

Opinion

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Sex selection 'approved' by the American Society for Reproductive Medicine (ASRM)¹

By Selena Ewing

Introduction

The acting head of the Ethics Committee for the ASRM, John Robertson² has said that it is sometimes ethically acceptable for couples to choose the sex of their children by selecting either male or female embryos and discarding the rest. These remarks, contained in a letter³, suggest a new ASRM position that is in conflict with earlier policy decisions.

The ASRM's position

Following an inquiry regarding the ASRM's position on PGD and sex selection by Dr Norbert Gleicher, chairman of the board of the Center for Human Reproduction (operating nine fertility clinics), Robertson prepared a letter of response. Robertson's letter was written after consultation with another committee member. He said he thought it reflected the group's position. The committee would have discussed the question at its September meeting, but it was cancelled due to the terrorist attacks in New York and Washington. The committee is expected to discuss the letter at its next meeting in January 2002.

The ASRM prepared a media release⁴ later to counter some media coverage of the situation. The media release seemed not to clarify the matter but to obscure it and paint it as a particularly difficult ethical issue. The media release stated that "obviously, individual members of the ASRM, and even the Ethics Committee and Board of Directors may have different views, which they are free to express", and suggested that people read the relevant reports by the Committee, which can be found at www.asrm.org/Media/Ethics/ethicsmain.html. But although not articulated as official policy, the Committee should have been aware of the immediate effect of this kind of informal advice. "We will offer it immediately. Frankly, we have a list of patients who asked for it," Gleicher stated⁵.

In Robertson's letter the acceptable use of the sex selection technique is explained by the term "gender variety" meaning a couple who already had a child of one sex could

¹ The American Society for Reproductive Medicine incorporates 8500 members, and includes affiliated societies such as the Society of Reproductive Surgeons, the Society for Reproductive Endocrinology and Infertility, the Society for Male Reproduction and Urology, and the Society for Assisted Reproductive Technology. Most US fertility clinics abide by the guidelines set down by this committee.

² Mr Robertson is an ethicist and lawyer at the University of Texas.

³ <http://www.nytimes.com/2001/09/28/health/genetics/28EMBR.html>, <http://www.msnbc.com/news/635415.asp?0si=-#BODY>

⁴ "ASRM Position on Gender Selection", ASRM Media Release October 1 2001. Statement by J B Younger, Executive Director.

⁵ <http://www.nytimes.com/2001/09/28/health/genetics/28EMBR.html>

ethically select embryos that would guarantee them that the embryo selected was of the opposite sex.

This is at odds with previous statements by the Committee. The official position in 1994 was that “whereas preimplantation sex selection is appropriate to avoid the birth of children with genetic disorders, it is not acceptable when used solely for nonmedical reasons”. However, it seems that the Committee’s *ethical* positions may change as technology changes: “Since 1994, the further development of less burdensome and invasive medical technologies for sex selection suggests a need to revisit the complex ethical questions involved”⁶. Hence a new report was written in 1999.

This report stated that selecting embryos solely to have a child of a particular sex “should be discouraged” because “the initiation of IVF with PGD solely for sex selection holds even greater risk of unwarranted gender bias, social harm and the diversion of medical resources from genuine medical need”.

In May 2001 another report was written, regarding *preconception methods of sex selection*. This stated the following⁷:

“If flow cytometry or other methods of preconception gender selection are found to be safe and effective, physicians should be free to offer preconception gender selection in clinical settings to couples who are seeking gender variety in their offspring if the couples (1) are fully informed of the risks of failure, (2) affirm that they will fully accept children of the opposite sex if the preconception gender selection fails, (3) are counseled about having unrealistic expectations about the behaviour of children of the preferred gender, and (4) are offered the opportunity to participate in research to track and access the safety, efficacy, and demographics of preconception gender selection. Practitioners offering assisted reproductive services are under no legal or ethical obligation to provide nonmedically indicated preconception methods of gender selection.”

Sex selection methods and justifications

Currently, methods available for prepregnancy and prebirth sex selection are:

- 1) *prefertilization separation* of X-bearing from Y-bearing spermatozoa, with subsequent selection for artificial insemination or for IVF
- 2) *preimplantation genetic diagnosis* (PGD) followed by the sex selection of embryos for transfer
- 3) *prenatal genetic diagnosis* followed by sex-selective abortion

The Committee says that “there is presently little debate over the ethical validity of PGD for sex selection when its aim is to prevent the transmission of sex-linked genetic disease”⁸.

⁶ “Sex selection and preimplantation genetic diagnosis”, ASRM Ethics Committee, *Fertility and Sterility* Vol 72, No 4, October 1999, pp595-598

⁷ “Preconception gender selection”, ASRM Ethics Committee, *Fertility and Sterility* Vol 75 No 5, May 2001, pp861-864

⁸ ASRM Ethics Committee, October 1999

The concerns identified by the ASRM *against* preconception gender selection are as follows⁹:

- a) the potential of such techniques to increase or reinforce gender discrimination
- b) concerns for the welfare of children born as a result, who may be expected to act in certain gender-specific ways
- c) creation of sex ratio imbalances

Arguments *for* preconception gender selection identified by the ASRM include:

- a) it serves the desires of couples who have strong preferences about the sex of their offspring
- b) couples might choose not to have another child unless they can be assured of “gender variety”
- c) couples might resort to postconception selection methods

The Committee concedes that these are “largely self-imposed” by parents, but suggests that in the end good is achieved because “if the child is born with the desired gender, the child presumably will be wanted and loved”¹⁰. They imply that Western preferences for gender are ethical in comparison with gender preferences in developing countries because parents might prefer a particular gender “without thinking that one gender is superior to another”¹¹.

The full text of reports can be found at: www.asrm.org/Media/Ethics/ethicsmain.html.

Ethical evaluation

How the ASRM sees it

The ASRM frequently uses the term “nonessential characteristics of offspring” in the context of embryo selection for implantation. They assume a difference between medical and non-medical sex selection¹². Medical sex selection is performed “with the goal of eliminating disease and suffering”. The ASRM believes that “there is presently little debate over the ethical validity of PGD for sex selection when its aim is to prevent the transmission of sex-linked genetic disease. In this case sex selection does not prefer one sex over the other for its own supposed value ... and when the genetic disorder is severe, efforts to prevent it can hardly be placed in a category of trivializing or instrumentalizing human reproduction”¹³.

They also assume a moral chasm exists between PGD and abortion, not merely because ‘pregnancy’ is defined as occurring at implantation, but also because PGD

⁹ ASRM Ethics Committee, May 2001

¹⁰ ASRM Ethics Committee, May 2001

¹¹ ASRM Ethics Committee May 2001

¹² ASRM calls for distinct medical and ethical assessment of four motivations for gaining sex information: (1) essential part of or by-product of PGD for medical reasons or (b) through a test for sex identification via PGD for medical reasons; (c) patient undergoing IVF as part of fertility treatment but PGD solely requested for purpose of sex selection, and (d) patient who is fertile requesting IVF and PGD purely for sex selection. ASRM Ethics Committee October 1999

¹³ ASRM Ethics Committee, October 1999

helps to reduce the incidence of eugenic abortions (considered bad by some) which is therefore a good thing.

The ASRM believes that these ethical issues must be addressed not only because they perceive ethics follow rather than guide technological change, but also because concerns about the use of such technology “inevitably encounter what has become a strong presumption in favor of reproductive choice”¹⁴. In other words, the policy positions which guide America’s fertility treatment industry are not based on any particular values, but are servant to technology and to the ideology of choice.

The ASRM vaguely suggests that there are limits to the strength of claims which appeal simply to ‘choice’ by saying that “the right to reproductive freedom has never been considered an absolute right, certainly not if it is extended to include every sort of decision about reproduction or every demand for positive support in individuals’ reproductive decisions”¹⁵. But it is certainly not in the interests of the ASRM to argue against reproductive choice, because it is the lifeblood of the entire IVF industry. In 1985, a survey of geneticists showed that they generally regard sex selection as a logical extension of parents’ acknowledged right to choose the number, timing, spacing and genetic health of children. So withholding any service, including sex selection, would be regarded as medical paternalism and an infringement on patient autonomy¹⁶.

The first mistake the ASRM makes is to distinguish between ‘medical’ and ‘nonmedical’ reasons for PGD. This distinction could be morally licit, “if prenatal diagnosis respects the life and integrity of the embryo and the human foetus and is directed towards its safeguarding or healing as an individual”¹⁷. But generally in the IVF industry, PGD is clearly meant to benefit the parents and certainly not any embryo with a disability.

The second mistake is their use of the word ‘prevention’ to justify elimination of ‘unhealthy embryos’. Based upon highly speculative and tendentious notions of human personhood as well as a biologically incorrect understanding of when human life begins, they are in fact eliminating *individuals* with disease, and disability, and perhaps other unwanted characteristics such as sex. The elimination of embryonic human beings with disease or disability is based on prior subjective judgments about individuals whose lives are not worthy to be lived, and about the way society values people with disabilities and disease.

PGD as ‘quality control’

When scientists become involved in human reproduction, the relationship between scientist and child becomes one of ‘producer’ to ‘product’. Because the producer has a responsibility to the consumer, an element of *quality control* is implicit, up to the point

¹⁴ ASRM Ethics Committee, October 1999

¹⁵ ASRM Ethics Committee, October 1999

¹⁶ Wertz and Fletcher, cited in the *Encyclopedia of Bioethics* (ed W T Reich) Simon & Schuster MacMillan, New York 1995, pg 2214

¹⁷ Sacred Congregation for the Doctrine of the Faith, *Donum Vitae* (Instruction on Respect for Human Life in its Origin and on the Dignity of Procreation), St Paul Publications, March 1987, I, n2

where it becomes considered 'unethical' to transfer a 'low-quality' embryo to the womb¹⁸.

So what constitutes quality? What are the essential elements and what are the non-essential elements, i.e. what are the minimum standards up to which the product must reach? The answer to this question is necessarily arbitrary, and depends on who has the ultimate power of decision-making. If it is accepted that parents have unlimited reproductive rights to the point where they can utilise any available technology by which to have a child with the characteristics they desire, then 'essential' becomes whatever the parents decide, and is highly reliant on cultural standards. For example, in China, "while people want both sons and daughters, sons are considered essential and daughters are not", and sex selection is therefore relatively common¹⁹.

At the minimum, it is considered in the IVF industry that an essential element is a *viable product*, or a healthy embryo. Unhealthy embryos are thus rejected and eliminated before implantation. This is said to be medically necessary to eliminate genetic disease and to prevent the birth of a disabled child.

Acceptance of the principle of quality control implies that there are some lives not worth living (referring to children) and that there are some burdens that no one ought to carry (referring to parents). This principle ultimately relies on the community's acceptance of abortion for disability. Where PGD is concerned, the elimination of disabled individuals occurs at a much earlier stage, a stage of a human being's life that has been defined as not morally significant. Public acceptance of PGD is intrinsically linked with that of eugenic abortion, which in turn is based on notions of 'reproductive choice', and 'lives not worth living', as well as the contemporary penchant for excluding from moral consideration all those human beings we are pleased to describe as "non-persons".

In any case, 'prenatal diagnosis' is available to most pregnant women in the Western world, together with elective abortion. So the continued acceptance of (a) reproductive choice ideology, and (b) the denial of the humanity of the embryo and foetus, suggests that sex selection will eventually be accepted either during pregnancy or before pregnancy has become established. The two, the 'right to choose' and the killing of the preborn embryo or foetus, cannot be separated. For example, in India since the introduction of sex selection technology, female foetuses in particular are commonly aborted, leading paradoxically to "demands by feminists and others that clinics should

¹⁸ "Ongoing pregnancies achieved by transfer of bad-quality embryos do not necessarily need to be considered high-risk pregnancies... nevertheless, a significantly higher percentage of malformations in newborns derived from heavily fragmented embryos requires consultation with the patient before the transfer of such embryos. On the basis of our data and considering the legal restrictions of preimplantation diagnosis in some countries, it may be recommendable to exclude bad-quality embryos from transfer. If the gynecologist has informed the patient about these problems and both have decided together to accept a higher risk of malformations, either amniocentesis should be considered or the intensity and frequency of ultrasound observations should be increased to minimize perinatal morbidity and mortality." Ebner *et al*, "Embryo fragmentation in vitro and its impact on treatment and pregnancy outcome", *Fertility and Sterility* Vol 76 No 2, August 2001, pp281-285

¹⁹ "Should One be Free to Choose the Sex of One's Child?", Dharma Kumar, in *Ethics, Reproduction and Genetic Control*, ed. Ruth F Chadwick, Routledge, London 1994 pg 176.

be banned, although many hold at the same time that there should be no restrictions on abortion itself.”²⁰

Conclusion

I am not a Catholic, but it is not difficult to see that deliberations in medical ethics benefit from being grounded in the consistent ethic of the Catholic Church which is steadfastly committed to the protection of all human life. By beginning at the ‘beginning’ – that is, with a principled acceptance of the value of life from fertilisation onward – one does not become tempted to reclassify as expendable the embryo or the foetus, or any other human being already in existence which stands in the way of desired and desirable social and personal goals. While Gleicher and Robinson may see ‘good’ in the happiness of successful IVF parents with healthy babies, they seem to see nothing but ‘evil’ in the ‘suffering’ of a child born with thalassaemia. But a child, healthy or not, is a good in himself or herself and should never be classified as a preventable ‘evil’.

If PGD is to be considered a medical intervention, then it must fulfill the following: “As with all medical interventions on patients, one must uphold as licit procedures carried out on the human embryo which respect the life and integrity of the embryo and do not involve disproportionate risks for it but are directed towards its healing, the improvement of its condition of health, or its individual survival”²¹.

Indeed, “interventions which are not directly curative, the purpose of which is the production of human beings selected contrary to the personal dignity of human beings, to their integrity, and to their identity. Therefore, they can in no way be justified on the pretext that they will produce some beneficial results for humanity in the future”²².

But in this case PGD does not fulfill this role. So the particular characteristics of embryos being discussed – whether they be sex, disease status, or eye colour – have little relevance. If the principles of reproductive ‘choice’, ‘medical necessity’ and ‘quality control’ have been accepted, then any characteristics of embryos being selected for implantation could eventually be subject to testing. The ASRM completely misses the point when it only considers social outcomes of sex selection such as gender bias, parental expectations and sex ratio imbalances.

²⁰ Dharma Kumar, 1994.

²¹ *Donum Vitae*, I, n3,

²² *Charter for Health Care Workers*, Pontifical Council for Pastoral Assistance to Health Care Workers, Vatican City 1995, pg 24