Who’s Got Parental Rights? The Intersection Between Infertility, Reproductive Technologies, and Disability Rights Law

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It is estimated that ten to twenty percent of couples in the developed world experience infertility.1 Factors such as late childbearing increase the rates of infertility, particularly when race and economic disadvantages are considered.2 Additionally, infertility and the experience of infertility often result in significant emotional and psychological costs to those involved.3 It is thus not surprising that assisted reproductive technologies (“ART”)4 are often viewed as much more than a remedy.

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1 See Miryam Z. Wahrman, Fruit of the Womb: Artificial Reproductive Technologies & Jewish Law, 9 J. GENDER RACE & JUST. 109, 111 (2005) (noting statistics). Infertility is generally defined as “the inability to initiate, sustain or support pregnancy.” AMERICAN HERITAGE DICTIONARY 538 (3d ed. 2000).


4 See Wahrman, supra note 1, at 112-13. ART includes an array of technologies that target both female and male factors causing infertility. See generally id. The leading forms are in-vitro fertilization (“IVF”), where the egg is fertilized in a lab’s Petri dish and then implanted in the
Today, ART technologies not only provide an answer for approximately ninety-five percent of infertility cases, but they have also given a “second chance” to those who have no other alternative. ART predominantly assists the following groups: relatively older women, even post menopausal; single mothers, including widows who choose to have their late husbands’ children through posthumous conception; and grandparents who lost a child, yet want to experience grandparenthood and have a familial genetic lineage.

womb; Intra-Cytoplasmic Sperm Injection (“ICSI”), in which sperm are mechanically injected into individual eggs to overcome the male’s infertility. Id. There is also the harvesting of gametes, sperm and egg, from both living and dead donors for the purpose of procreation, including through surrogacy. See ASRM IFFS Surveillance, Fertility & Sterility 87(4) Supp. 1, 1-68, at 51 (2007).

5 See Wahrman, supra note 1, at 128.


7 See Daar, supra note 3, at 31-33; Laura Dwyer, Dead Daddies: Issues in Postmortem Reproduction, 52 RUTGERS L. REV. 881, 881-82 (2000); Louise M. Terry & Ann Campell, The Child That Might Be Born, Commentary, 32 HASTINGS CENTER REP. 3, 11-12 (2002); Kathryn D. Katz, Parenthood from the Grave: Protocols for Retrieving and Utilizing Gametes from the Dead or Dying, 2006 U. CHI. LEGAL F. 289, 293-94 (2006). According to a study by the University of Pennsylvania, in the years from 1980 to 1995, eight-two requests were made at infertility clinics for post-mortem gamete retrieval and unitization. See Dwyer, supra, at 881 n.6; see also Katz, supra at 294 (stating “[t]he fact is that requests for [post-mortem gamete retrieval and unitization] are numerous, they appear on a worldwide basis, and their number is expected to grow”). International courts that addressed this issue include Israel, Australia, and a few states in the United States, such as California, Wisconsin, Chicago, Florida, and Massachusetts. See Dwyer, supra, at 882 n.7; Rebecca Dresser, Protecting Posthumous Children, HASTINGS CENTER REP. 8, 8-9 (2002); Tomer Zarchin, Court Orders Deceased Teen’s Sperm Saved for Posthumous Conception, HAARETZ (June 15, 2009), http://haaretz.com/news/court-orders-deceased-teen-s-sperm-saved-for-posthumous-conception-1.278098.

8 Dwyer, supra note 7, at 881-82. Nineteen-year-old Jeremy Reno shot himself in a game of Russian Roulette and prior to his death, his mother had doctors keep him alive long enough for doctors to remove his sperm, so she could become a grandmother. Id. at 881. The mother wanted to “find an egg donor and a surrogate mother to become artificially inseminated with her son’s surgically removed sperm and to carry her grandchild.” Id. See also Zarchin, supra note 7 (indicating that the Ramat Gan Family Court in Israel decided that a hospital must retain the sperm of a deceased fifteen-year-old cancer patient for five years in order for his family to utilize it to create posthumous descendants); see generally Belinda Bennett, Posthumous Reproduction and the Meanings of Antonymy, 23 MELB. U. L. REV. 286 (1999) (noting the various legal ramifications that result by creating non-traditional families from posthumous sperm of those who have died).
Access to ART may represent more than a remedy for those unable to procreate. Studies have shown a growing sense of entitlement to ART, particularly among women who delayed childbirth as part of the so-called “new middle class morality,” which emphasizes higher education, as well as professional and financial independence for women prior to childbirth. The argument from the entitlement perspective is that for women who have developed themselves both professionally and economically prior to embracing parenthood, ART has in fact become a right. June Carbone, who has most recently discussed the regulatory framework of advanced reproductive activities, expressed, “[f]or those who wait—and accumulate greater wealth, power, and income in the interim—the ability to conceive may then be seen as a matter of right, with the new reproductive technologies providing well-deserved comfort.” An appropriate question, thus, is whether there are such rights for obtaining the assistance of reproductive technologies. If so, who holds these rights, and under what conditions are these rights granted?

This essay examines these questions from an international human rights perspective. First, this article suggests that despite the significant opportunities for “alternative” procreation methods, the actual ability to exercise them is limited, often for reasons beyond cost. Rather, this article demonstrates that these limitations are often due to the interjection of both religious beliefs and socio-cultural prejudices into the decision-making about ART related issues of both the new partners in the procreation process and the courts. Second, this article discusses decisions delivered by the European Court of Human Rights (“ECHR”) in this context. These decisions illustrate that socio-cultural presumptions about parenthood (in)capabilities, the “normal” familial structure, and gender are often critical factors in determining the extent of the right to ART. This article concludes with a discussion of the possibility of overcoming these challenges in view of the Convention on the Rights of Persons with Disabilities (“CRPD”). The aforementioned treaty aims to equalize the rights of people with disabilities, inter alia, by overcoming stigma and prejudice through the requirement of reasonable accommodation and through the use of new technologies. While politically

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9 Carbone, supra note 2, at 1748; see Sara McLanahan, Diverging Destinies: How Children are Faring Under the Second Demographic Transformation, 41 DEMOGRAPHY 607, 608 (2004) (families and children with mothers of high educational achievement generally enjoy more stable, traditional family lives with greater resources).

10 See generally Carbone, supra note 2, at 1765.

11 Carbone, supra note 2, at 1765 (emphasis added).


13 See CRPD supra note 12 and accompanying text. The CRPD contains fifty articles delineating a
contentious, this article suggests that the CRPD treaty may be a valuable tool to ensure that individuals and couples who are medically and socially infertile are neither unjustly denied access to ART, nor excluded from the panoply of parenthood.

I. Too Many Partners in the Decision of Procreation

It is clear that ART has changed the traditional way of reproduction. Compared to natural reproduction, in which the intended parents are typically the only decision-makers, ART involves many more players who have a role in the reproduction decision-making process. In fact, at times, there may be as many as six individuals involved.\textsuperscript{14} For instance, when the prospective parents face medical conditions that prevent the reproduction of “healthy” gametes, such as the mother’s age or the inability to carry the pregnancy to term, gamete donors and surrogate partners are the only substitutes for traditional procreation. Similarly, when “non-traditional families” are concerned, the providers of such services commonly become additional partners, as they provide the only substitutes for traditional procreation. Thus, in addition to the prospective parents, the sperm donor, the ova/egg donors, the surrogate mothers, and the reproductive agencies providing these services have all become critical actors in the ART reproduction decision-making process. Simultaneously, doctors and other related health professionals have also emerged as vital players in the reproduction process. These professionals possess invaluable knowledge as to the functions of the human body; and significantly, these health care professionals have the necessary knowledge regarding how to use the new reproductive technologies to help prospective parents procreate despite their functional impairment.

The implications of the emergence of many partners in the reproductive multitude of rights that should be afforded to persons with disabilities. \textit{See CRPD supra} note 12. One of the recurring themes of the Convention is the implementation of these rights through the use of reasonable accommodation for persons with disabilities. \textit{See CRPD supra} note 12 and accompanying text. The definition section of the Convention explains reasonable accommodation as the “necessary and appropriate modification [sic] and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms.” \textit{See CRPD supra} note 12 and accompanying text.

\textsuperscript{14} \textit{See} Ardis L. Campbell, \textit{Determination of Status as Legal or Natural Parents in Contested Surrogacy Births}, 77 A.L.R. 5TH 567, 573 (2000). Campbell provides an example of a case where there was the possibility of six individuals who could be the “parents” of a child: a sperm donor, an egg donor, the intended mother, the intended father, the surrogate mother, and the surrogate mother’s husband. \textit{Id. See also} Theresa Glennon, \textit{Choosing One: Resolving the Epidemic of Multiples in Assisted Reproduction}, 55 VILL. L. REV. 147, 177-178 (2010) (describing influence of fertility specialists in decision making process as depending upon the context in which they operate).
decision-making process are significant and twofold. First, the plethora of parties constituting the new parental “partnership” creates an informal, yet distinctive market, characterized by a clear power imbalance between the prospective parents and the health care professionals. As the social price of barrenness is high, the devastation felt by some infertile individuals often exceeds the desperation experienced in other medical contexts. This creates a situation in which the cost of the good itself is dwarfed by its perceived benefits, resulting in parents following doctors’ advice regardless of risks, costs, and probabilities of success. Moreover, as ART is neither medically necessary nor life-threatening—indeed, some have even questioned whether ART provided to fertile patients constitutes “health care” at all—doctors and other health providers have the discretion to determine whether in fact patients may take advantage of this technology. Thus, health professionals’ power not only extends to the type of treatment a patient may demand and receive, but critically, providers may also control whether the patient is even selected for treatment. Second, the existence of several reproductive partners implies that the respective social and cultural prejudices of any one of them further compounds the decision-making process and can promptly become a conclusive factor as to whether one would be able to procreate. The reality is that if the religious and cultural beliefs of one of the partners’ clashes with the parental desire to procreate, the provider can simply determine that the prospective parent lacks the eligibility to parent a child and hence refuse the treatment. As this article discusses below, the social and cultural discrimination in the ART context has facilitated a group of so-called socially infertile individuals, impacting far more people than previously imagined.

II. Religious and Socio-Cultural Voices in the Context of ART

Although in most societies procreation holds a central place in the lives of individuals and the social fabric of a community, no other medical development has raised as many opposing voices as reproductive technologies. Religious authorities have

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15 See generally Paul LAURITZEN, PURSUING PARENTHOOD: ETHICAL ISSUES IN ASSISTED REPRODUCTION (Indiana University Press 1990); Kimberly D. Krawiec, Price and Pretense in the Baby Market, in BABY MARKETS: MONEY AND THE NEW POLITICS OF CREATING FAMILIES 41-55, (Michele B. Goodwin ed., Cambridge University Press 2010). See also Daar, supra note 3. Strong emotional reactions to infertility can motivate some to aggressively seek infertility treatment. Id. See also Michele Goodwin, Relational Markets in Intimate Goods, 44 TULSA L. REV. 803, 816-17 (2009). The ability to purchase sperm and ova affords women the ability to complete their families without the social stigma, bureaucracy, and frustration of appearing genetically weak due to their infertility or genetic deficiency. Id. at 815.


17 See id.
been particularly vocal with regard to ART. They have raised acute concerns about the moral adequacy of ‘playing God’ in the holy act of human creation;\textsuperscript{18} they are bothered by the status of pre-embryos and embryos in light of the abortion controversy;\textsuperscript{19} and they worry about the implications such technologies may have on the religious identity of the child.\textsuperscript{20} While some religions, such as Baptist, Presbyterian, Anglican Church, and Jehovah’s Witness, have liberal attitudes toward ART, others have absolutely rejected ART.\textsuperscript{21} The Vatican, for example, declared such technologies as “immoral and absolutely unlawful,” viewing IVF as a disregard for human life and as a technology used to separate human procreation from sexual intercourse.\textsuperscript{22} The Eastern Orthodox Church has likewise rejected the use of this procedure and prohibited the use of such technologies because they are viewed as adulterous acts.\textsuperscript{23} Similarly, ostensibly all Muslim societies proscribe most forms of ART, given that under Islamic law, ART is seen as adultery, illegal sexual intercourse, or a source of confusion regarding paternal lineage.\textsuperscript{24} Furthermore, as religious considerations have often entered the national legal arena, they may also apply to individuals who would not have otherwise followed the tenets of their respective religious faith. The Vatican’s great influence in Italy, for instance, has led to the complete prohibition of surrogacy and other ART-related technologies in the country.\textsuperscript{25} Similarly, the pro-natalist culture and key religious (Jewish) commandments in Israel resolved in regulations allowing only full surrogacy and requiring that the surrogate and the intended mother belong to the same religion.\textsuperscript{26}

\textsuperscript{18} See Wahrman, \textit{supra} note 1, at 130 (describing general Rabbinic leniency toward ART as viable means of fulfilling man’s obligation to procreate).


\textsuperscript{22} See \textit{id.} at 257.

\textsuperscript{23} See \textit{id.} at 258.

\textsuperscript{24} Mahdi Zahraa and Shaniza Shafic, \textit{An Islamic Perspective on IVF and PGD, With Particular Reference to Zain Hashmi, and Other Similar Cases}, 20 ARAB L. Q. 152, 162-63 (2006).


Thus, regardless of whether one is religious, secular, or all together atheist, religious limitations are determinative in the decision who will be entitled to become a parent via ART.

Both individual and institutional social and cultural beliefs regarding parenthood and procreation further affect the availability of ART. Tackling these social and cultural beliefs, however, is hard for two reasons. First, addressing such beliefs is distinctively difficult, as the actual rationales are often socially entrenched and taken for granted. Second, these beliefs may enter the discussion disguised as legal standards. For instance, national laws often mandate that doctors who provide ART services must determine “parental eligibility” before carrying out the procedure. However, such national mandates are commonly unaccompanied by clear guidelines as to the criteria for determining parental eligibility. They are often too speculative and leave much room for subjectivity in the decision-making. Doctors, health professionals, and other ART-related providers are therefore entrusted with a significant maneuvering power, whereby their own religious and cultural inclinations may influence the decision about who constitutes an appropriate parent.

One striking example to illustrate the effect of doctors employing their own religious and cultural beliefs in this decision-making process is clinician attitudes towards treatment of individuals with disabilities—a minority group estimated at over six hundred fifty million worldwide and that comprises about ten percent of the world’s population. Although some change in attitude has taken place in the past couple of decades, significant prejudices about these individuals’ (in)capacities remain.

domestic-ova-donations-1.295004. The egg donation must be anonymous, and to ensure the maternal religious linage, the donor’s and the recipient’s religion must be matched. Id. Also, a baby born to a Jewish family from a non-Jewish donor will have to undergo conversion. Id. This is the case, for instance, in the United Kingdom and Israel. See Josephine Johnston, Judging Octomom, 39 HASTINGS CENTER REP. 3, 23, 24 (2009); Ploni et al v. Attorney General, Tel-Aviv (Family Court in Israel, Tel-Aviv, no. 26140, Judgment of Feb. 15, 2010); see also John A. Robertson, The Octuplet Case - Why More Regulation Is Not Likely, 39 HASTINGS CENTER REP., 26, 27-28 (2009). This requirement may also be issued by medical associations or any other clinic as guidance.

27 See Daar, supra note 3, at 67-68.
28 See Daar, supra note 3, at 67-68. According to a University of Pennsylvania study, one in five U.S. treatment providers expressed that they would refuse treatment to unmarried women, including single and lesbian women. See id. at 43.
Consequently, persons with disabilities have often been excluded from the panoply of parental rights, as well as precluded from obtaining reproductive services.\textsuperscript{32} The assumption has been that their disability—regardless of what it is or whether unrelated to their reproductive organs per se—prevents them from functioning as parents.\textsuperscript{33} This is particularly so with regard to women with disabilities.\textsuperscript{34} Although studies have indicated that fertility rates among women with disabilities and women without disabilities are similar,\textsuperscript{35} the medical profession, and society more broadly, often does not see beyond the disabilities. Rather, women with disabilities have often wrongly and unfairly been seen as asexual objects, persons without “normal” familial and sexual needs, or a mere burden on society.\textsuperscript{36} Indeed, Justice Holmes’ statement in the 1927 case of\textit{Buck v. Bell}\textsuperscript{37} that “three generations of imbeciles are enough[!]” unfortunately still echoes.\textsuperscript{38} While compulsory sterilization of women with disabilities is certainly no longer sanctioned as a form of the community’s right to defend itself from public health epidemics, as was suggested in\textit{Buck v. Bell}, it is still practiced.\textsuperscript{39} The suggestion that
persons with disabilities will be actively assisted in reproduction is thus commonly viewed as uncanny because many see it more suitable to work towards the prevention of future generations of persons with disabilities, rather than assist existing disabled persons to procreate.

The development of disability-related screenings and genetic manipulation before the embryo’s implementation and during pregnancy is further indicative of this attitude. However, nothing in these developments indicates a higher prevalence of disability among ART fetuses or children born to parents with disabilities. In fact, studies have demonstrated that the significant factors that increase the likelihood that children conceived through ART will be born with birth defects, genetic disorders, and other ailments are the woman’s age, multiple births, and arguably, the technologies themselves. Even so, to the author’s knowledge, no study has shown that parents with disabilities who use ART are at higher risk than non-disabled parents who use ART to have a child with disabilities—particularly when types and origins of the disabilities experienced are factored in. The “fear” of a higher likelihood of a child with a disability should thus lead to two conclusions. First, if this fear were indeed at the heart of the refusal to assist persons with disabilities in reproduction, then all ART procedures involving risk factors that increase the likelihood a child will be born with a disability ought to be prohibited. As discussed above, these factors include women of older age (particularly over the age of forty) who use ART, women who have had multiple births (more than twins), and ironically, perhaps also the general use of these technologies. However, there is no such general prohibition. The second conclusion is that the conventional exclusion of women with disabilities from reproductive treatments is clearly a form of unjustified discrimination on the basis of disability, and it cannot reasonably hold. This is particularly so, though not limited to, situations in which ART

Seattle hospital appointing a disability rights advocate to oversee sterilization and other growth-stunting procedures performed upon a young disabled girl “whose parents sought to keep her small through . . . experimental medical treatment”; Courtney Trenwith, Parents Win Bid to Sterilize Daughter, BRISBANE TIMES, (Mar. 9, 2010) (describing the ruling of an Australian court approving a hysterectomy on a severely disabled eleven-year-old girl). Cf. Michael Higgins, Court Denies Bid to Sterilize Mentally Disabled Woman, CHI. TRIB., Apr. 19, 2008 (presenting an Illinois Appellate Court decision denying a guardian’s request to have a mentally disabled woman sterilized).


services are otherwise available to the general population. Even if one’s disability may be a consideration when the prospective parents experience genetic disabilities—an issue that is controversial on its own—generalizing such exclusion to the entire population of persons with disabilities, merely on the basis of one’s disability, violates contemporary norms of equality and justice.

Other groups that have been historically denied access to ART technologies are sexual minorities—lesbian women, gay men, and transgender individuals. While in some instances courts have accepted the argument that doctors’ refusal to treat lesbian couples on the basis of their sexual orientation falls within the scope of unlawful discrimination, when doctors’ religious freedom is at stake, there is little doubt that discrimination against same-sex couples in the context of ART is still prevalent. For instance, though ART is hardly regulated in the United States, the few laws in place regarding the parenting rights of those individuals who use ART to conceive children are often restricted to heterosexual married couples. In other countries, gay couples are explicitly banned from utilizing ART treatments. Furthermore, ART clinics make parental eligibility decisions according to their own ideological and religious beliefs. The Nightlight Christian Adoptions agency, for instance, does not offer fertility treatment to unmarried men, and even if single women are theoretically “eligible,” the clinic warns that “genetic families [the gamete donors] commonly prefer placement with a married couple”—a preference that is determinative. Thus, in effect, gay men,

42 Darshak M. Sanghavi, Wanting Babies Like Themselves, Some Parents Choose Genetic Defects, N.Y. TIMES, Dec. 5, 2006 (describing pre-implantation genetic diagnosis, a process by which embryos are created in test tubes, as a means by which individuals with disabilities may choose to have children sharing their disabilities); Erik Parens, & Adrienne Asch, The Disability Rights Critique of Prenatal Genetic Testing, 29 HASTINGS CENTER REP. 5, S1-S22 (1999).


45 John A. Robertson, Gay and Lesbian Access to Assisted Reproductive Technology, 55 CASE W. RES. L. REV. 323, 325 (2005) (discussing Canada and Sweden’s recognition of gay and lesbian’s access to ART despite many countries denial of access); Lynn D. Wardle, Global Perspective on Procreation and Parentage by Assisted Reproduction, 35 CAP. U. L. REV. 413, 425-31 (2006). Italy, Germany, France, Austria, the Czech Republic, Denmark, Hungary, Iceland, Norway, Poland, the Slovak Republic, Switzerland, Portugal, and most Islamic nations ban homosexual couples from accessing and using ART treatments. See Wardle, supra, at 425-29.

46 Daar, supra note 3, at 43. In the U.S., one in five treatment providers expressed that they would refuse treatment to unmarried women, including single and lesbian women. Id.

lesbian women, and other individuals and couples who have untraditional family structures are practically excluded from ART technologies. Far more blatant is the exclusion of transgender individuals from procreation and family life in the broader context. Specifically, some nations’ laws condition ART availability to transgender individuals on the grounds that they undergo a sex-change operation. Transgender individuals may therefore have to discard their otherwise naturally healthy reproductive organs to fulfill this requirement or accept that these requirements prevent them from pursuing biological children in the future. Furthermore, as discussed in Part V, when transgender individuals have used ART, their road to legal parenthood may be equally as burdensome.

A common justification doctors and assisted reproductive technology related providers have used in denying services to parents in non-traditional families is that their family structure does not provide a sufficiently stable physical, emotional, and financial environment to ensure the child’s maximum development and growth. In legal terms, opponents thus claim that the use of assisted reproductive technology in such contexts would be against the child’s “best interests.” However, in practice, this argument is


50 Eisfeld, supra note 49, at 21 (discussing sterilization requirements in Germany, France, and the Netherlands); Norton, supra note 49, at 189-90 (discussing Japan’s sterilization requirement).

51 Sozos J. Fasouliotis & Joseph G. Schenker, Social Aspects in Assisted Reproduction, 5 HUM. REPROD. UPDATE 26, 26-27 (1999) (noting the role of assisted reproduction technology in the functioning of families and in child development over time). See Katz, supra note 7, at 289-315 (discussing generally the ethical and legal issues involving procreative rights of the deceased and the decision-making problems that lie in their relatives and progeny); see also id. at 299 (mentioning the development of protocols and physician regulations with respect to the requests of significant others to commence post mortem artificial insemination procedures).

52 See Katz, supra note 7, at 313-15 (noting that in posthumous conception scenarios, questions of ethics and feasibility also revolve around the possible financial benefits to such children born posthumously and as to whether or not such conception violates the reproductive freedoms of
without merit. In a multicultural society, there is hardly any consensus as to what counts as the child’s best interest, and also, it has never been scientifically proven that untraditional family structures are in any way detrimental to the child. In fact, studies have consistently shown the opposite result.\textsuperscript{53} That is, in terms of family relations, parenting qualities, and social and emotional development, children conceived via the use of ART are frequently equal, if not better off than naturally conceived children.\textsuperscript{54} Furthermore, whereas studies have shown that fertile heterosexual individuals and couples often conceive children unintentionally, those with non-traditional family structures who resort to ART are more likely to be “financially and emotionally invested” and committed to raising the child prior to making the decision to pursue parenthood.\textsuperscript{55} Thus, the arguable “detrimental effect” on a future child can only attest to a process of “othering,”\textsuperscript{56} though this is an unsupported attestation at best.

As this section illustrated, the intersection between religious and socio-cultural beliefs, parenthood, and the use of ART has meant that in addition to the significant group of people who experience medical infertility, there is an ever-increasing group of people who face social infertility and are prevented from enjoying ART-related scientific developments. Some have of course successfully resorted to fertility or reproductive

\textsuperscript{53} See generally Susan Golombok et al., Families Created by the New Reproductive Technologies: Quality of Parenting and Social and Emotional Development of Children, 66 CHILD DEV. 285, 285-98 (1995) (examining a study performed on family relationships and the development of children in families conceived through in vitro fertilization and donor insemination); Zaira Papaligoura & Colwyn Trevarthen, Mother-Infant Communication Can Be Enhanced After Conception by In-Vitro Fertilization, 22 INFANT MENTAL HEALTH J. 591, 591–610 (2001) (analyzing a study completed to examine the levels of stress associated with artificial pregnancy, specifically regarding early communication between mothers and their children conceived via varying artificial fertilization techniques).

\textsuperscript{54} See Golombok et al., supra note 53, at 285-98; Papaligoura & Trevarthen, supra note 53, at 591–610.


\textsuperscript{56} “Othering” refers to the psychological process by which one defines and secures his or her own positive identity through the emphasis on distinctions between ‘us’ and ‘them,’ mainly through the stigmatization of an ‘other.’ While this process is not always negative, it often is. See T. K. OOMMEN, PLURALISM, EQUALITY AND IDENTITY: COMPARATIVE STUDIES, 111-12 (Oxford University Press 2002).
tourism, which is when individuals purchase reproductive services outside of their country. However, this option is available only to the wealthier who can privately afford it, and even for those who have the means, discriminatory hurdles in the process of becoming an ART parent often remain upon their return to their respective countries. Moreover, although certain limits to one’s right to reproductive freedom may be acceptable—for example, cloning and age of prospective parents—any restriction should be able to withstand the test of a democratic society and human rights, particularly the core principles of equality, non-discrimination, and due process.

In the next section, the legal challenges faced by prospective parents are further examined in light of international human rights law. Despite the universally stipulated right to found a family and the well established principle prohibiting discrimination, religious and socio-cultural prejudices have permeated the legal discussion. Thus, as the examination of rulings delivered by the ECHR disappointingly shows, the court’s ability to craft a resolution to ART dilemmas grounded in human rights has been curtailed.

III. Legal Ambiguity

A legal argument for a “right” to reproductive technologies can be made on a few grounds. First, international human rights law, including some of the most commonly adopted and ratified treaties, contains an array of provisions that may include such a right. Most relevant to the suggestion of the existence of a right to ART is the right to found a family and enjoy the responsibilities of parenthood, as well as the right of parents to “decide freely and responsibly on the number and spacing of their children.”

Second, support for this “right” to ART can further be substantiated on the

57 See e.g., Tomer Zarchin, Gay Father of Twins Born to Indian Surrogate Denied Permission to Bring His Sons Home, HAARETZ, May 9, 2010; Matt Wade, Babies Left in Limbo as India Struggles with Demand for Surrogacy, THE SYDNEY MORNING HERALD, May 1, 2010. Some states criminalize citizens who purchase reproductive services not available in their country. Some countries, for example Italy, also criminalize individuals who publicize gametes banks and services that are available abroad. See Robertson, Protecting Embryos and Burdening Women: Assisted Reproduction in Italy, supra note 25, at 1695.

practical level. Health insurance programs increasingly recognize infertility as a medical condition and hence cover at least some of the associated medical costs. Moreover, some countries provide such services as an integral part of their national health insurance. Third, the thriving international reproductive market further reinforces the claim of ART as a right. Due to the vibrancy and competitiveness of the reproductive industry, the prices of these ART services have decreased and are expected to further decline. ART services are thus becoming more financially accessible to a wider range of individuals and couples. This also allows for an ever increasing voice of prospective parents who, as consumers, can now choose from an array of possible medical interventions, as well as have a say in the determination of the sex and other traits of their future offspring. Therefore, despite the concerns about the social implications of ART, particularly of reproductive tourism, the extension of health care coverage to encompass ART and the thriving international reproductive market are evidence of an increasing acceptance of ART as an entitlement. Indeed, even though neither of these factors can automatically be translated into a general entitlement, the increasing subsidy and availability of such services as an integral part of health care services, as well as the

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59 See Daar, supra note 3, at 31.
60 See Daar, supra note 3, 30-31, 37. For instance, Finland, the Netherlands, the United Kingdom, and Israel are countries which provide ART services as part of their national health insurance plans. Id. In Israel, a court found eligible for nationally covered IVF treatment an uninsured woman who was neither a permanent resident nor a citizen in Israel but was married to an Israeli man who experienced infertility. See Ploni v. General Health Services, AA 141/07 (Labour Court, Nov. 4, 2008).
61 Michael J. Malinowski. Creating Life? Examining Legal, Ethical, and Medical Issues of Assisted Reproductive Technologies: A Law-Policy Proposal to Know Where Babies Come From During the Reproduction Revolution, 9 J. GENDER RACE & JUSTICE 549, 549-68 (2006). The ART market is among the largest markets in the world, generating billions of dollars per year. Id. at 549. It includes sperm and egg banks, private and independent clinics, surrogacy agencies, and other related services. See id. The shortage of gametes donors and the exploitation of infertile individuals’ agony have also led to a flourishing black market, an aspect that is beyond the scope of this essay.
application of patients’ rights, informed consent, and choice, have arguably moved the ART discussion beyond the rights to have a family to the scope of the universally recognized right to the enjoyment of the highest attainable standard of physical and mental health.64

Regardless of these developments, however, whether these aforementioned references to family rights also include any form of ART is still open for debate. Examination of the work of relevant international bodies, which have interpreted the right to found a family under international law standards, shows that they have done so only conservatively. The focus of these bodies has been on gender equality in the family, for instance, the freedom to receive health services, to decide about procreation, and to choose both the number and spacing of the children.65 While these are important aspects in the context of reproduction, it is impossible to glean from them any state’s duties to assist those who want to procreate through ART.

Certainly, the passivity of these international bodies in tackling ART-related dilemmas can be explained in light of international politics. Efforts to set up a legally binding universal framework that would sort out the possibilities and limits of ART have failed, and the international community has ultimately opted for a declaration.66 The Universal Declaration on Bioethics and Human Rights, promulgated in 2005, references in general terms new scientific and technological developments; however, it does not explicitly address ART.67 Also, provisions that could be related to reproduction are limited to the general statement requiring the “protection of present and future generations” and to the prohibition of illegal transnational “traffic[ing] in organs, tissues, samples, genetic resources and genetic-related material.”68 Nevertheless, the self-restraint of the international committees may be understandable: these bodies may

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68 See id. at 4, 7.
be concerned with igniting a fervent religious and cultural clash if they attempted to impose a certain medical practice, particularly one that is such a controversial issue across the world. However, such a reluctance to actively engage in a discussion about a right to found a family and a right to ART cannot stand when the issue is before a judicial body whose role is to provide justice when human rights violations are at stake. Yet as the next section shows, this is nonetheless the stance the ECHR has decided to endorse.

IV. The ECHR – Is It Indeed the Protector of Human Rights?

It is well established that the ECHR was promulgated as the protector of human rights among states in the European Union. One principle goal of the ECHR is to rule on applications alleging violations of civil and political rights as set out in the European Convention on Human Rights. Since 1998, individuals have been able to apply directly to the ECHR for review of their claims. Pertinent to this discussion is the ECHR’s mandate that explicitly includes jurisdiction over cases of biomedicine and human rights.

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71 The European Convention for the Protection of Human Rights, supra note 69 (setting out the ECHR rules on individual or state applications alleging violations of the civil and political rights). See COUNCIL OF EUROPE, List of the Treaties Coming from the Subject-Matter: Human Rights, http://conventions.coe.int/Treaty/Commun/ListeTraites.asp?MA=3&CM=7&CL=ENG (last visited Nov. 20, 2010) (for a list of all Protocols). Judgments finding violations are binding on the states concerned and they are obliged to execute them. Judgments of the court are decided by a majority vote, though judges are also entitled to append to the judgment a separate opinion, either concurring or dissenting, or a bare statement of dissent. In addition, the court may, at the request of the Committee of Ministers, give advisory opinions on legal questions concerning the interpretation of the Convention and Protocols. See The Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, Dec. 1, 1990, 218 U.N.T.S. 213 (entered into force Jan. 1, 1997) [hereinafter Convention on Human Rights and Biomedicine]; see generally THE EUROPEAN COURT OF HUMAN RIGHTS BASIC INFORMATION ON PROCEDURES, http://www.echr.coe.int/ECHR/EN/Header/Thc+Court/How+the+Court+works/Procedure+before+the+Court/ (providing further information about the procedures for filing a case at the ECHR and about the composition of the court); THE
Specifically, the European Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine, the 1997 Oviedo Convention, contains important provisions relevant to the ART context. First, the convention stipulates as its purpose and objective to protect “the dignity and identity of all human beings and guarantee everyone, without discrimination, respect for their integrity and other rights and fundamental freedoms with regard to the application of biology and medicine.”72 It further prioritizes the interests and welfare of the human being over the interests of society or science, it requires equitable access to health care of appropriate quality, and it explicitly prohibits “any form of discrimination against a person on grounds of his or her genetic heritage.”73 Thus, the broad language of this proposition seems to suggest that exclusion from the panoply of ART on grounds such as gender, sexual identity, and disability, including genetic-related disability, is, or at the very least should be, directly prohibited.74 Yet to what extent are the rulings of the ECHR in cases revolving around ART in line with these principles? As the following examination of the court’s ruling shows, much legal uncertainty regarding ART as a right remains unresolved, and furthermore, questions arise as to the genuine reasons behind the court’s rulings.

V. ART Dilemmas in the ECHR

There have been limited instances in which the ECHR has embraced the
opportunity to expand on principles of equal access and reproductive technologies. Nevertheless, a close examination of the cases before the court dealing with these issues reveals several crucial misinterpretations and failed opportunities to equalize the rights of all people to ART.

The first opportunity for the ECHR to issue an opinion regarding ART as a right was in the case of *X, Y and Z v. the United Kingdom* in 1997. In this case, a social family comprised of a biological mother, a female-to-male transgender father, and an anonymous-donor-IVF child applied to the ECHR requesting that the (new) man be registered as the legal father of a child. The case arose as the applicants alleged that the refusal of the British government to register the man as the legal father violated Articles 8 and 14 of the European Convention on Human Rights, the right to respect private and family life, and the non-discrimination provision, respectively.

In a fourteen to six decision, the majority of the court denied the request. The ECHR ruled that the state has a “wide margin of appreciation” in making such determinations with respect to a transsexual’s rights, expressing that the rights of parents and transgendered individuals, as well as of the legal impact of ART, are in flux. Instead, the court noted that the new man was not prevented from acting as the social father. Dismissing the couple’s concern that the lack of legal recognition would negatively affect the child’s sense of personal identity, security, and ability to enjoy some family-related benefits, such as automatic inheritance, the court noted that “the extent to which the absence of a legal connection between [the father and the child] will affect the latter’s development” is uncertain.

While the latter statement may be correct, the ruling seems logically inconsistent

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76 Id. at 146-48, 150.
77 See id. 143, 169 (examining the history of dealing with transsexuals and children conceived by ART). The court reiterated that because there is little common ground on these issues amongst the member states of the Council of Europe the respondent state must be afforded a wide margin of appreciation. Id.
78 See id. at 171.
79 See id. at 145, 171. The court addressed certain concerns of X and Y pertaining to the lack of legal recognition as Z’s parents. X, Y and Z, 24 Eur. Ct. H.R. at 145. The court stated that the failure of automatic inheritance can be solved by X making a will. Id. Also, as far as social concerns, the court stated that as far as X not being on Z’s birth certificate, in the United Kingdom, a birth certificate is not a common use for identification purposes. Id. Further, as far as Z’s personal security, the court noted that X was not prevented from acting as Z’s father in social settings and that X and Y could apply for joint residency, which under English law, would automatically confer upon them full parental responsibility of Z. Id.
when the facts of the case are considered. The couple met shortly before the father had re-assignment surgery, and they had cohabited for over ten years at the time of the petition. The father had his own identity documentation changed, and there was no doubt that he had been acting as the father of the child in every meaning of the term but his original physical birth. Also important are the facts that both the sex-change operation and the IVF procedure were paid for by the national health insurance; a special approval for the IVF procedure for the couple was required and given by a medical ethics committee, only after an in-depth examination of relevant scientific data and consideration of the interests at stake; and before the IVF proceeding, British national law required the father to give a written informed consent and to formally commit that he would serve as the future child’s father, consent and commitment that he undoubtedly performed.\footnote{See X, Y and Z, 24 Eur. Ct. H.R. at 175 (Casadevall, J., dissenting) (rejecting the majority’s ruling that a violation of Article 8 did not occur). Judge Casadevall discusses why the outcome of this case should be decided differently from the Rees and Cossey cases. \textit{Id.} at 176. Judge Casadevall points to two reasons to deviate from prior precedent. \textit{Id.} First, this case concerns “family life,” where three applicants are bound together, Y is Z’s mother, and X assumes the male role of father. \textit{Id.} at 177. Second, the state permitted X to undergo hormone treatment and authorized Y to undergo artificial insemination that resulted in the birth of Z. \textit{Id.} The state should take all reasonable measures to allow the parties to live normal lives, without discrimination, and respect their private family lives. \textit{Id.}}

The subsequent instinctive quandary thus, is why deny these parental rights once the child is already born? This question is particularly pertinent considering that as the ECHR stated, it was apparent “that the legal recognition sought \textit{would not} interfere with the rights of others or require any fundamental reorganization of the United Kingdom system of registration of births,”\footnote{See \textit{id.} (pointing to the Human Fertility and Embryology Act 1990 as authorizing a man to register as the father of child born to female partner by artificial insemination); see \textit{generally} Human Fertilization and Embryology Act, 1990, c. 37 § 28 (U.K.) (defining “father” in situations where the child born as result of artificial insemination). The Act outlines several different methods by which a woman may be artificially inseminated. \textit{Id.} The Act provides guidelines for determining who should be treated as the father of the child born to a woman using each of the varied artificial means for conception. \textit{Id.}} and the British Human Fertility and Embryology Act of 1990 allowed a man to be registered as the father of a child born to his female partner by artificial insemination using a sperm donor.\footnote{See \textit{id.} (pointing to the Human Fertility and Embryology Act 1990 as authorizing a man to register as the father of child born to female partner by artificial insemination); see \textit{generally} Human Fertilization and Embryology Act, 1990, c. 37 § 28 (U.K.) (defining “father” in situations where the child born as result of artificial insemination). The Act outlines several different methods by which a woman may be artificially inseminated. \textit{Id.} The Act provides guidelines for determining who should be treated as the father of the child born to a woman using each of the varied artificial means for conception. \textit{Id.}} The ECHR’s additional observations are equally confusing. Although the ECHR refused to recognize the new man as the legal father of the child, it commented that the man could apply for
a joint residence order in respect of the child. Under local English law, acceptance of applications for joint residence automatically confers upon the non-parent the same responsibilities as a natural parent. The court further noted that if the couple chose to do so, they would be “in a similar position to any other family where, for whatever reason, the person who performs the role of the child’s ‘father’ is not registered as such.”

The ECHR’s justification is additionally problematic, however, on two grounds. First, it ignores the issue of choice. Other heterosexual fathers who are not registered as a child’s parent normally choose not to be registered. If they decided to “formalize” their relationship with the child and register, however, they would normally have no legal barriers to do so, unless the circumstances are such that they raise a child who is not their own. In X, Y and Z, in contrast, not only was the applicant the sole and undisputed father, but furthermore, the ability of the applicants to make a choice as to registration was taken away from them by operation of British law. Second, the court did not resolve the issue of dual legal status of parenthood that this state of affairs created, thus giving the impression that the decision was either not well thought through, or worse, that it was merely providing a bandage to a patient who needed a surgery. If the joint residence would automatically confer responsibilities of a transgender individual as natural parent, and it is an acceptable option, why is legal registration as a parent not likewise an acceptable option? Moreover, while the joint registration will confer responsibilities as a natural parent, why not also grant the

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83 See X, Y and Z, 24 Eur. Ct. H.R. at 171 (describing ability of man to acquire full parental responsibilities by applying for joint residence order). The man can live with the child and provide emotional and financial support. He can give the child his surname and refer to himself as the child’s father. The result is a relationship that is roughly the same as a relationship involving a heterosexual male performing the role of father but not registered as such. Id.

84 Id.

85 Id.

86 Arguably, a form of lack of choice may also exist in instances in which a man raises a child that is not his own, and he is not functioning as the sole father of a child; for example, when a woman raises her children from previous relationship with another man, yet the biological father still functions as the children’s parent as well. This scenario is distinguished from X, Y and Z though, as the child already has a person who is registered as the father; furthermore, it may be part of the raising parent’s choice, that is, the birth of the child was not a decision the raising parent had any say about, and he entered the relationship knowing that this is the case and with no expectations of being registered as the father. See generally, X, Y and Z, 24 Eur. Ct. H.R. at 171.

87 See id. at 147-48 (describing circumstances of Y’s impregnation and Z’s birth). When the hospital ethics committee agreed to provide the treatment, they asked X to acknowledge himself as the father according to the Human Fertility and Embryology Act 1990. Id. at 147.
accompanying parallel recognition of parental rights, in this case, including registration? If the court accepted the applicant’s request for legal registration as a parent, these aforementioned double standards would have been easily resolved.

The validity of the ECHR’s deference to the concept of the states’ “margin of appreciation” is further questioned by the court’s own remarks. While the ECHR justified its decision to uphold the United Kingdom’s discretionary interests by referencing the lack of consensus amongst the Convention’s signatories as to whether preserving the anonymity of the sperm donor or upholding the child’s right to know the donor’s identity would better serve the child’s interests, the ECHR simultaneously suggested that the couple keep the man’s lack of legal recognition in secret. As the court stated, “unless [the couple] choose[s] to make such information public, neither the child nor any third party will know that this absence is a consequence of the fact that X [the applicant] was born female.” But if the benefits of one level of secrecy concerning the donor’s identity to the child are already in doubt, the suggestion of adding another level of secrecy by those who raise the child should be all the more questionable.

The second instance in which the ECHR was confronted with an ART-related issue was in 2006 in the case of Evans v. United Kingdom. The facts of this case were marked by a frozen embryo conflict. The prospective parents had gone through ART treatment, but they had separated before the embryos were implanted in the womb, and subsequently, they disagreed on whether to pursue conception of the fertilized embryos. Attempting to balance the woman’s interest in wanting to continue with the implantation process, and the man’s interest in discarding the embryos, the ECHR ultimately held that the right not to procreate prevails over the right to do so.

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88 Id. at 144, 169.
89 One could argue that the court’s decision merely reflects its sense that it is not the appropriate forum to create a standard about sperm anonymity. See id. at 171 (stating that the only way others would know of the truth of the situation and thus any negative effects that would arise would be if the couple made the information public). This argument is erroneous in the author’s view. First, courts commonly intervene in an array of policy considerations—and particularly when the policies violate human rights. Second, the court’s presumed decision not to decide whether to accept or reject an existing policy is a decision in itself that takes a particular stance about what the standard should be.
92 Id. at 411-12 (describing facts of case).
93 Id. at 424-30 (providing the court’s analysis for this issue). The court first discussed the various provisions of the Human Fertilization and Embryology Act of 1990 intending to show what the United Kingdom government legislated in regards to the IVF procedures and protocols. Id. at 424. The court then discussed some cases that illustrated the “bright-line” rules that were
this decision may resonate with some, including some national laws allowing a party to withdraw one’s consent at any stage up to the moment of embryo implantation, the decision ignores critical facts of the case.

More specifically, in Evans, a thirty-five-year-old woman, who was in the process of receiving fertilizing treatment, was diagnosed with serious pre-cancerous tumors in both ovaries. Before having the ovaries removed, the couple was advised to extract some eggs for IVF. Although the woman requested that the clinic freeze her unfertilized eggs, the husband reassured her that there was no risk for her future bearing of his child and for her motherhood by fertilizing her eggs with his sperm, so they subsequently proceeded with the treatment. As the ECHR described the undisputed circumstances of the case, “J [the partner] reassured the applicant that they were not going to split up, that she did not need to consider the freezing of her eggs, that she should not be negative and that he wanted to be the father of her child.” Both parties signed the necessary consent forms, and following the IVF procedure, six embryos were created and frozen for future implantation. Several years later, the couple split, the

interpreted by the European Court of Human Rights and how the Act of 1990 and its bright-line rule should be similarly interpreted. Id. at 424-25. Accordingly, the court then spelled out how the Act of 1990 compelled IVF clinics to adhere to the “dual consent” requirement rigidly, considering no exceptions. Id. at 425-30.

Evans, 43 Eur. Ct. H.R. at 419. Denmark, France, Greece, and Switzerland are nations which have specifically legislated the right of either party to withdraw one’s consent at any stage up to the moment of embryo implantation. Id. The court also mentioned how this right is included in “secondary legislation” in the Netherlands, while clinical practice in Belgium, Germany, and Finland provide for the same right. Id. A male donor enjoys this similar “veto power” in Iceland, Sweden, and Turkey. Id. See also Davis v. Davis, 842 S.W.2d 588 (Tenn. 1992) (Supreme Court of Tennessee held that generally, in a dispute regarding the custody of pre-embryos, the party who withdraws the consent and seeks to destroy the embryos has a greater interest). But see Nachmani v. Nachmani, 50(4) P.D. 661 (Isr.) (Supreme Court of Israel ruled that woman incapable of childbirth had a right to have her frozen embryo implanted in a surrogate against the wishes of male gamete donor). In that case, dual consent was also required, but the woman’s right to procreate, even with the aid of a surrogate mother, trumped the man’s right to not have his sperm used to father a child. Id. The court also considered a variety of state court cases from the United States that eschewed a bright-line approach in favor of other approaches such as contractual obligations. See Evans, 43 Eur. Ct. H.R. at 420-21.

Id. at 411.

Id.

Id. The nurse explained that the clinic did not actually freeze unfertilized eggs and that the procedure in general had a lower chance of success. Id.

Id.

See Evans, 43 Eur. Ct. H.R. at 412. The consent forms signed by J permitted the use of his sperm for fertilization of the applicant’s eggs in vitro and the subsequent use of any embryos created for the treatment of himself and the applicant together. Id. Further, he also checked off
husband withdrew his consent, and the husband requested that the embryos be destroyed.\textsuperscript{100} Upon the husband’s withdrawal of consent, the clinic refused to continue the implantation of the embryos.\textsuperscript{101}

Nevertheless, when the woman filed the complaint, the ECHR was quick to dismiss her claim that her rights to privacy and family life, as well as to non-discrimination, were violated under Articles 8 and 14 of the European Convention on Human Rights. The court rejected her argument that the situation of the male and female parties to IVF treatment cannot be equated and that in light of the specific circumstances, a fair balance between the parties would be preserved by holding the husband to his consent.\textsuperscript{102} Furthermore, while the court declared having “great sympathy” for the plight of the woman who, in light of the decision, had lost all possibilities of having a genetic child,\textsuperscript{103} neither the role of the husband nor the subsequent reliance of the woman on his promises were properly discussed.\textsuperscript{104} Instead, the court ruled that in the exceptional circumstances of the case, the absence of the power to override the withdrawal of the husband’s consent does not upset the fair balance required by the right to privacy in Article 8.\textsuperscript{105}

Finally, the third ruling on ART-related issues was in the 2007 case of Dickson v. United Kingdom.\textsuperscript{106} Here, a Grand Chamber of the ECHR reversed a previous decision of the ECHR and accepted a couple’s petition that the government’s, and the prison’s, refusal to allow them to use ART violated their right to privacy and family life under Article 8 of the European Convention on Human Rights.\textsuperscript{107} In this case, the man was serving a life sentence in prison and his wife was an ex-prisoner.\textsuperscript{108} The court ruled that a box labeled “[s]torage,” which gave his consent for storage of sperm and embryos for a period of ten years. \textit{Id.} Meanwhile, the applicant consented to the same treatment but her consent form referred to eggs instead of sperm. \textit{Id.}

\textsuperscript{100} See \textit{id.}

\textsuperscript{101} See \textit{id.} (stating that the clinic informed applicant that because of J’s withdrawal of consent, the clinic was now legally obligated to destroy the embryos). The legal obligation arises from the specific language of the statute. \textit{See} Human Fertilization and Embryology Act, 1990, c.37, § 12, sched. 3, s.8(2) (Eng.).


\textsuperscript{103} See Evans, 43 Eur. Ct. H.R. 21 at 429.

\textsuperscript{104} See \textit{id.} at 427-30.

\textsuperscript{105} See \textit{id.} at 428-29.


\textsuperscript{107} See \textit{id.}

\textsuperscript{108} \textit{Id.} at 73-76. The man had been convicted of murder and sentenced to life imprisonment with a tariff of fifteen years, and the woman he met through a prison pen-pal network had since been
in the context of the right to family, the state has both negative and positive duties, and while it declined to elaborate what these latter duties entailed, the court ultimately held that the authorities’ refusal to allow the couple to pursue IVF violated the couple’s rights. The ECHR rejected the government’s argument that allowing prisoners guilty of serious offenses to conceive children would undermine the public confidence in the prison system, reasoning that offending public opinion cannot justify automatic forfeiture of rights since under the Convention system “tolerance and broadmindedness are the acknowledged hallmarks of democratic society.” The ECHR also dismissed the government’s argument that the absence of a father for a long period would have a negative impact on any child conceived and consequently, on society as a whole.

Instead, the ECHR stated that this justification “cannot go so far as to prevent parents who so wish from attempting to conceive a child in circumstances like those of the present case . . . .” The court found, in light of the interest in rehabilitation of prisoners, that the authorities failed to strike a fair balance between the competing public and private interests involved and that the rights of the applicants to family life were violated. Moreover, the court awarded the applicants non-pecuniary damages for the distress they experienced, as well as reimbursement for costs and expenses.

released from prison. Id. The man and woman wished to have a child, so they applied for facilities for artificial insemination. Id. In their application, they argued that the length of their relationship, the man’s uncertain release date, and the woman’s age, made it unlikely that they would be able to have a child together without the use of artificial insemination. See id.

109 Dickson, 46 Eur. Ct. H.R. at 70-71. In comparing the positive and negative obligations, the court began by stating that an individual should be protected from arbitrary interference by the public authorities. Id. at 70. The negative obligations of the state do not require any actions from the state, in that they “merely compel the State to abstain from such interference.” Id. On the other hand, the positive obligations require the state to partake in some action to protect the individual against interference by public authorities. See id. “These obligations may involve the adoption of measures designed to secure respect for private and family life even in the sphere of the relations of individuals between themselves.” Id.

110 Id. at 75. Although the court ruled against the government, it did accept that maintaining public confidence in the penal system has a role to play in the development of penal policy. Dickson, 46 Eur. Ct. H.R. at 75. The court went on to point out that as the European penal policy has evolved, there has been an increasing importance placed on the rehabilitative aim of imprisonment. Id.

111 Id. at 76. The court pointed out, in this regard, that the second applicant was not imprisoned and would have been able to take care of a child until her husband was released. See id.

112 Id. Although the court rejected the government’s argument, it acknowledged that, “the authorities, when developing and applying the policy, should concern themselves, as a matter of principle, with the welfare of any child.” Id. The court even asserted the positive obligations of the court in ensuring the protection of children, just not so far as preventing parents from conceiving, if they so wish. Dickson, 46 Eur. Ct. H.R. at 76.

113 Id. at 90-96. In evaluating the conflicting individual and public interests, the court considered
Regardless of whether one approves or disapproves of the court’s decision in *Dickson*, that a prisoner has a right to access ART services, one may question why the court has excluded some important factors from its consideration. Significantly, these excluded factors include: the expected long absence of the biological father from the child’s life, and the ability of the father, a man serving a life sentence in prison, to financially provide for the child. Although, in this author’s view, these considerations are not absolute or fixed, that is, a single parent household may work perfectly well for both the parent and the child, the lack of discussion is odd. If the child’s possible future desire to have a relationship with the child’s biological father was a relevant argument in *X, Y and Z*, and if the financial concern was relevant in *Evans*, why were these matters not part of the discussion in the *Dickson*? Even if the court, and perhaps justly so, no longer finds these considerations to be as significant to the determination of the child’s welfare and best interests, though these factors are normally integral to any claim that involves children, an examination of the specific circumstances of the case is essential. Also, because this decision departs from previous legal decisions, it commonly would be followed by rationalized justifications, yet such reasons are ostensibly missing from the discussion in *Dickson*.

The result of these cases is that the court’s rulings provide inconsistent answers to the questions raised above. Despite its explicit powers in the context of biomedicine and human rights, the court did not provide any clear guideline about whether ART is, or under what circumstances it would be, part of one’s right to found a family and to privacy. The court’s rationales also send mixed messages. If one accepts the premise that *Dickson* stands for the proposition that the right to privacy and reproductive freedom through the use of ART is primary or fundamental, it is not clear why in *Evans* the man’s right not to procreate prevailed over the woman’s right to do so, particularly considering that the immediate result was that only the man was left with this freedom. If the court was concerned about protecting parental reproductive freedom from state intervention, the apparent rationale behind *Dickson*, it is not clear why in *X, Y and Z* the court declined to provide a similar protection on those same grounds when the child was already born, and the applicant undisputedly functioned as the applicant’s interest in artificial insemination as their only hope for having children together a matter of vital importance. *Id.* at 72. The court awarded non-pecuniary damages because the authorities did not appropriately treat the matter as one of such vital importance. *Id.*

114 See discussion infra below.


116 *Dickson*, 46 Eur. Ct. H.R. at 90-96. Though the court did not explicitly acknowledge a right to ART, it recognized the vital importance of a person’s desire to procreate, a finding that indicates the court gave great weight to the plight of individuals in these specific circumstances. *Id.*
the child’s father.

In light of the inconsistency in the court’s rulings as illustrated above, the next section examines two conventional explanations regarding the factors driving the ECHR’s decisions and challenges their validity in the particular cases. The section then suggests two alternative—and more hidden—explanations to the court’s rulings, proposing that rather than upholding fundamental human rights to all, the ECHR’s decisions are tainted with social and cultural biases.

The first explanation is that the refusal to impose financial, emotional, or psychological parental responsibilities is inappropriate when the child is unwanted by one of the prospective parents involved. If correct, this hypothesis would presumably justify the court’s decision in Evans, as the husband’s withdrawal of consent to the implementation of the embryos clearly illustrates his refusal to take on parental financial responsibilities. Yet, the financial imposition of parental obligation is not uncommon in other parenthood disputes. Furthermore, the legal responsibility of parents could have also been lifted, as it has, for instance, in the context of sperm donors. The court could therefore have taken the woman up on her commitment that she would not seek monetary assistance from the man to ease any financial burden. However, financial considerations also do not seem to have controlled the ECHR’s decisions in either

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118 In the case of parental divorce, spouses still hold the obligation to provide child support—at times, also when the child is not biologically theirs. See Child Support Act, 1991, c. 48 (Eng) (providing guidance for the kind of support spouses must pay to their children after parents divorce); see also Godin v. Godin, 725 A.2d 904 (Vt. 1998). In a more controversial decision, the Supreme Court of Vermont denied a request of an ex-husband to order blood tests for his fifteen-year-old child who was born during his marriage. Id. at 523. It was the child herself, who following rumors within her family, raised the question as to her biological father, and the mother admitted that she has been sexually involved with another man at the time of the conception when the husband was away. Id. at 516, 526. It should also be noted that following the rumors and the questioning of paternity, the relationship between the child and the presumed father had already deteriorated. As the dissenting judge expressed,

the disclosure that plaintiff (the ex-husband) is not Christina’s biological father has fundamentally altered this family . . . we cannot order that plaintiff to love Christina as his daughter or provide her the parental guidance we would expect of a father. Nor can we order Christina to treat plaintiff as her father.

Id. at 532 (Dooley, J., dissenting). Nonetheless, the court denied the ex-husband’s request to prove that he is not biologically related to the child and held him financially responsible to her needs. Id. at 526.

Dickson or X, Y and Z. The financial factor was not part of the balancing in Dickson, given the failure of the court to consider the question of whether the father, serving life in prison, would actually be able to financially support the future child. On the other hand, when the social father in X, Y and Z was willing, and instead, was practically exercising parental financial responsibilities, the ECHR chose to ignore it.

The second explanation builds on the court’s assumption that there is an inextricable psychological and emotional attachment, which is seemingly based on the genetic tie. If correct, this hypothesis would presumably justify the Evans and perhaps also the X, Y and Z rulings. In Evans, the court assumed the husband would automatically be emotionally attached to the child, a burden that the court refused to impose. Comparatively, in X, Y and Z, the court gave a priority to the presumable emotional interest that the genetic father of the child and possibly, the child herself, would have, rather than that of the applicant. Yet as studies have shown, the implications of such a tie have often been exaggerated. Furthermore, genetic ties are basically social constructs that do not withstand to a cross-cultural test. In fact, in Western and the United States legal systems, the genetic tie has been recognized as a construct, as opposed to a natural given. Moreover, it has certainly been contested in the context of families established with gamete donors, where the main motivation for gamete donation, particularly sperm donors, has been found to be the financial compensation, rather than the genetic link. Hence, it seems that at least questioning the presumed automatic attachment on the basis of a genetic tie is necessary.

In addition, there are two other possible alternative explanations for the court’s rulings. The first one is rooted in gender-based considerations, whereby the court’s decisions are motivated by a desire to uphold a masculine and patriarchal culture. Male genetic interests thus prevail both in clashes with the government, as demonstrated in Dickson, and with the woman’s interests, as demonstrated in Evans. This theory also explains the impossible “balancing” between the spouses’ emotional burden of having an unwanted child and the burden of not having a child. This explanation is further

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120 See Dickson, 46 Eur. Ct. H.R. at 42.
124 See Roberts, supra note 63, at 232.
125 Roberts, supra note 63, at 209-11; Waldman, supra note 117, at 1049-52.
126 Waldman, supra note 117, at 1049-52.
128 See Waldman, supra note 117, at 1029.
supported by the fact that in *Evans*, the court’s decision meant that only the mother would never have a biological child; the court ignored the additional physical burden women go through for egg retrieval, which by far exceeds the man’s burden.\(^\text{129}\) In a similar vein, in *X, Y and Z*, the woman-to-man transgender individual is not fully seen as a man, hence “justifying” the dismissal of the request for legal parenthood.\(^\text{130}\)

The second possible explanation revolves around the experience of disability and the historical, and still present, discrimination on this basis. Accordingly, the ECHR, perhaps as an extension of the social and cultural beliefs of society itself, prioritizes the rights of non-disabled individuals over those of persons with disabilities. The ECHR failed to comprehend that when a person with disabilities is concerned, the form of a state’s involvement that is required in order to uphold human rights may be different than the conventional non-discrimination and non-interference approach. Yet if one seriously thinks about human rights to all, it becomes clear that such an accommodation is essential. Thus, rather than focusing on the conventional state’s “non-interference approach” and on individuals as separate atoms, attention should also be given to a state’s positive obligations and to the rights of individuals “as part of their inter-dependent relationship with the state and society at large.”\(^\text{131}\)

From this perspective, the ECHR’s acceptance of the request for IVF treatment in *Dickson* is expected. Physically, the applicants had the capacity to procreate and whether inside or outside the prison, they enjoy a right to privacy and to family, as well as the freedom from state’s interference in this regard.\(^\text{132}\) Conversely, both the female-to-male transgender applicant in *X, Y and Z* and the applicant in *Evans* experienced physical impairment that prevented them from procreation in “the traditional way.”\(^\text{133}\) Their situation hence required the application of additional considerations of public policy, as discussed below, which in light of the ECHR’s conservatism, were missed. In both cases, the closest option to traditional reproduction that was available to the

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\(^{129}\) See Waldman, *supra* note 117, at 1029.

\(^{130}\) See *supra* notes 75-90 and accompanying text (discussing the *X, Y and Z* case).


\(^{133}\) Within the transgender movement, the assumption that transgenderism is a disability has been debated. Regardless, it is still categorized as a disability under WHO regulations. See *infra* Part IV. The court’s discussion also suggests that it viewed the new man as “abnormal.” See *X, Y and Z* v. United Kingdom, 24 Eur. Ct. H.R. 143 (1997); *Evans* v. United Kingdom, 46 Eur. Ct. H.R. 34 (2006).
applicants was through the use of ART, a process that is characterized by inherent interdependency. Furthermore, the fact that their disability in becoming parents was at least partially attributed to the prejudiced social and cultural environment should have been taken into account. In X, Y and Z, prejudice operates in the requirement that the female-to-male transgender must give up reproductive organs to be eligible for sex-change surgery, although it is not medically necessary; similarly, prejudice is evident in society’s lack of “tolerance and broadmindedness” in accepting various forms of families, a tolerance that the court demanded to uphold in Dickson. In Evans, the husband’s promises disabled the applicant, who relying on his pledge, was left unable to otherwise use her eggs. Thus, had the court recognized the historical discrimination against persons with disabilities and the societal obligation to equalize the conditions so that such individuals are fully included in society, on the one hand, and the interdependent nature of such ART claims, on the other hand, the court would have ruled otherwise.

VI. Looking Ahead

Consideration of the CRPD may be valuable in future discussions on the right to have a family through the use of ART. The CRPD was adopted in 2007 and entered into force in May 2008, with the purpose “to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.” In Article 2, the Convention further stipulates states’ responsibility to provide “reasonable accommodation” to equalize the rights of persons with disabilities. In Article 23, the Convention reiterates the right to found a family and explicitly requires that states eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood, and relationships. Article 23 also ensures that the

134 See X, Y and Z, 24 Eur. Ct. H.R. at 147 (stating X being born with female genitalia and his subsequent gender reassignment surgery precluded avenues for traditional reproduction leaving artificial insemination by donor as an option); see also Evans, 46 Eur. Ct. H.R. at 758 (explaining existence of pre-cancerous ovarian cells created need for ovarian removal and extraction of eggs for in vitro fertilization to preserve ability to bear children).


137 CRPD, supra note 12, art. 1. See also CRPD and Optional Protocol, http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf (providing date the treaty was entered into force, the registration date, as well as the signatories and their reservations or objections, if any).

138 CRPD, supra note 12, art. 2. Article 2 defines “reasonable accommodation” as “necessary and appropriate modification[s] and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms.” Id.
means necessary to enable individuals to exercise these rights are provided.\textsuperscript{139} Additionally, in Article 26, the Convention requires that persons with disabilities be provided with the same range, quality, and cost of health care services and programs as provided to others, including services in the area of sexual and reproductive health. Furthermore, in an array of provisions, the Convention links between states commitment to equalize the rights of persons with disabilities and the development, availability, and use of new technologies.\textsuperscript{140}

Read together, these CRPD provisions may have great implications in future discussions on the right to a family and the availability of ART. Although the treaty does not include a definition of persons with disabilities, it applies to “[individuals] who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.”\textsuperscript{141} Thus, persons who experience medical infertility would intuitively—as has also been accepted in some judicial decisions\textsuperscript{142}—fall within the scope of individuals who face an impairment; the treaty’s protections would therefore

\textsuperscript{139} CRPD, supra note 12, art. 23. Article 23 specifically states there is a right to all persons with disabilities who are of marriageable age to found a family on the basis of free and full consent of the intending spouses. \textit{Id.}

\textsuperscript{140} See CRPD, supra note 12, art. 4(1)(f) (stating CRPD requires party-states to undertake full realization of disabled human rights through promoting development of universally designed goods, services, equipment, and facilities); see also CRPD, supra note 12, art. 32 (recognizing the importance of international cooperation). This article aims to facilitate cooperation in research and access to scientific and technical knowledge, as well as to provide “technical and economic assistance, including by facilitating access to and sharing of accessible and assistive technologies, and through the transfer of technologies.” \textit{Id.}

\textsuperscript{141} CRPD, supra note 12, art. 1. Article 1 specifically reads, “[t]he purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.” \textit{Id.} “Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.” \textit{Id.} Note that while the latter reference in Article 1, as to who would be included within the scope of “persons with disabilities,” is stipulated as part of the treaty’s purpose and merely provides the targeted group for protection under the convention, yet the definition provision in Article 2 does not provide a definition of the term. \textit{Id.} art. 2.

\textsuperscript{142} Yindee v. CCH Inc., 458 F.3d 599, 601 (7th Cir. 2006); see also Spees v. James Marin, Inc., No. 2010 WL 3119969, at *15 (6th Cir. Aug. 10, 2010) (stating general consensus that increased risk of miscarriage constitutes impairment). In Yindee, a former employee sued a former employer under the Americans with Disabilities Act. \textit{Yindee}, 458 F.3d at 601. The employer was granted summary judgment because although infertility is a disability, the former employee’s infertility was not a cause of any negative treatment by the former employer. \textit{Id.}
apply if these individuals are discriminated against or prejudiced on any social, cultural, or religious grounds.

The CRPD may also be a helpful mechanism with respect to the individuals who experience social infertility, as discussed above. Even though there is no consensus whether sexual orientation and transgenderism have physical or medical basis, there is an argument that both are potentially included in the category of individuals experiencing “disorders of adult personality and behaviour,” as determined by the World Health Organization (“WHO”). Transgender individuals may be classified as individuals who suffer from “gender dysphoria,” or from “sexual identity disorder,” and with regard to sexual orientation, there is a reference to “unspecified disorders of sexual preference.” Classifying these groups as persons with disabilities is of course politically charged and may raise concerns that such categorization would further perpetuate social myths that sexual orientation, and particularly transgender people, are abnormal or inferior. Certainly, this is not the argument this author advances. The reality, however, is that exactly because some may indeed see such individuals as persons with disabilities, disability laws can be of help. Such laws are aimed at eliminating the stereotypes and stigmas associated with disability, and they

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143 See Sabatello, supra note 48 (discussing transgenderism); see generally Peter S. Bearman & Hannah Brückner, Opposite-Sex Twins and Adolescent Same-Sex Attraction, 107 THE AM. J. OF SOC. 1179 (2002).


146 See WORLD HEALTH ORG., International Statistical Classification of Diseases and Related Health Problems (1996), available at http://www.who.int/classifications/apps/icd/icd10online/ (follow “F00-F99” hyperlink; then follow “F60-F69” hyperlink); see also Rachel D. Lorenz, Transgender Immigration: Legal Same-Sex Marriages and Their Implications for the Defense of Marriage Act, 53 UCLA I. REV. 523, 528 (2005) (citing the American Psychiatric Association’s definition of Gender Identity Disorder); Levi & Klein, supra note 145, at 74-75.

147 See Levi & Klein, supra note 145, at 74-75.

148 See Levi & Klein, supra note 145, at 75. Levi and Klein explain that anti-discrimination statutes use the term “disability” not in its colloquial sense meaning physical infirmity or debilitation, but rather to refer to the prejudice, hostility, and misunderstanding of others about their health conditions. Id. at 74-75. This explains how transgendered individuals, while lacking physical disabilities, still theoretically qualify under the statutory definitions. Id. at 74-75. Seven states currently recognize transgenderism as a disability that qualifies as a permissible means to bring a cause of action under state disability anti-discrimination statutes. Id. at 74-75.
provide a legal channel to do so. Indeed, the use of such a statutory remedy is necessary because as shown earlier, the interaction between transgender individuals and homosexuals, as persons with disabilities, and society—and particularly in the ART context, their interaction with doctors, health professionals, and other providers of relevant services—is often what hinders their full and effective participation in society as parents and families. Moreover, using a disability framework would demonstrate the irrational grounds of discrimination. If a physical or mental basis exists for sexual identity and orientation, the CRPD would require the mitigation of the circumstances that lead to undue discrimination by upholding the stipulated principle of respecting human differences. Conversely, if no such physical or mental basis for sexual identity and orientation exists, the process of “othering” is the only explanation for the automatic denial of ART services to such individuals and couples. “Othering,” however, cannot stand in a proper legal system that demands equality while recognizing human diversity. It also disregards nature that allows for a continuum and fluidity of human sexuality rather than merely two extremes. Thus, unless parental capabilities in a particular case are clearly shown to be detrimental to the future child, appropriate accommodation, in the form of ART, is required for persons who experience medical and social disability, especially when ART is available to the general population.

VII. Conclusions

The legal complexities associated with the field of reproductive technologies, and whether such a right to these technologies exists, are abundant. In addition to the several external partners in the process of procreation becoming the norm, there are also many opportunities for prejudicial factors to enter into the decision-making process. As shown, this is particularly so with regard to presumptions about parental (in)capacities, the presumed “normal” familial structure, and gender preference. Thus, even though ART may increasingly be viewed as an entitlement through insurance plans and reduced costs, there is a lack of legal clarity as to whether or not, and under what conditions, a “right” to ART may exist.

This conclusion may not be surprising. The intersection between religious beliefs, socio-cultural values, and science is undoubtedly controversial, and the legal system and legal institutions often lag behind. As this article shows, however, it is the

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150 CRPD, supra note 12, at art. 3(d).
social and cultural prejudice that emerges from this intersection to which the problem can be attributed. Consequently, a significant class of individuals cannot exercise their right to found a family, despite the existence of these scientific technologies and indeed, the availability of these scientific technologies to others. Adding medically infertile individuals to this category, which already includes socially infertile individuals and couples, further exemplifies that the universal right to found a family is highly compromised.

While a decision on a case-by-case basis is required, the CRPD and its provisions provide a possible venue to further advance a right to found a family through ART in the future. Its specific language can provide a viable framework, and perhaps a better alternative, for the discussion. Indeed, from the goal of ensuring equality of rights, non-discrimination, and inclusion, to its requirement to eliminate historical prejudice through the concept of “reasonable accommodation,” to its explicit references to family rights, and to the link the treaty makes between all these and scientific developments as a means to achieve these goals, the Convention is ripe to provide an appropriate remedy. Although the classification of transgenderism and sexual orientation as disorders is contentious, individuals belonging to such groups may nevertheless benefit from using this system of law to overcome stigma and discrimination. Ultimately, society has an obligation to ensure that in light of the existence of such scientific developments, prejudices and stigmas do not stand as the barriers to one’s exercise of his or her internationally recognized right to found a family.