, in the process of investigating long-term joint damage, her father learned he was positive for human lymphocyte antigen B27 (HLA-B27) and was thus predisposed to a variety of inflammatory diseases.¹⁵⁶ Judy herself grew up with mysterious joint pains that were largely dismissed by physicians, and she was never diagnosed with a disability.

Little is understood about the interactivity between this gene and the development of autoimmune diseases, as complex and varied biological

154. For an overview of the genetic indicators of deafness and ways carriers can pass deafness on to their offspring, see A. Eliot Shearer, Michael S. Hildebrand, Amanda M. Schaefer & Richard J.H. Smith, Genetic Hearing Loss Overview, GeneReviews (Feb. 14, 1999), <https://www.ncbi.nlm.nih.gov/books/NBK1434/> [<https://perma.cc/7PQH-24SD>] (last updated Sept. 28, 2023).

155. This anecdote draws inspiration from the author's firsthand family experience.

156. Padmini Parameswaran & Michael Lucke, HLA-B27 Syndromes, StatPearls, <https://www.ncbi.nlm.nih.gov/books/NBK551523/> [<https://perma.cc/XWT8-LGBP>] (last updated July 4, 2023).

and environmental factors contribute to disease manifestation.¹⁵⁷ Individuals who are HLA-B27 positive are more likely to develop ankylosing spondylitis and spondyloarthropathies than are those without the gene.¹⁵⁸

Judy could afford only one round of IVF. After a conversation with her father, she decided to test her embryos for the gene HLA-B27. Having learned from her great-aunt about the physical, social, and financial challenges of life with lupus, Judy feared passing a gene on to her children that would increase their chances of developing an autoimmune disease. Without a college education and the ability to fund childcare, she worried she could not afford a child with an autoimmune disease.

When the clinic reported the results of Judy's PGT, Judy learned that all her embryos produced after one cycle of IVF were carriers for HLA-B27. Notwithstanding her initial concerns around raising a child with the potential to develop a disability, Judy requested to implant the embryos. The clinic refused her request, citing its commitment to procreative beneficence—the notion conferring an ethical responsibility to produce embryos and fetuses that will have the best possible life.¹⁵⁹ The clinic reasoned it is ethically impermissible to facilitate the creation of a child that could face legitimate health concerns in their lifetime.

Unexpectedly, Judy successfully gave birth to a daughter several years later. At a young age, her daughter would develop juvenile arthritis, ankylosing spondylitis, and uveitis.

Her daughter would also grow up to question the assumption that her life—despite, and perhaps because of, her suffering—was not the *best possible one*.

157. See Anthoula Chatzikiyriakidou, Paraskevi V. Voulgari & Alexandros A. Drosos, What Is the Role of HLA-B27 in Spondyloarthropathies? 10 *Autoimmunity Revs.* 464, 465 (2002) (“[T]he autoimmune diseases are complex disorders with both genetic and environmental factors contributing to their manifestation which is also extremely heterogenic.”).

158. Muhammad Asim Khan, HLA-B27 and Its Pathogenic Role, 14 *J. Clinical Rheumatology* 50, 50 (2008). These autoimmune conditions result in increased inflammation in joints and ligaments, causing chronic pain and, in some cases, spinal fusions. Spondyloarthritis, *Am. Coll. Rheumatology*, <https://rheumatology.org/patients/spondyloarthritis> [<https://perma.cc/NH4V-DV6K>] (last updated Feb. 2023).

159. See generally Julian Savulescu, Procreative Beneficence: Why We Should Select the Best Children, 15 *Bioethics* 413, 415 (2001) (“Procreative Beneficence implies couples should employ genetic tests for non-disease traits in selecting which child to bring into existence and that we should allow selection for non-disease genes in some cases even if this maintains or increases social inequality.”); Schiavone, *supra* note 18, at 294 (“The primary ethical conflict that emerges from using PGD to ensure that a child is born with some sort of disability, disease, or otherwise harmful disorder, is between two ethical principles known as beneficence and autonomy.”).

III. TOWARD AN ANTIDISCRIMINATION FRAMEWORK FOR REPRODUCTIVE SERVICES THAT MAXIMIZES DIVERSITY AND AUTONOMY

Cam, Lia, and Judy do not presently have legal recourse to remedy clinic denials of fertility services on the basis of clinicians' judgments about the quality of disabled life. Because the ADA has not yet been interpreted to capture disease carriers and no law prohibits discrimination based on genetic information in healthcare services, these women are underserved by present antidiscrimination law.

From this void, abortion opponents may see opportunity. Consistent with prior attempts to invoke disability rights toward constraining reproductive freedom,¹⁶⁰ proponents of fetal personhood may encourage resolving this gap by recognizing embryos as people within the meaning of the ADA. This Part presents the relative advantages and limitations of two possible avenues for closing the coverage gap that would protect women's autonomy, including the choice to select *for* disabled life.

A. *Solution I: Expanding GINA*

GINA has only provided coverage in the context of health insurance and employment.¹⁶¹ Many scholars have criticized GINA for its narrow scope, advocating for broader coverage. Some scholars argue GINA should include a provision on disparate impact.¹⁶² Others propose broadening GINA's scope to embrace other contexts, such as property and privacy rights.¹⁶³

Were GINA amended to prohibit discrimination in the delivery of goods and services, individuals like Cam, Lia, and Judy would unquestionably be captured. As defined by GINA, genetic information includes "(i) such individual's genetic tests, (ii) the genetic tests of family members of such individual, and (iii) the manifestation of a disease or disorder in family members of such individual."¹⁶⁴ GINA's extension to genetic information gathered in the context of fertility services would prohibit clinics from denying services based on a patient's family history and even the results of PGD.

Some states have already passed laws extending genetic discrimination prohibitions beyond the context of healthcare and employment. Massachusetts was one of the first states to pass laws prohibiting genetic discrimination, adding "genetic information" to its list of protected

160. See *supra* notes 56–63 and accompanying text.

161. See *supra* notes 117–125 and accompanying text.

162. See, e.g., Ifeoma Ajunwa, Genetic Data and Civil Rights, 51 Harv. C.R.-C.L. L. Rev. 75, 100 (2016).

163. Anya E.R. Price, Comprehensive Protection of Genetic Information: One Size Privacy Models May Not Fit All, 79 Brook. L. Rev. 175, 177 (2013).

164. 42 U.S.C. § 2000ff(4)(A) (2018).

classes.¹⁶⁵ In 2011, California passed the California Genetic Information Nondiscrimination Act (CalGINA), which prohibits genetic discrimination in housing, lending, and emergency services.¹⁶⁶ California also amended its Unruh Civil Rights Act to prohibit businesses from engaging in discrimination based on genetic information.¹⁶⁷ CalGINA's legislative history reveals a motivation to broaden genetic protections beyond federal law, noting the state possessed a "compelling public interest in realizing the medical promise of genomics[,] . . . relieving the fear of discrimination and prohibiting its actual practice."¹⁶⁸ So far, no state has explicitly expanded genetic discrimination to the provision of reproductive services.

1. *Limitations of Extending GINA: The End of PGD as We Know It?* — There are several drawbacks to expanding GINA to prohibit discrimination in the provision of reproductive services: Such an extension may represent the end for PGD. A law of this kind could be said to capture the use of PGD to select against embryos with *any* conditions. While this Note does not go so far as to suggest PGD is a fundamental right,¹⁶⁹ the testing has an important function in enhancing women's autonomy, allowing women for whom parenting a child with a disability is financially burdensome¹⁷⁰ or medically risky¹⁷¹ to gain information about their choice.

Legislators amending GINA may face challenges agreeing on language that distinguishes discrimination by service providers based on disability-related animus and discrimination by service providers acting on a patient's informed desire to select against disability. Situating a solution in nondiscrimination law, however, may resolve this concern. The ADA

165. Mass. Gen. Laws Ann. ch. 175, § 108I (West 2024).

166. California Genetic Nondiscrimination Act of 2011, ch. 261, 2011 Cal. Stat. 95 (codified in scattered sections of Civ., Educ., Elec., Gov't, Penal, Rev. & Tax., and Welf. & Inst.). CalGINA extended protection to: (1) "all business establishments of every kind whatsoever;" (2) access to any "program or activity that is conducted, operated, or administered by the state or by any state agency, is funded directly by the state, or receives any financial assistance from the state;" (3) housing, including mortgage lending; and (4) emergency medical care and services. *Id.* CalGINA may even apply protections to discrimination by public schools. See Tyler Wood, Comment, Genetic Information Discrimination in Public Schools: A Common-Sense Exception, 49 U. Pac. L. Rev. 309, 323 (2018) (arguing CalGINA covers a real-life example of a public school's genetic discrimination against a student with genetic markers for cystic fibrosis).

167. California Genetic Nondiscrimination Act of 2011, § 3, 2011 Cal. Stat. 98.

168. See *id.* § 1.

169. Some scholars have argued there is a fundamental right to PGT protected by substantive due process. See Sorensen, *supra* note 26, at 182 (advocating a fundamental right to PGD to prevent constraints on ART regulation).

170. For more on the complicated lived experiences that can inform the choice to terminate a pregnancy after prenatal testing, see McKinney, *supra* note 144 (encouraging that selective abortion be viewed "in the context of social circumstances where many women do not have access to support systems for raising children with disabilities").

171. See *supra* notes 65–71 and accompanying text.

and GINA rely on individual lawsuits for enforcement, and those seeking the benefits of PGD would be unlikely to sue a service provider for offering it. A broadscale prohibition on PGD, on the other hand, would mean forgoing the benefits of expanded choice this reproductive technology has presented to many women. The concern for overregulating this technology, though, may deter legislators from supporting any new legislation, leaving women like Lia, Cam, and Judy as collateral damage in a war on the spread of disease waged by developing technologies.

B. *Solution II: Expanding Bragdon Interpretation to Provide ADA Coverage for Disease Carriers Based on Disabling Attitudes*

Bragdon's expansive ruling on HIV and reproduction could be interpreted more expansively to prohibit discrimination against individuals like Cam, Lia, and Judy. The Sixth Circuit's ruling in *Darby*¹⁷² and the 2008 Amendments¹⁷³ opened the door to the extension of *Bragdon's* theory of ADA coverage to many genetic conditions. The *Darby* court correctly observed the ADA's spirit of inclusion regarding disability coverage, ruling an individual with a genetic mutation that substantially limited cell growth can plausibly allege disability.¹⁷⁴ While *Darby* did not extend to all genetic carriers,¹⁷⁵ interpreting *Darby* in combination with *Bragdon* invites the conclusion that many genetic carriers denied reproductive services meet the ADA's deliberately broad coverage requirements.¹⁷⁶

The Supreme Court in *Bragdon* reasoned an asymptomatic individual who is HIV-positive was substantially limited in the major life activity of "reproduction"¹⁷⁷ in two ways: (1) a woman with HIV risks passing the condition on to her partner when conceiving a child¹⁷⁸ and (2) a woman

172. *Darby v. Childvine, Inc.*, 964 F.3d 440, 445 (6th Cir. 2020) (ruling an individual's genetic mutation and noncancerous abnormal cell growth resulted in a plausible claim of disability under the ADA); see also *supra* notes 94–96 and accompanying text.

173. ADA Amendments Act (ADAAA) of 2008, Pub. L. No. 110-325, 122 Stat. 3553 (codified at 29 U.S.C. § 705 (2018) and scattered sections of Title 42 of the U.S.C.).

174. See *Darby*, 964 F.3d at 445, 447; see also Jessica L. Loiacono, Substantially Mutated: Are Genetic Mutations "Disabilities" Under the Americans With Disabilities Act?, 62 B.C. L. Rev. 446, 449 (2021) (arguing the *Darby* court correctly interpreted the ADA to extend to genetic mutations).

175. Such a broad ruling was unlikely. In *Bragdon*, the Supreme Court advised "whether respondent has a disability covered by the ADA is an individualized inquiry." *Bragdon v. Abbott*, 524 U.S. 624, 657 (1998) (Rehnquist, C.J., concurring in the judgment in part and dissenting in part).

176. 42 U.S.C. § 12102(1)(A)–(C) (broadening statutory definitions of disability and encouraging cases to focus less on the issue of whether a claimant was disabled and more on the issue of whether discrimination occurred).

177. *Bragdon*, 524 U.S. at 638 (majority opinion) ("Reproduction and the sexual dynamics surrounding it are central to the life process itself.").

178. *Id.* at 639 ("[A] woman infected with HIV who tries to conceive a child imposes on the man a significant risk of becoming infected.").

with HIV risks passing the infection on to her child during gestation and childbirth.¹⁷⁹ In its discussion of major life activities, the Court also pointed to the “economic and legal consequences” reproduction presents for individuals like the Respondent, which include “costs for antiretroviral therapy, supplemental insurance, and long-term health care for the child who must be examined and, tragic to think, treated for the infection.”¹⁸⁰ In its evaluation of the compounded limitations presented by status as a genetic carrier, the Court even permitted consideration of a potential child’s healthcare.¹⁸¹ Just as the *Bragdon* Respondent was substantially limited by the financial and medical implications of having a child with HIV, so too are individuals like Cam, Lia, and Judy. In fact, in these anecdotes, women face discrimination *because* of this very limitation: the prospect of transferring a genetic anomaly on to a child.

Darby and subsequent circuit court interpretations of *Bragdon* strengthen the case for ADA coverage of individuals who are disease carriers. In *Darby*, the Sixth Circuit dismissed the district court’s characterization of the plaintiff’s genetic condition as one “that might lead to a disability in the future,” pointing to its present biological effects.¹⁸² The *Darby* court restated the reasoning in *Bragdon* as providing that “HIV qualifies as a disability under the ADA because of its immediate effect on . . . bodily functions, not because it will eventually develop into AIDS.”¹⁸³ Since the *Darby* plaintiff alleged sufficient facts to show a reasonable jury could determine the presence of her genetic mutation substantially limited normal cell growth, the court held she presented a satisfactory showing of disability.¹⁸⁴

Other circuits have not yet reviewed cases involving the question of a genetic carrier’s disability status and thus have not yet deviated from the *Darby* court’s treatment of this issue of first impression.¹⁸⁵ Therefore, *Darby*

179. *Id.* at 640 (“[A]n infected woman risks infecting her child during gestation and childbirth, *i.e.*, perinatal transmission.”).

180. *Id.* at 641.

181. *Id.*

182. *Darby v. Childvine, Inc.*, 964 F.3d 440, 446 (6th Cir. 2020) (internal quotation marks omitted) (quoting *Darby v. Childvine, Inc.*, No. 1:18-CV-00669, 2019 WL 6170743, at *4 (S.D. Ohio Nov. 20, 2019)).

183. *Id.* (citing *Bragdon*, 524 U.S. at 637). The court goes on to clarify that “[t]o qualify as a disability . . . a condition must substantially limit a major life activity, not merely have the potential to cause conditions that do.” *Id.*

184. *Id.* at 445 (“Taking all of that together, it is at least plausible that *Darby* is substantially limited in normal cell growth ‘as compared to’ the general population.”).

185. Several cases in the other circuits have cited *Darby* to ultimately dismiss claims of disability status, but the facts did not constrain application of the ADA to individuals with genetic mutations. See *Chancey v. BASF*, No. 23-40032, 2023 WL 6598065, at *4 (5th Cir. Oct. 10, 2023) (holding an individual claiming disability discrimination based on a workplace COVID-19 policy was not regarded-as disabled because plaintiff may contract COVID-19 in the future); see also *Reid v. Aubrey’s Rest. Inc.*, No. 20-5440, 2021 WL 5174392, at *8 (6th Cir. July 12, 2021) (holding that an acute, two-day “bout of abdominal pain” did not qualify as disabled under the ADA).

and *Bragdon*—read together—herald a framework whereby some genetic conditions that substantially limit a woman’s ability to reproduce qualify as disabilities under the ADA.

1. *Limitations of the Bragdon–Darby Extension to Genetic Carriers Seeking Reproductive Services.*

a. *Many Genetic Conditions Are Not Substantially Limiting Enough.* — Extending *Bragdon* and *Darby* may be constrained by the lack of scientific evidence pointing to the immediate physiological dimensions of some genes and the risk that courts will deem transmission of these conditions a direct threat within the meaning of the ADA.

Importantly, *Darby* did not impose a requirement that genetic mutations inhibit cell growth, specifically, to plausibly classify as disabilities. Even so, it is unlikely courts would read *Bragdon* and *Darby* to extend to all three conditions described in Part II of this Note. Decided at the pleading stage, *Darby*’s opinion merely “opened the possibility” that the ADA captures genetic mutations as disabilities and remanded the case to the district court for a factual inquiry before which the case settled.¹⁸⁶ Such a factual inquiry might have compared BRCA1’s effects on normal cell growth to the substantial limitations presented by HIV.¹⁸⁷ Plaintiffs alleging denial of reproductive services based on disease carrier status may not survive such a factual inquiry.

A court may conclude Judy’s status as HLA-B27 positive, for example, does not constitute a substantial limit on reproduction in the same way that the *Bragdon* Court reasoned HIV does. Opponents could argue that Judy, having never been diagnosed with an autoimmune disease, is merely predisposed to developing a disability in the future.¹⁸⁸ While the prospect of potential disease for her offspring constrains her reproductive choices, courts may reason HLA-B27’s largely unknown and disparate physiological effects¹⁸⁹ do not compare to “the immediacy with which [HIV] begins to

186. *Darby*, 964 F.3d at 446 (“Whether a diagnosis of HIV is an apt analogy for the[se] genetic issues . . . is a fair point of debate. . . . [I]t is enough to note that *Bragdon* was decided at summary judgment, . . . thereby allowing the courts to consider more developed medical and factual evidence regarding the condition at hand.”). Before the district court could rule on the matter, the parties came to a settlement agreement and the district court dismissed the case on November 18, 2020. *Darby v. Childvine, Inc.*, No. 18-cv-00669, 2019 WL 6170743 (S.D. Ohio dismissed Nov. 18, 2020).

187. See Loiacono, *supra* note 174, at 459 (“[H]ad the case not settled, the principal issue on remand would likely have been whether the BRCA1 mutation presently and substantially affects normal cell growth in a manner similar to HIV.”).

188. While the association between HLA-B27 and disabilities is well established, the “disease pathogenesis remains unclear,” rendering it more difficult for plaintiffs to outline the present physiological effects of the gene. Anna S. Sahlberg, Kaisa Granfors & Markus A. Penttinen, HLA-B27 and Host-Pathogen Interaction, *in* *Molecular Mechanisms of Spondyloarthropathies* 235, 235 (Carlos López-Larrea & Roberto Díaz-Peña eds., 2009).

189. Many individuals who carry the gene for HLA-B27 do not ultimately present symptoms consistent with autoimmune diseases. Studies estimate five percent of HLA-B27 positive people get ankylosing spondylitis or associated forms of spondyloarthropathies. See,

damage the infected person's white blood cells."¹⁹⁰ For genetic indicators with unknown or minor physical manifestations, courts may dismiss these conditions as indicative only of future disabilities, which *Bragdon* and *Darby* exclude from ADA coverage.¹⁹¹

Cam's case for coverage based on DMD carrier status could present similar barriers. Because "DMD-carriers are usually asymptomatic," Cam cannot point to any then-existing physiological manifestations of her genetic condition.¹⁹² Lia and her husband may also struggle to prove GJB2 carriers are substantially impaired because of the mere presence of the genetic mutation, without more.¹⁹³ Like the Petitioner in *Bragdon*, Cam and Lia risk transmitting a condition on to their children, but courts may not uniformly consider this a substantial limitation analogous to HIV, which presents risk of infection transmission during conception, gestation, and childbirth.¹⁹⁴ Chief Justice William Rehnquist, in his *Bragdon* opinion, admonished such an extension as clearly beyond the scope of the ADA, stating, "Respondent's argument, taken to its logical extreme, would render every individual with a genetic marker for some debilitating disease 'disabled' here and now because of some possible future effects."¹⁹⁵

These concerns over coverage may be resolved in some cases under the regarded-as-disability prong of the ADA.¹⁹⁶ Where evidence of present physiological genetic effects is lacking, stigmatic and social effects are evident. Given the roots this provision has in the motivation to dispel the

e.g., Muhammad Asim Khan, *Ankylosing Spondylitis and Axial Spondyloarthritis* 22 (2d ed. 2023). HLA-B27 is also only one of multiple genes involved in disease production, which can also be triggered by environmental factors. *Id.*

190. *Bragdon v. Abbott*, 524 U.S. 624, 637 (1998).

191. *Darby*, 964 F.3d at 446 ("We agree that a genetic mutation that merely predisposes an individual to other conditions, such as cancer, is not itself a disability under the ADA."); see also *Bragdon*, 524 U.S. at 635 (holding that HIV immediately affects an individual's immune system and thus constitutes a disability, in contrast to a predisposition).

192. Josef Finsterer, Claudia Stöllberger, Birgit Freudenthaler, Desiree De Simoni, Romana Höftberger & Klaus Wagner, *Muscular and Cardiac Manifestations in a Duchenne-Carrier Harboring a Dystrophin Deletion of Exons 12–29*, 7 *Intractable Rare Disease Rsch.* 120, 120 (2018). Research indicates "some of the DMD-carriers become symptomatic and develop a progressive DMD-like phenotype" resulting in skeletal-muscular weakness and cardiac disease. *Id.* Even so, the case study presented in Part II of this Note considers Cam an asymptomatic DMD carrier. See *supra* section II.B.1.

193. Some studies show women who are heterozygous carriers of pathogenic GJB2 gene mutations experience more hearing loss compared to women without the gene mutation. See D. Groh, P. Seeman, M. Jilek, J. Popelář, Z. Kabelka & J. Syka, *Hearing Function in Heterozygous Carriers of a Pathogenic GJB2 Gene Mutation*, 62 *Physiological Rsch.* 323, 323 (measuring hearing loss in GJB2 carriers across gender). Nonetheless, the potential development of future hearing loss is unlikely to amount to a disability under the ADA. See *supra* notes 95–100 and accompanying text.

194. *Bragdon*, 524 U.S. at 639 (outlining the different ways an HIV infection could constrain a woman in the process of engaging in reproduction).

195. *Id.* at 661 (Rehnquist, C.J., concurring in the judgment in part and dissenting in part).

196. 42 U.S.C. § 12102(3)(A) (2018).

disabling effects of social attitudes, courts may interpret fertility clinic assumptions about a woman's genetic condition as sufficiently disabling to qualify for ADA coverage.¹⁹⁷ This job should be made easier after the passage of the ADAAA, which instructs, "[T]he question of whether an individual's impairment is a disability under the ADA should not demand extensive analysis."¹⁹⁸ While courts may require a clear showing of discriminatory stereotyping on the part of healthcare professionals for such a ruling, the regarded-as prong may offer a remedy for some women discriminated against based on their genetic status.¹⁹⁹

b. *Future Child Interests as Direct Threat.* — Assuming a court recognized all genetic carriers as disabled, some individuals may be denied ADA coverage under an independent basis: the ADA's "direct threat" provision, which permits refusal of treatment when a condition "poses a direct threat to the health or safety of others."²⁰⁰ In *Bragdon*, when the Court remanded the question of whether a patient's HIV infection met this designation, it characterized the direct threat defense as reconciling the "importance of prohibiting discrimination against individuals with disabilities" with the "protect[ion of] others from significant health and safety risks, resulting, for instance, from a contagious disease."²⁰¹ In the reproductive health context, this would amount to the characterization

197. See *supra* section I.B.2. EEOC regulations interpreting the regarded-as-disability prong also mention attitudes as a driving force to this analysis of coverage. The regulations read, "[A] physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others toward such impairment." 29 C.F.R. § 1615.103(4) (ii) (2024). For more on the attitudinal drive behind the regarded-as prong of the ADAAA, see Elizabeth F. Emens, *Disabling Attitudes: U.S. Disability Law and the ADA Amendments Act*, 60 *Am. J. Compar. L.* 205, 210 (2012). Professor Elizabeth Emens points to the unique ways attitudes drive antidiscrimination law for disability, especially in permitting an antidisubordination model that is not applied to race and sex in the same way. In discussing the unusual asymmetrical model of the ADA, Emens notes, "I think the assumption that disability truly signals inferiority means that (almost) no one expects disabled people to take over society and subordinate nondisabled people." *Id.* at 228.

198. ADA Amendments Act of 2008, Pub. L. No. 110-325, § 2, 122 Stat. 3553, 3554 (codified in scattered sections of Title 42 of the U.S.C.).

199. Decisive administrative guidance by the DOJ could assist in clarifying the ADA's coverage for individuals with genetic conditions. The *Bragdon* Court deemed compelling the conclusion of the Office of Legal Counsel of the DOJ that the Rehabilitation Act covers "symptomatic and asymptomatic HIV-infected individuals against discrimination." *Bragdon*, 524 U.S. at 642 (internal quotation marks omitted) (quoting Application of Section 504 of the Rehab. Act to HIV-Infected Individuals, 12 *Op. O.L.C.* 264, 264-65 (1988) (Preliminary)). The Court also "dr[ew] guidance from" DOJ regulations that added "HIV infection (symptomatic and asymptomatic)" to the list of disorders amounting to a physical impairment. *Id.* at 646-47 (internal quotation marks omitted) (quoting 28 C.F.R. § 36.104(1) (iii) (2024)). Were the DOJ to recognize some asymptomatic genetic conditions as disabilities under the ADA, an extension of *Bragdon* and *Darby* that captures the discrimination described in this Note would be more likely.

200. 42 U.S.C. § 12182(b)(3).

201. *Bragdon*, 524 U.S. at 649 (citing *Sch. Bd. of Nassau Cnty. v. Arline*, 480 U.S. 273, 287 (1987)).

that providing reproductive services to a genetic carrier parent is a direct threat to the resulting child.

Professor Carl Coleman claims the direct threat defense would be unlikely to prevail in the context of ART because “[w]ithholding ARTs would not have led to the birth of the child without the impairments.”²⁰² Drawing from the logic of courts that opted against recognizing a tort of “wrongful life,” Coleman emphasizes that “courts cannot rationally determine whether the burdens of a particular existence outweigh the benefits of life itself.”²⁰³ He concedes there are still some situations where the birth of a child who experiences “such unqualified suffering” could be “harmed by the technologies that enabled” their birth.²⁰⁴ Nonetheless, Coleman surmises few disabilities would arise to this level and that the “remote possibility of harm to the child probably would not satisfy the direct threat defense.”²⁰⁵ To strike the balance between antidiscrimination and antisuffering in this context, Coleman proposes an alternative framework for applying the direct threat defense whereby courts weigh the relative risks and benefits of using ART compared to other reproductive and parenting choices available under the circumstances.²⁰⁶ In other words, Coleman’s proposal substitutes the judgment of physicians for the judgment of courts.

Those emphasizing the goal of promoting antisuffering may be concerned about taking this evaluation away from physicians. Even if courts adopted Coleman’s proposed approach to evaluating direct threat in these cases, though, scientific judgment would not be overlooked altogether. In assessing the risk of direct threat, *Bragdon* notes the views of “public health authorities” are entitled to “special weight and authority.”²⁰⁷ Even Chief Justice Rehnquist’s opinion concedes “a presumption of validity when the actions of those authorities themselves are challenged in court.”²⁰⁸ In the case of reproductive service denials, the Court would likely give some deference to the determinations of ASRM, ethics committees, and medical practitioners about what genetic disorders present a direct threat to future life.

202. Carl H. Coleman, *Conceiving Harm: Disability Discrimination in Assisted Reproductive Technologies*, 50 *UCLA L. Rev.* 17, 44 (2002).

203. *Id.* at 45–46; see also *Becker v. Schwartz*, 386 N.E.2d 807, 812 (N.Y. 1978) (“Whether it is better never to have been born at all than to have been born with even gross deficiencies is a mystery more properly to be left to the philosophers and the theologians.”); *Ellis v. Sherman*, 515 A.2d 1327, 1329 (Pa. 1986) (“[W]e regard the assertion that the child has been injured by its existence as too speculative for us to determine.”).

204. Coleman, *supra* note 202, at 46.

205. *Id.* at 47.

206. See *id.* at 50.

207. *Bragdon v. Abbott*, 524 U.S. 624, 650 (1998).

208. *Id.* at 663 (Rehnquist, C.J., concurring in the judgment in part and dissenting in part).

Some individuals at risk of passing fatal diseases on to their children, like Cam, may fail under a direct threat defense when courts defer to public health authorities and compare other available reproductive options. Nonetheless, a theory of coverage that permits Cam to bring an ADA claim would still empower courts to reexamine purely scientific judgments against the risk of disability discrimination. At present, these scientific judgments go unchecked, and a void in antidiscrimination law persists.

CONCLUSION

In the face of receding legal protections for women seeking reproductive care and as new technologies have the potential to weed out people with disabilities, legal scholars and practitioners alike must begin to consider solutions that bridge movements for disability rights and women's autonomy. Antidiscrimination law has the potential to fill this gap, empowering individuals to challenge decisions based on disability-related animus while preserving and expanding access to these technologies, rather than constraining it. New gene-editing and genetic-testing technologies will continue to develop, raising important questions about the ethical implications of unequal access to and discriminatory application of these technologies. As those developments proliferate, the law must provide recourse for technological imperfections in ways that maximize women's choice and center disability as diversity. Maybe then women like Judy will understand that their choice to bring disabled life into the world is exactly that: their choice—and nothing to be ashamed of.

