Gender Selection: Is There a European View?

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There is no European view on gender selection. Conclusions of the ESHRE Ethics Task force are reported.

KEY WORDS: Gender selection; Europe; ESHRE.

Since many centuries the ability to choose the sex of one's children has been desired by couples. Aristotle advised sexual intercourse in Northern wind to get a boy and in Southern wind to get a girl. Nearer in time, Millot (1), who was the obstetrician of Queen Marie Antoinette of France (1820), wrote: *it is the last movement of the woman that determines the sex of the child: it is the side on which she lies at the ejaculation time that drives to sex of the child: always a boy when she is on the wright side and always a girl on the left side...*

During the last decades many methods have been suggested claiming to be 70–85% successful:

- dietary methods,
- in vivo methods: timing essentially, and
- in vitro methods: sperm preparation mainly.

In France, after a publication by Stolkowski and Choukroun (2), the dietary method was the most popular for years.

They treated women desiring a boy with a specified diet and supplements designed to achieve a high concentration of potassium and sodium and a low magnesium and calcium concentration. The diet for couples desiring females was the reverse. The couples started the diet 1½ cycles before conception. Excluding one set of male/female twins, 39 of the 47 had the child of

their choice; 7 did not. The claimed success ratio, 84%, is noteworthy. However, there was no control group of couples not abiding by the prescribed menu, nor were assays of serum or cervical mucus electrolytes performed to verify that the recommended ionic concentrations were achieved. It provided an inexpensive method of sex preselection but very approximative and unverified.

Preferences for a male or female child and the need for sex selection vary among societies.

Although amniocentesis and chorionic villus sampling have not altered sex ratios in Western countries, the use of these procedures is associated with an altered sex ratio in China and India in favor of male children. Sex selection offers the possibility of avoiding female infanticide and midtrimester abortions.

A London gender clinic published in 1996 the social characteristics of 902 couples attending a sex preselection clinic. The ethnic origins were Asian Indians 56.4%, European 32.8%, Chinese 3.7%, and others 6.4%. More Europeans expressed that they would have had a baby regardless of whether sex selection was possible. This shows that in Europe, gender selection is more an ethical individual concern than a social need. The Council of Europe (1996) in Article 14 of the Convention on Human Rights and Biomedicine expresses: *The use of medically assisted procreation shall not be allowed for the purpose of choosing a future child's sex, except where serious hereditary sex related disease is to be avoided.*

The European Society of Human Reproduction and Embryology established an Ethics Task

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Force including F. Shenfield, G. Pennings, P. Devroey, C. Sureau, B. Tarlatzis, and Jean Cohen. A meeting in September 2001 concerned preimplantation genetic diagnosis and has its provisory conclusions:

Regarding the issue of sex selection for non-medical reasons by means of PGD, the Task Force has not been able to reach a unanimous decision. Two positions can be distinguished: those opposed to every application of sexing for non-medical reasons and those who accept sex selection for family balancing.

POSITION 1: SEX SELECTION AND HUMAN RIGHTS

For some sex selection for nonmedical reasons is intrinsically sexist. Sex selection for social reasons is seen as an issue of human rights which entails nondiscrimination on grounds of sex (as well as religion or phenotype), enshrined in both the Universal Declaration of Human Rights of 1948 and the European Convention of Human Rights of 1950.

It may also be asked whether making it acceptable to select one sex in preference to another, at the moment of conception of by PGD, will make it easier or harder to promote antidiscriminatory measures in other areas of life, at a time when worldwide discrimination, usually against women, is still very widespread. Moreover, PGD is a method used to prevent disease or suffering and to be of the "wrong" gender in the eyes of one's family, whether male or female, cannot be defined as a disease. The possible compromise of family balancing is still regarded as inherently sexist.

Finally, it is felt that children would benefit to be born in a society in which acceptance rather than rejection of any difference (phenotype, gender, or disabilities) is the norm to the extent that the projection offered by Human Rights has become redundant. However, there is no evidence as yet that this ideal is within reach.

POSITION 2: SEX SELECTION FOR FAMILY BALANCING

The wish to increase autonomy, while avoiding conflicts with other ethical principles, leads to the position that sexing for nonmedical reasons is only allowed to

balance the family. No selection is allowed for the first child or when there are an equal number of both sexes. The application of the technology for family balancing is not considered as good but as morally acceptable. Consequently, sexing for this reason should be permitted.

The restriction of sex selection to applications for family balancing gives parents more control of the composition of their family and simultaneously avoids the potential disasters (like a skewed sex ratio in society) caused by the unrestricted application of sex selection.

However, the application should not jeopardize other generally accepted moral principles such as the principle of justice (as expressed in the equality of the sexes) and the principle of respect for the autonomy of the future person. The application for family balancing differs from the unrestricted application because the parents do not and cannot choose a child of a certain sex but choose a child of the other sex. This choice does not express a hierarchy or an inequality between the sexes and thus cannot be considered as intrinsically sexist. Parents who wish to have children of both sexes believe that the upbringing of boys can be different from the upbringing of girls and that the parent-child relationships may differ according to the sex of the child.

The parental choice does not endanger the autonomy of the future child. If the autonomy of the child is not threatened by being born as a girl (or a boy), then this principle is not infringed when the girl (or boy) is born as a result of parental choice. Moreover, the parents do not choose the sex of a future child but a future child of the other sex.

Similar to the decision making concerning other matters in reproduction, the decision about the technique to be used should be discussed between fertility specialist and patient. The preference for a specific method will be influenced by the reproductive history of the patient.

Depending on a number of characteristics like age of the mother, desired family size, and strength of the desire for the other sex, patients may opt for a more reliable method rather than for a less reliable but cheaper and less invasive method. The technique should be safe and performed according to the rules of good clinical practice. The application should be supported by psychological counselling to inform the parents of the different aspects of the treatment. This implies for PGD a thorough discussion of all possible scenarios, including the

possibility of not having embryos of the desired sex, not getting pregnant and misdiagnosis. The need to rely on PGD for nonmedical sexing will decrease if other methods reach a comparable level of reliability without the costs and efforts connected to this method.

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