

DEBATE

Sex selection and preimplantation diagnosis

A response to the Ethics Committee of the American Society of Reproductive Medicine

Julian Savulescu^{1,2,3} and Edgar Dahl¹

¹Ethics Program, Murdoch Institute, Royal Children's Hospital, Flemington Road, Parkville 3052, Melbourne, and ²Bioethics Programme, Centre for the Study of Health and Society, University of Melbourne, Australia

³To whom correspondence should be addressed at: The Murdoch Institute, Royal Children's Hospital, Flemington Road, Parkville 3052, Melbourne, Australia.
E-mail: savulesj@cryptic.rch.unimelb.edu.au

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In its recent statement 'Sex Selection and Preimplantation Genetic Diagnosis', the Ethics Committee of the American Society of Reproductive Medicine concluded that preimplantation genetic diagnosis for sex selection for non-medical reasons should be discouraged because it poses a risk of unwarranted gender bias, social harm, and results in the diversion of medical resources from genuine medical need. We critically examine the arguments presented against sex selection using preimplantation genetic diagnosis. We argue that sex selection should be available, at least within privately funded health care.

Key words: preimplantation genetic diagnosis/sex selection

Introduction

In its recent statement 'Sex Selection and Preimplantation Genetic Diagnosis', the Ethics Committee of the American Society of Reproductive Medicine concluded that it is ethically appropriate to employ these new reproductive technologies to avoid the birth of children suffering from X-linked genetic disorders (Ethics Committee of the American Society of Reproductive Medicine, 1999). However, to use preimplantation genetic diagnosis and sex selection solely for non-medical reasons, the Committee claims, is morally inappropriate. The Committee 'does not favour its legal prohibition', but it strongly advises that sex selection and preimplantation genetic diagnosis for non-medical reasons 'should be discouraged'.

Why does the Ethics Committee think that sex selection and preimplantation genetic diagnosis for non-medical reasons is ethically inappropriate and ought to be discouraged? Although the Committee acknowledges that individuals enjoy procreative liberty and that 'serious reasons must be provided if a limitation on reproductive freedom is to be justified', it

claims that the social risks of sex selection outweigh the social benefits. What are these 'social risks' supposed to be?

The reservation against sex selection for non-medical reasons is often based on the assumption that it will invariably lead to a serious distortion of the sex ratio. The Committee has certainly been wise not to rely on this highly speculative objection. According to the available empirical evidence, individuals in Western societies do not have a preference for a particular sex. Most couples still wish to leave the sex of their children 'up to fate'. And those few who would want some control over the gender of their children desire to have a 'balanced family', that is a family with both daughters and sons, most often one daughter and one son (Stratham *et al*, 1993).

While sex selection in the West is unlikely to disturb the sex ratio (Simpson and Carson, 1999), more openly available sex selection would further distort the sex ratio in Asia. The male to female ratio is nearly 1.2 in China and some parts of India. In 1990, there were 100 million women 'missing' as a result of various forms of discrimination (Benagiano and Bianchi, 1999). But some have argued that disturbed sex ratios may not be detrimental to women. Advantages which have been postulated include increase in influence of the rarer gender, reduced population growth and interbreeding of different populations (Sureau, 1999). In a practical sense, sex selection employing preimplantation genetic diagnosis may be preferable to the alternatives. It would be morally preferable to many people to termination of 'wrong sex' pregnancies or female infanticide (Sureau, 1999) and is preferable to increasing population burdens in an attempt to have a child of the desired sex (Simpson and Carson, 1999).

The Committee also does not base its reservation about sex selection on vague 'slippery slope' arguments. The Committee is well aware that it is perfectly possible to draw a legal line between the selection for sex and the selection for other characteristics, such as eye colour, height or intelligence. Thus, if there is consensus that selection for sex is morally acceptable but selection for, let us say, intelligence is not, professional or legislative controls can be employed to allow the former but not the latter. Arguments claiming that sex selection is the initial step down a road that will inevitably lead to the creation of 'designer babies' or a 'new eugenics' are simply invalid.

However, if it is not the fear of a distorted sex ratio or a slide towards eugenics, then, what are the social risks the Committee is referring to? The Committee rests its case against sex selection for non-medical reasons upon four claims. Firstly, sex selection is to be opposed because it identifies 'gender as a reason to value one person over another'. Secondly, it may 'contribute to a society's gender stereotyping and gender discrimination'. Thirdly, because it is 'unreasonable for indi-

viduals who do not otherwise need IVF to undertake its burdens and expense solely to select the gender of their offspring'. And fourthly, because it represents a 'misallocation of limited medical resources'.

Consider the first objection. The claim that couples requesting sex selection 'identify gender as a reason to value one person over another' is simply unsound. Couples seeking the service of Gender Clinics are typically in their mid-thirties, have two or three children of the same sex and wish to have at least one child of the opposite sex. Their choice for a child of a particular sex depends entirely upon the sex of the children they already have. If they already have two or three boys they tend to choose a girl, if they already have two or three girls they tend to choose a boy (Fugger *et al.*, 1998). Since their choice is simply based on the gender of already existing children, and not on the absurd assumption that one sex is 'superior' to another, the claim that these couples are making a sexist choice is an unjustified accusation.

The existing data of Gender Clinics also undermine the second objection of the Committee that sex selection for non-medical reasons may 'reinforce gender bias in a society'. Since couples seeking sex selection are almost exclusively motivated by the desire to balance their family and choose girls with the same frequency as boys, it is hard to see how their choices are supposed to contribute to a society's gender discrimination (Khatamee *et al.*, 1989; Liu and Rose, 1995). If these were real concerns, sex selection could be limited to balancing family sex, and only after the first child.

The third objection that it is 'unreasonable' for a woman to undergo a burdensome IVF treatment solely to select the sex of her child smacks suspiciously of medical paternalism. The Committee seems to be aware of this as it tones down its statement in the following sentence, saying that 'individuals may be free to accept such burdens'. Yet, it insists, 'to encourage preimplantation genetic diagnosis for sex selection when it is not medically indicated presents ethical problems.' What ethical problems does it present? Unfortunately, we are not told. More importantly, the issue is not whether preimplantation genetic diagnosis for sex selection is to be 'encouraged', but whether the mere fact that an IVF treatment cycle imposes a burden on a woman is a sufficient reason to 'discourage' her. If a woman is aware of the physical and psychological costs to herself but thinks having a child of a certain sex is worth the trouble, it is an autonomous decision that needs to be respected. After all it is her life and her body. The Committee seems blind to the importance of gender to parents, and that parents are best left to themselves to make decisions about the constitution of their family (Savulescu, 1999).

The Committee did not focus on the physical risks of preimplantation diagnosis to children born and these clearly need to be evaluated in any sex selection procedure (Benagiano and Bianchi 1999; Simpson and Carson, 1999). Experience so far is encouraging, with several hundred children being born after PGD without apparent detriment. Systematic review is continuing (ESHRE PGD Consortium Steering Committee, 1999).

The fourth and last objection of the Committee is that

preimplantation genetic diagnosis for sex selection constitutes 'inappropriate use and allocation of medical resources'. To our knowledge, no-one has so far seriously advocated that the state, i.e. the tax-payer, should subsidize sex selection for non-medical reasons. Again, the Committee seems to be aware of this when it continues: 'If an individual is able and willing to pay for desired services, there is no direct, easy way to show how any particular set of choices takes away from the right of others to basic care.' Nonetheless, it claims: 'Yet even here, individual and group decisions do have an impact on the overall deployment of resources for medical care and on the availability of reproductive services.' The Committee is relentless in its claim that allowing sex selection is a misallocation of resources, repeating itself at least four times on this issue. Since this objection seems to be the most compelling, it would have been helpful to show how a privately paid service for sex selection can possibly deprive the community of its scarce medical resources. If people are permitted to spend their own money on cosmetic surgery without being accused of violating 'the right of others to basic care', it is hard to see why couples willing to spend their own money on sex selection should be treated differently. Moreover, given the burdens, the expense and the low success rate of IVF, it is highly unlikely that preimplantation genetic diagnosis for sex selection will ever become so widespread as to have an 'impact on the overall deployment of resources for medical care and on the availability of reproductive services'.

Thus, when the Committee concludes that preimplantation genetic diagnosis for sex selection poses a 'risk of unwarranted gender bias, social harm, the diversion of medical resources from genuine medical need and should therefore be discouraged', it seems that the boldness of its statement is in conspicuous contrast to the weakness of its arguments.

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