The Sex Selection Debate: A Comparative Study of Sex Selection Laws in the United States and the United Kingdom

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INTRODUCTION

Sex selection, also commonly known as gender selection, refers to the use of reproductive technologies for the deliberate and unnatural selection of a fetus’s gender, which can occur before or after conception. Couples use sex selection for a variety of medical and nonmedical reasons. For example, a couple may use sex selection to have a daughter if they already have a few sons or they may choose to have a daughter if there is a family history of a hereditary disease linked to the male gene. Though historically more common in certain countries, the moral, ethical, and legal implications of sex selection have placed the practice at the center of a global debate for centuries. As of 2009, thirty-six nations from Europe, Asia, North America, and the Oceanic Islands had passed laws pertaining directly to the topic of sex selection, with five of the countries explicitly prohibiting it under any circumstances, thirty-one countries explicitly prohibiting it for ‘nonmedical’ reasons, and no countries explicitly permitting it.1

Currently, sex selection is

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1 Memorandum from Marcy Darnovsky, Ctr. for Genetics & Soc’y on Countries with Laws or Policies on Sex Selection to the N.Y.C. Sex Selection Meeting 1 (Apr. 2009), available at http://geneticsandsociety.org/downloads/200904_sex_selection_memo.pdf. The five countries explicitly prohibiting sex selection for any reason are Austria, New Zealand, South Korea, Switzerland, and Vietnam. Id. at 2. The thirty-one countries prohibiting non-medical sex selection are Australia, Belgium, Bosnia & Herzegovina, Bulgaria, Canada, China, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, India, Israel, Italy, Latvia, Lithuania, Netherlands, Norway, Portugal, Russia, San Marino, Singapore, Spain, Turkey, and the United Kingdom. Id. See also infra Part III.B.1 for an analysis of the implied effects of current U.S. law.
impliedly permitted in the United States for both medical and nonmedical reasons,² while the United Kingdom explicitly prohibits sex selection for nonmedical reasons.³

As modern society practices sex selection for both medical and nonmedical reasons, the customary methods of infanticide and abortion have been joined by newly-developed scientific procedures and innovative reproductive technologies.⁴ From an ethical and moral perspective, most societies seem to accept the use of sex selection for medical reasons, while opposing its use for nonmedical reasons.⁵ Such medical reasons typically include preventing a child from inheriting a genetic disorder or a disease, such as hemophilia or muscular dystrophy when those disorders have been linked to sex.⁶ On the other hand, nonmedical, or “social,” reasons for sex selection have included “family balancing,” family rebuilding,⁷ or simply a general preference for a child of one sex over the other.⁸ Most of the controversy surrounding sex selection relates to these nonmedical

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³ Human Fertilisation and Embryology Act, 1990, 37, §§ 3-4, sch. 2 (Eng.) (providing some allowances for certain methods of sex selection subject to regulatory licensing requirements); see, e.g., supra note 1, at 6–7.
⁵ See, e.g., Julian Savulescu & Edgar Dahl, Sex Selection & Preimplantation Diagnosis: A Response to the Ethics Committee of the American Society of Reproductive Medicine, 15(9) HUMAN REPROD. 1879 (2000).
⁶ SEX SELECTION, supra note 4, at 1; see also Ashley Bumgarner, Note, A Right to Choose?: Sex Selection in the International Context, 14 DUKE J. GENDER L. & POL’Y 1289, 1291 (May 2007).
⁷ An example of family balancing is when a couple already has multiple sons and desires to have a daughter. An example of family rebuilding is when a couple’s daughter dies and it wishes to make their family whole again by having another daughter.
⁸ SEX SELECTION, supra note 4, at 1.
reasons, as evidenced by the distinction between laws and regulations in the United States and the United Kingdom.

Many international organizations have weighed in on the topic of sex selection, generally advocating for women’s rights and access to reproductive technologies while condemning gender discrimination and violence against women. In terms of sex selection, the World Health Organization (WHO) has expressed concern for the underlying gender biases embedded in certain cultures rather than the reproductive technology itself. The WHO has stated that “[r]estricting access to certain reproductive technologies . . . to prevent an imbalanced [sex] ratio in a . . . society should not” infringe upon the “human rights of women.” The WHO’s reasoning is that it is not technology, but rather the “social, cultural, political and economic” causes of gender biases within the society that are at the heart of the sex selection problem. Further, the WHO asserts that restrictions on the use of reproductive technology are acceptable as long as they “[p]romote responsible use;” “[a]void reinforcing gender discrimination;” “[a]void reinforcing [economic, social, and geographic] inequities;” and “[e]nsure women’s access to safe abortion and other [reproductive] services.”

According to the United Nations (UN), restrictions on sex selection practices can lead to negative consequences for women in countries with a strong preference for sons, including violence against women and forced sex-selective infanticide. The UN’s Special Rapporteur on Violence against Women defines forced sex

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9 WORLD HEALTH ORG., PREVENTING GENDER-BIASED SEX SELECTION: AN INTERAGENCY STATEMENT: OHCHR, UNFPA, UNICEF, UN WOMEN AND WHO 4, 10 (2011) [hereinafter WHO].
10 Id. at 4.
11 Id. at 4, 10.
12 Id. at 10.
selection as a form of violence against women and asserts that the only solution is to challenge established gender roles in countries with a preference for male offspring. Similarly, the Center for Reproductive Rights (CRR) takes a “rights-based approach” to sex selection. The CRR expresses its outrage over the practices of sex selection and sex-selective abortion, but argues that an outright prohibition could lead to more unsafe reproductive practices and violence against women in countries with a clear preference for sons.

For its part, the Council of Europe has taken a distinctly stricter approach to sex selection. Twenty-eight of the forty-seven members of the Council of Europe (CoE) and sixteen of the twenty-seven members of the European Union (EU) have ratified the Convention of Human Rights and Biomedicine (CHRB), which reflects a far more cautious attitude toward sex selection than that of groups like the WHO, UN, and CRR. Article 14 of the CHRB asserts that sex selection should only be permitted for medical reasons in cases where a “serious hereditary sex-related disease” is at issue. The CoE has also tasked the Working Party on the Protection of the Human Embryo and Foetus (Working Party) with drafting reports

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16 Id.

17 Convention on Human Rights and Biomedicine pmbl., Apr. 4, 1997, C.E.T.S. No. 164. Note that the U.K. is not a signatory to this Convention. Id.

18 “The use of techniques 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.” Id., ch. IV, art. 14; see also COUNCIL OF EUR., Human Embryo & Foetus (2012), http://www.coe.int/t/dg3/healthbioethic/Activities/04_Human_embryo_and_foetus_en/default_en.asp.
pertaining to “the protection of the human embryo in vitro.” In this capacity, the Working Party has produced studies on ethical concerns as well as the biological effects on the embryo related to reproductive technologies that assist in procreation. It seems clear that many European governments are willing to commit to greater restrictions on sex selection than those advocated by leading organizations in the global community.

This note will seek to increase the reader’s awareness of the issues surrounding sex selection and will forecast the future of sex-selection laws in the United States by means of a comparative law analysis. Part I will establish the historical background of sex selection through a discussion of its use in ancient China and India to fulfill a widespread cultural preference for sons, as well as its continuing influence in those cultures today. Part II will examine sex-selection techniques that have become available as a result of modern advances in reproductive technologies, and will discuss the concerns and moral dilemmas that have emerged along with them. Part III will compare sex-selection laws in the United Kingdom and the United States, as well as the respective public opinion of each regarding sex selection and the techniques employed. As there is currently no federal law explicitly pertaining to sex selection in the U.S., the discussion will focus on its relevant case law and proposed legislation. Alternatively, the analysis of U.K. law will focus on the specific legislation that lays out its legal framework for regulating sex selection. Finally, Part IV will discuss possibilities for the future of sex-selection law in the United States. It will consider whether it would be feasible for the U.S. to establish a legal framework similar that of the U.K. in light of current U.S. case law and reproductive rights. In conclusion, Part IV will recommend a legal course of action for the U.S. in terms of its use of reproductive technologies for sex selection as well as other genetic characteristics.

I. THE TRADITIONAL PRACTICE OF SEX SELECTION

Throughout history, societies have striven “to control the sex of offspring” because of their underlying cultural beliefs, particularly

19 Id.
20 Id.
in societies with a cultural, social, economic, and legal preference for males. While early methods of sex selection were either “biologic” or “symbolic,” modern methods of sex selection primarily involve the use of reproductive technologies. Countries like China and India that have exhibited a historical cultural preference for sons, often along with a propensity for violence against women, infanticide, and sex-selective abortion, are now seeing an increase in the use of the modern reproductive technologies for the purpose of sex selection.

A. CHINA

China represents the quintessential example of a culture that historically places more worth on sons than daughters. While sons have traditionally supported their parents in their old age and eventually inherited the family property after they died, daughters stayed with their families until they married and eventually shared in their husband’s inheritance. As a result of making males more essential to the survival of the family unit, cultural attitudes allowed for sex selective abortion as well as the practices of female infanticide through drowning, starvation, and poisoning.

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22 See, e.g., Bumgarner, supra note 6, at 1295.
23 “Biologic” methods involved techniques such as manipulating the female’s diet prior to sexual intercourse and changing sexual positions during intercourse. Jones, supra note 21, at 4–5. “Symbolic” methods involved the use of superstitious techniques such as placing certain good luck charms near the bed to encourage the creation of a male or a female during intercourse. Id. See also Naryung Kim, Breaking Free From Patriarchy: A Comparative Study of Sex Selection Abortions in Korea and the U.S., 17 UCLA PAC. BASIN L.J. 301, 302 (Fall 1999/Spring 2000).
24 Timothy R. Loveland, Sex-Selective Abortion Law in China & Corresponding Conception in the U.S., 21 ANNALS HEALTH L. ADV. DIR. 173, 173 (2012); see, e.g., Bumgarner, supra note 6, at 1294; see infra Part II for a discussion on modern reproductive technologies.
25 “In Chinese society, human life evolves through stages of worthiness based not only on age and ability, but also on gender and class.” Loveland, supra note 24, at 179 (citing Susan M. Rigdon, Abortion Law & Practice in China: An Overview with Comparisons to the U.S., 42 SOC. SCI. MED. 543, 544 (1996)).
26 Id. at 180; see also Frank van Balen & Marcia C. Inhorn, Son Preference, Sex Selection & the “New” New Reproductive Technologies, 33(2) INT’L J. HEALTH SERV. 235, 238 (2003).
27 Loveland, supra note 24, at 180–81; van Balen & Inhorn, supra note 26, at 238.
Consequently, laws regulating abortion and protecting pregnant women from violence date back to as early as the Qing and Tang Dynasties.28

While China’s male-to-female ratio has been historically high compared to the rest of the world, the male majority has continued to increase despite years of laws, regulations, and policies aimed at easing the disparity.29 Toward the end of the 20th century, China’s male-to-female birth ratio was 106 males to every 100 females.30 By 2009, this number had increased to 121 males for every 100 females.31

One explanation for this increase in the male majority is the astounding number of girls that go missing in China every year. The United Nations Population Fund (UNFPA) estimated the “total number of missing girls”32 to be “163 million in Asia alone” in 2005.33 In today’s China, the nation’s One-Child Policy exacerbates the continuing effects of a deep-rooted cultural preference for males,34 and pressure is greater than ever on expectant mothers to

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28 The Qing Dynasty lasted from 1644 to 1911 A.D., and the Tang Dynasty lasted from 618 to 906 A.D. Loveland, supra note 24 at 179–80.
29 See Loveland, supra note 24, at 174; see also van Balen & Inhorn, supra note 25, at 238.
30 Van Balen & Inhorn, supra note 26, at 238.
31 Loveland, supra note 24, at 174.
32 The term “missing girls” refers to girls that have not been born or that have been killed via abortion or infanticide as a result of the widespread use of sex-selective practices. Amartya Sen, Missing Women – Revisited: Reduction in Female Mortality has been Counterbalanced by Sex Selective Abortions, 327 BRIT. MED. J. 1297, 1297 (Dec. 6, 2003), available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC286281/.
33 Loveland, supra note 24, at 174 (citing MARA HVISTENDAHL, UNNATURAL SELECTION: CHOOSING BOYS OVER GIRLS AND THE CONSEQUENCES IN A WORLD OF MEN 6 (2011)); see also Sen, supra note 32, at 1297; van Balen & Inhorn, supra note 26, at 238.
34 China’s One-Child Policy is a forced birth control policy that came about in 1980 when the nation’s leaders determined “that forcibly restricting population growth would” benefit the Chinese economy following a period of food shortage and famine during a national voluntary birth control campaign. Generally, the One-Child Policy mandates that families have no more than one child each. Families are also required to have a birth permit when a child is born, and will be heavily fined if they do not. History of the One-Child Policy, ALL GIRLS ALLOWED, http://www.allgirlsallowed.org/one-child-policy (last visited Feb. 8, 2014).
produce a son. Unfortunately, this dynamic often results in violence against the mother including banishment from the family, increased health risks from repeated pregnancies, and in more extreme cases, murder, suicide, and bride trafficking.

The Chinese government has responded to such violence against women by implementing several protective laws over the past few decades. For example, the Marriage Law of 1980 prohibits any act that causes harm or death to infants, and the Law on the Protection of Rights and Interests of Women of 1992 allows women “to inherit property, obtain fair labor wages, [gain] equal status in family matters,” and receive an education equal to that of men, and prohibits violence against women bearing daughters. Furthermore, as modern reproductive technologies have become available throughout China, the Law on Maternal and Infant Health Care of 1994 “prohibits the use of medical technologies such as ultrasound . . . to identify the gender of the fetus” in order to prevent Chinese women (and their husbands) from detecting the sex of their prenatal child and

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35 Loveland, supra note 24, at 175; see also Bumgarner, supra note 6, at 1297.
36 See Bumgarner, supra note 6, at 1297–98, 1301; WHO, supra note 9, at v, 5–6.
39 Loveland, supra note 24, at 182.
41 Loveland, supra note 24, at 182; see WHO, supra note 9, at v; see also van Balen & Inhorn, supra note 26, at 239. See generally Law on Maternal & Infant Health Care, supra note 40.
aborting the pregnancy before it is born.\textsuperscript{42} Though sex-selective abortions have been more prevalent in China’s urban centers due to their affordability and accessibility in the cities, evidence suggests that sex-detecting technologies are nonetheless making their way into rural areas and producing similar results.\textsuperscript{43}

The battle against sex selection hinges on changing Chinese culture, and despite government implementation of laws banning and criminalizing sex-selective practices, China has a long way to go.\textsuperscript{44} First, while the anti-sex-selection laws represent a step forward, the government has been lax in enforcing them.\textsuperscript{45} Part of the problem is that enforcement can be problematic due to the difficulty of proving that violators are using ultrasound technology specifically for abortion or prenatal sex-determination rather than some other legitimate medical reason.\textsuperscript{46} Second, in attempting to combat discrimination against females, China has sought to emphasize the value of women by “broadcasting positive messages about girls, [giving] incentives to the parents of daughters, [distributing] housing and pension payments for rural parents with daughters,” and “… [encouraging] matrilineal marriages.”\textsuperscript{47} On the other hand, because many Chinese couples still feel the traditional societal pressure to bear a son, China’s One-Child Policy\textsuperscript{48} indirectly reinforces the preference for males in spite of laws protecting infants and women. Ultimately, the key to overcoming China’s cultural preference for

\textsuperscript{42} See WHO, supra note 9, at 181.
\textsuperscript{43} See WHO, supra note 9, at 2; see also van Balen & Inhorn, supra note 26, at 239.
\textsuperscript{44} See WHO, supra note 9, at 7; see also Loveland, supra note 24, at 184.
\textsuperscript{45} Bumgarner, supra note 6, at 1304; see also Loveland, supra note 24, at 184–85.
\textsuperscript{46} WHO, supra note 9, at 6.
\textsuperscript{47} See WHO, supra note 9, at 13. “Matrilineal” means that property is inherited through the female line of the family, while “patrilineal” means that property “is inherited through the male line” of the family. Id., at 7.
males will be a continued effort to attack the idea that males are more valuable than females.

B. India

Like China, India has a long tradition of favoring sons over daughters. The increasing disparity in its male-to-female ratio “reflect[s] a preference for boys as a result of deeply embedded social, cultural, political, and economic factors.” By India’s history demonstrates its preference for sons from the ancient Hindu scriptures to modern population censuses. India’s principal religion, Hinduism, teaches that life passes through the male as men recreate themselves through the agency of their sons. Furthermore, sons play an important role in the Hindu “notions of self-worth, fruitfulness and salvation” through their sacrificial duties, which “serve to liberate [their souls] and free [them] from the unending burdens of life.”

49 WHO, supra note 9, at 1.
50 See van Balen & Inhorn, supra note 26, at 237.
51 Id. (citing Aditya Bharadwaj, Why Adoption is not an Option in India: The Visibility of Infertility, the Secrecy of Donor Insemination & Other Cultural Complexities, 56(9) SOC. SCI. MED. 1867 (2003)). Hinduism teaches that man progresses through life in four stages: ashrama, grihastha dharma, vanaprastha, and sannyasa. During the first stage, the man acts as a student, devoting his time to “learning” scriptures, philosophy, science and logic” under the guidance of his guru in addition to learning to live in accordance with “a strict code of conduct.” Around age 20, the man enters the second stage of life, in which he returns home start and provide for his wife and children and support his parents while performing daily religious duties. When the man reaches his fifties and has grandchildren, he enters the third stage of life, transferring his duties as the head of the family over to his son and devotes himself to God in preparation for the fourth stage of life. By the time the man enters the fourth and final stage, his wife is under the care of their children, and the man devotes himself completely to the scriptures and meditation until he dies. In this manner, the Indian man teaches his son to fill his role, and then lets his son take that role so that he may devote the final stage of his life to religious practices. Satguru Bodhinatha Veylanswami, Advancing Through Life’s Four Stages, HINDUISM TODAY (last visited Nov. 14, 2013), http://www.hinduismtoday.com/modules/smartsection/item.php?itemid=5333.

52 Hindu sacrificial duties refer to duties to honor ancestors. This practice usually involves offering prayers for those who have passed. See van Balen & Inhorn, supra note 26, at 237.
cycles of birth and death." As in China, sons in India cared for their parents in their old age, families traditionally passed property to the son upon the parents’ death, and daughters were considered “temporary visitors” because they were only joined to their husband’s family through marriage. Moreover, daughters were considered an economic burden due to the practice of a bride’s family paying a dowry to the groom’s family upon marriage. Over the years, these societal and economic pressures have compelled many Indian women to betray their maternal instincts by engaging in infanticide and sex-selective abortion.

The availability of ultrasound technology has led to an even more pronounced disparity in India’s male-to-female ratio. In 2001, the Indian state of Haryana had a sex ratio of 861 females per 1000 males. In 2011, the sex ratio was 879 females per 1000 males, which was still below India’s national average sex ratio of 940 females per 1000 males despite the slight improvement. Like China, India has also taken legal measures in an attempt to combat the availability and use of ultrasound and other new reproductive technologies for sex-selection purposes. For example, the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act of 1994 prohibits “doctors, clinics, and all other persons from using prenatal diagnostic techniques, including ultrasound, to determine the sex of a fetus.” However, the Act allows use of such technology if

53 Id.
54 Id. at 238.
55 Id.; see also Bumgarner, supra note 6, at 1307.
56 See van Balen & Inhorn, supra note 26, at 238.
57 See WHO, supra note 9, at 1; see also Stranger, supra note 4, at 18.
61 Bumgarner, supra note 6, at 1302.
there is a medical need independent of sex determination. In 2003, the Act was amended to include portable ultrasound machines, which were being installed in automobiles so that people living in rural areas could have access to the technology.

Nevertheless, merely restricting access to reproductive technology does not go to the heart of the issue. The preference for males in India results from a deep-seated cultural attitude about females, and the only way to effectively combat this discrimination is to change the Indian people’s perception. In a step toward changing this paradigm, the Indian government passed the Hindu Succession Act of 2004 which allowed “daughters to inherit family property almost on par with sons” thereby making matrilineal succession possible for families with only daughters. In 2007, the Maintenance and Welfare of Parents and Senior Citizens Act recognized a woman’s right of inheritance in families with both daughters and sons by requiring that “both sons and daughters” care for their elderly parents “in proportion to the share of property” they would inherit. Such legal measures strike at the heart of male-to-female inequality at the familial level, and will play an important role in the coming years as modern reproductive technologies only make it easier to accomplish sex selection in India.

II. MODERN TECHNIQUES OF SEX SELECTION

While traditional methods of sex selection, such as abortion and infanticide, remain in use today, advancements in reproductive

62 Id.
63 See id. at 1303 (estimating mobile ultrasound machines comprise a $100 million business in India).
64 WHO, supra note 9, at 7.
66 WHO, supra note 9, at 7.
68 WHO, supra note 9, at 7.
69 In addition to infanticide, abortion, and the use of reproductive technology, there are also some supposed natural methods of sex selection including, but not limited to, using certain sexual positions and eating certain foods. Jones, supra note 21, at 4–6.
technology have allowed for the development of new techniques that do not involve killing the fetus or embryo. Modern sex selection methods fall under two basic categories: prenatal and pre-implantation.

Prenatal procedures occur post-conception, that is, after the fetus is already in the mother’s uterus, allowing parents to determine the sex of their fetus and accordingly terminate the pregnancy by abortion if they choose to do so. The most commonly used prenatal procedures include ultrasound, amniocentesis, chorionic villus sampling (CVS), and maternal blood tests. Ultrasound technology, the least invasive of the four methods, involves “direct[ing] a high-frequency sound source at the fetus” to produce a black and white image of the fetus from which a physician can determine the sex. By comparison, amniocentesis is a far more invasive procedure. In order to determine the sex, the doctor withdraws some “of the amniotic fluid . . . surround[ing] the fetus within the amniotic sac” and analyzes the genetic material of the cells. CVS is a similar method, except that the physician uses a sample of the placenta to determine the sex of the fetus. Finally, in maternal blood testing, the doctor screens a sample of the mother’s blood for certain sex-determinative genetic markers.


71 Bumgarner, supra note 6, at 1291; Jones, supra note 21, at 7–10.

72 Jones, supra note 21, at 7.

73 Bumgarner, supra note 6, at 1291–92; Jones, supra note 21, at 7.

74 Bumgarner, supra note 6, at 1292.

75 The black and white image is produced as a result of the echoes from the high-frequency sound varying with the density of the fetus. Jones, supra note 21, at 7.

76 Id.

77 Bumgarner, supra note 6, at 1292.

78 Jones, supra note 21, at 7. “This method is the most prevalent internationally.” Id. at 8.

79 Bumgarner, supra note 6, at 1292.

80 Id.; van Balen & Inhorn, supra note 26, at 236.
In contrast to prenatal methods, pre-implantation procedures are implemented prior to conception, that is, before the fetus is even in the mother’s uterus, in order to “facilitate conception” of a fetus with a predetermined sex. The most commonly used pre-conception procedures are sperm sorting, pre-implantation genetic diagnosis (PGD), and in vitro fertilization (IVF). Sperm sorting involves the use of “a laser beam to detect fluorescent-dyed chromosomes within individual sperm.” While a sperm contains either an X or Y chromosome, X chromosomes contain 2.8% more DNA than Y chromosomes and consequently appear brighter under the laser after the sperm is dyed with fluorescents. Once the sperm are identified as either X or Y, an automated sorting machine yields a sample containing primarily those sperm of the sex that the potential parents desire. Finally, the sperm and egg are joined together by IVF, artificial insemination, or intrauterine insemination.

In comparison to sperm sorting, a PGD is far more reliable. In addition to its use for sex selection, PGD is commonly utilized to screen for genetic disorders. During this procedure, the doctor

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81 Bumgarner, supra note 6, at 1291; Jones, supra note 21, at 8.
82 Van Balen & Inhorn, supra note 26, at 235.
83 Bumgarner, supra note 6, at 1293; J.A. Robertson, Extending Preimplantation Genetic Diagnosis: Medical and Non-Medical Uses, 29 J. MED. ETHICS 213 (2003).
84 Bumgarner, supra note 6, at 1293. The method of sperm sorting by use of a laser beam to detect the brightness of fluorescent dye was developed in 1995 and is known as the Microsort method. Microsort is the most commonly used method of sperm sorting today. SEX SELECTION, supra note 4, at 2. Its predecessor, the Ericsson technique, developed in the 1970s and involved the separation of sperm based on “their swimming ability.” Id.
85 SEX SELECTION, supra note 4, at 1.
86 Bumgarner, supra note 6, at 1293; SEX SELECTION, supra note 4, at 2.
87 Bumgarner, supra note 6, at 1293; SEX SELECTION, supra note 4, at 1.
88 Bumgarner, supra note 6, at 1293. Intrauterine insemination is “a form of artificial insemination where the sperm are introduced directly into the woman’s womb.” Artificial insemination is a more cost-friendly option for many couples as opposed to IVF, and it more closely resembles natural conception more because “fertilization . . . occur[s] naturally inside the woman’s body.” Id. With IVF, the sperm sample would be used to create an embryo that would be inserted into the woman. SEX SELECTION, supra note 4, at 2.
89 Bumgarner, supra note 6, at 1294.
90 Id.
removes one cell from each embryo in order to analyze their chromosomes and DNA. After identifying which embryos contain the preferred genetic characteristics, the doctor implants only those embryos into the woman’s uterus.

While PGD is more reliable than sperm sorting, it is also more expensive and often requires multiple attempts costing roughly $15,000 apiece. Furthermore, the use of IVF for either sperm sorting or PGD poses health risks to the mother including “ovarian hyper-stimulation syndrome [and] dangerous multiple births.” Especially because of these cost considerations and health dangers, modern reproductive technologies for both prenatal and pre-implantation sex selection remain at the heart of the sex selection debate in many countries today.

III. SEX SELECTION IN THE UNITED KINGDOM AND THE UNITED STATES

The debate over sex selection is not limited to countries that have traditionally exhibited a preference for males. On the contrary, sex selection has spurred much legal, moral, and ethical debate throughout the world in recent years. In the United Kingdom and the United States, surveys and polls demonstrate that socially, the two nations host a similar variety of opinions on sex selection. On the other hand, an examination of existing case law and legislation regarding sex selection in both nations reveals that legally, they have approached the issue in vastly different ways, which has led to vastly different reactions and consequences.

A. UNITED KINGDOM

1. EXISTING LEGAL FRAMEWORK FOR SEX SELECTION IN THE U.K.

First and foremost, sex-selection law in the United Kingdom differs from the United States in that the British government has chosen to regulate many aspects of sex selection and to prohibit it for

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91 Bumgarner, supra note 6, at 1294; SEX SELECTION, supra note 4, at 2.
92 Bumgarner, supra note 6, at 1294; SEX SELECTION, supra note 4, at 2.
93 Id.
94 Id.
95 SEX SELECTION, supra note 4, at 3–4.
nonmedical reasons. The Human Fertilisation and Embryology Act (HFE Act) of 1990\textsuperscript{96} requires that anyone creating, keeping, or using an embryo have a medical license.\textsuperscript{97} It also establishes the Human Fertilisation and Embryology Authority (HFEA)\textsuperscript{98} for the purpose of reviewing information about embryos and treatments covered by the HFE Act and advising the Secretary of State about such matters.\textsuperscript{99} In addition, the HFEA is responsible for issuing the HFEA Code of Practice (HFEA Code) to “secure the safety or efficacy of particular clinical or scientific practices . . . [raising] fundamental ethical and social questions,” such as sex selection.\textsuperscript{100} The introduction to the HFEA Code provides that:

[The HFEA] was established in response to deep public concern about the implications which new techniques for assisted reproduction might have for the perception and valuing of human life and family relationships. The Authority’s principal task is to regulate, by means of a system of licensing, audit and inspection, any research or treatment which involves the creation, keeping and use of human embryos outside the body, or the storage or donation of human eggs and sperm.\textsuperscript{101}

Under the HFE Act, licenses may only be granted for treatment services,\textsuperscript{102} nonmedical fertility services,\textsuperscript{103} storage,\textsuperscript{104} and research,\textsuperscript{105} and an activity for which a license is required can only be performed at the location named in the license or “under the supervision of an individual designated in the license.”\textsuperscript{106} Treatment centers in the U.K. cannot offer or use reproductive technologies to

\textsuperscript{96}Human Fertilisation and Embryology Act (HFE Act), 1990, 37 (U.K.) (amended 2008).
\textsuperscript{97}Id. § 3(1)(a)–(b).
\textsuperscript{98}Id. § 5(1).
\textsuperscript{99}Id. § 8(a).
\textsuperscript{100}HFEA, CODE OF PRACTICE, pt. 8, § 8.9(i)–(ii)(6th ed. 2003) [hereinafter HFEA CODE].
\textsuperscript{101}Id., Introduction, at 9.
\textsuperscript{102}HFE Act, supra note 96, sch. 2, § 1.
\textsuperscript{103}Id. sch. 2, § 1A. Non-medical fertility services include procuring and distributing sperm. Id. sch. 2, § 1A(1)(a)–(b).
\textsuperscript{104}Id. sch. 2, § 2.
\textsuperscript{105}Id. sch. 2, § 3.
\textsuperscript{106}Id. sch. 2, § 4(1)(a)–(b).
perform sex selection for social or nonmedical reasons, and only clinics licensed by the HFEA can perform sex selection for medical reasons. The HFEA Code also prohibits treatment centers from “select[ing] the sex of embryos for social reasons or . . . attempt[ing] to produce embryos in vitro” by splitting the embryo.

When it became clear in 2002 that many British citizens were using new reproductive technologies to select the sex of their children for nonmedical reasons, the government tasked the HFEA with conducting a “review of sex selection” techniques, including their safety and reliability, as well as “arrangements for their regulation.” In the course of its review, the HFEA employed qualitative and quantitative research methods to “investigate how individual members of the public approach and grapple with the complex issues surrounding sex selection.” In its final report, the HFEA recommended that: (1) abortion remain legal only for medical reasons under the Abortion Act of 1967; (2) PGD be permitted only for medical reasons by a clinic and physician that meets the licensing requirements under the HFE Act; and (3) the HFE Act only allow sperm sorting when used in furtherance of IVF treatments.

In justifying its recommendations, the HFEA first asserted that IVF and PGD are extremely technical and risky procedures that should only be used “where there is a genuine health benefit to

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107 HFEA Report, supra note 70, ¶ 13, at 8.
108 HFEA CODE, supra note 100, § 8.9(i)-(ii).
109 Suzi Leather, Chair’s Foreword to HUMAN FERTILISATION & EMBRYOLOGY AUTHORITY (HFEA), SEX SELECTION: OPTIONS FOR REGULATION: A REPORT ON THE HFEA’S 2002–03 REVIEW OF SEX SELECTION INCLUDING A DISCUSSION OF LEGISLATIVE & REGULATORY OPTIONS, 2003 (U.K.), available at http://www.hfea.gov.uk/docs/Final_sex_selection_main_report.pdf. The HFEA’s review was prompted by couples’ increasing use of reproductive technologies, such as PGD, to select the sex of their children for nonmedical reasons like family balancing. Id.
111 Id. at 5; Abortion Act, 1967, c. 87 (U.K.).
112 See HFE Act, supra note 96, sch. 2.
113 HFEA Report, supra note 70, at 5.
balance these risks.” Moreover, the HFEA stated that it strongly considered the potential situation of a “child born as a result of sex selection.” Its main concerns were for the potential “psychological harm if a child [found] out that [he or] she had been sex-selected, the possibility of preferential or prejudicial treatment to fit parental expectations,” and “the potential for favoritism and neglect of existing children.” Further, the HFEA noted that its recommendations were greatly influenced by a finding that the public was generally “uncomfortable with the idea of choosing a child’s sex to balance a family” or to fulfill some other nonmedical purpose.

The primary recommendations of the HFEA’s report were adopted and codified as an amendment to the HFE Act in 2008. As a result, nonmedical sex selection remains illegal in today’s United Kingdom, while medical sex selection is heavily regulated by licensing requirements.

2. Sex Selection in British Society

a. Public Opinion

In its 2003 report, the HFEA made clear that it relied heavily on surveys and studies of public opinion in making its recommendations for the regulation of sex selection. These studies revealed that while many British citizens were in favor of regulating sex selection because they believed it to be morally wrong and potentially negative for society, others felt it would deprive them of the right to create the family they desired.

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117 Id.
118 Id.
119 Id. at 220–23. In 2005, the U.K. Department of Health (DoH) conducted a review, and in 2004, the Parliamentary Science and Technology Committee (SCT) “launched an inquiry into human reproductive technologies and the law,” hoping to put reproductive technology regulations before “Parliament for a debate.” Id. at 223.
120 See id. at 222.
Over the course of the consultations it conducted for its report, the HFEA identified several common concerns related to sex selection including: (1) the reason for using sex selection (medical versus nonmedical); (2) the invasiveness of the technique utilized; (3) the reliability of the technique used; (4) the consequences of misdiagnosis; (5) the parents’ attitude toward selecting the sex of their child; and (6) the overall impact on society of the widespread use of sex selection.123

One survey conducted for the report indicated that married couples in both the United States and the United Kingdom desired to use sex selection with their second child for the purpose of family balancing without exhibiting a general preference for one gender over the other.124 Another HFEA opinion poll taken of a representative sample of the British population revealed that the majority did not agree “that any parent should have the right to choose the sex of their child.”125 Similarly, a majority of those polled “thought that sex selection should be regulated,”126 though most respondents also indicated that they supported the use of sex-selection techniques for medical reasons.127 Only a minority128 believed that such techniques “should be available for ‘family balancing’ . . . or ‘other nonmedical reasons’ such as social and cultural reasons.”129 Overall, many British citizens found it difficult to reconcile constraining the rights of others through legislation with

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122 Sex Selection: Report Summary, supra note 121, at 19.
123 Id. ¶ 38, at 12–13.
124 HFEA Report, supra note 70, ¶ 26, at 10 (noting that a high percentage of those actively seeking selection in the U.K. were from ethnic populations originating outside Europe).
125 Id. ¶ 45, at 14.
126 Id.
127 Id.
128 The HFEA Report indicated that a minority of the respondents reported feeling desperate for a child of one sex over the other. Id. ¶ 69, at 18.
129 Id. ¶ 47, at 14.
their own moral opposition to a practice they felt interrupts the “virtuous course of Nature.”

b. Reproductive Tourism

In recent years, many British couples have traveled to the United States for sex-selection procedures, resulting in what has come to be known as “reproductive tourism.” Dr. Jeffrey Steinberg, a British IVF specialist practicing in the U.S., attributed this phenomenon to the strict regulation of the practice in the U.K. Dr. Steinberg, the director for the New York and Los Angeles offices of the Fertility Institutes, claimed that he sees “around 40 British couples every year for [family balancing], with each IVF cycle costing £30,000.”

According to one news source, sex selection has become a “multimillion-dollar industry” in the U.S., largely due to reproductive tourism from countries like the U.K. that have banned sex selection for nonmedical reasons. Many American sex-selection clinics engage in target marketing techniques toward British forums for

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130 Id. ¶¶ 63–64, at 17. The HFEA also polled colleges and universities in the U.K. that had included the topic of sex selection in their debate clubs or on certain courses’ syllabi and found that most students seemed to agree with the HFEA’s stance that sex selection should be allowed for medical reasons, but not nonmedical reasons. Id. ¶ 84, at 22.

131 E.g., Mitchison, supra note 114; Int’l Laws on Gender Selection, GENDER-BABY, http://www.gender-baby.com/lifestyle/legal-issues/international-laws-on-gender-selection/ (last visited Feb. 9, 2014) (“This new phenomenon is called ‘reproductive tourism’ where people travel for gender selection and general infertility treatments such as IVF.”).


134 Ahmad, supra note 132. Dr. Steinberg even claimed to have received business from some of the U.K.’s political leaders. Id. Further, Dr. Steinberg said that his typical “patients are . . . around 30 years old, educated, married, middle to upper class,” and already have at least one other child. Jasmeet Sidhu, Gender Selection Has Become a Multimillion-Dollar Industry, HUFFINGTON POST (Sept. 17, 2012, 10:33 AM), http://www.huffingtonpost.com/2012/09/17/gender-selection--_n_1889991.html.

135 Sidhu, supra note 134.
mothers who desire a child of a specific sex. One such website, in-gender.com, reported receiving “more than 10,000 British emails a year” from women expressing their “sadness,” “guilt,” and “desperation” due to their inability to choose the sex of their child.

c. Religious Organizations

In addition to the British public, the HFEA also surveyed various British religious organizations for their views on sex selection. Most “[c]hurches and religious groups . . . argue[d] that sex selection was contrary to divine wisdom revealed through holy scripture since it . . . circumvent[ed] the will of God.” Some even claimed that sex selection equated to playing God. In its response to the HFEA consultation, the Catholic Bishops’ Conference compared sex-selection methods to manufacturing a child. The Church of England Public Affairs Unit (Church of England) “opposed the use of sex selection for non-medical reasons” due to the physical and psychological risks and possible social harms. However, it also commented that it did not view the use of reproductive technology as the equivalent of playing God; rather, it takes the position that God created humans with the expectation that they would use their intelligence and creativity to act as co-creators in producing offspring.

136 See id.
137 Mitchison, supra note 114. These women are said to suffer from gender disappointment. “Some women feel a momentary twinge of sadness when they find out the gender of their baby. For others, the disappointment cuts deeper, and can even turn into depression.” Morgan Brasfield, Gender Disappointment: Expectant Mothers Confess Secret Regrets, TODAY (Jan. 29, 2013, 9:48 AM), http://www.today.com/moms/gender-disappointment-expectant-mothers-confess-secret-regrets-1C8144610.
138 HFEA Report, supra note 70, ¶ 72, at 19.
139 Id. Many of these religious organizations were also opposed to sex selection for medical reasons when methods like PGD were used. Id. ¶ 74, at 19.
140 Id.
141 Id. ¶ 73, at 19. The Catholic Bishops’ Conference also distinguished between “the acceptability of sex selection itself and the . . . acceptability of the methods for achieving it.” Id. While it compared the act of sex selection to that of manufacturing a child, it stated that sex selection undertaken in the normal course of “sexual intercourse in conditions . . . deliberately chosen by a married couple in order to maximize the change of having a child of one sex rather than the other” was permissible. Id.
142 Id. ¶ 72, at 19.
in God’s image. Thus, the Church of England opposes the use of sex selection for nonmedical reasons because of the possible risks to the child, and like other religious organizations, it seems to find the use of reproductive technology to be acceptable as long as people are using them to live in accordance with God’s teachings.

d. Medical Institutions

Many medical organizations also responded to the HFEA’s consultation, generally taking the position that sex-selection techniques should only be used for medical reasons when the health risks are minimal. The Royal College of Obstetricians and Gynaecologists (RCOG) supported the use of sex-selection techniques for medical reasons “only when [they have] been shown to be reliable and free from health risks.” The British Medical Association (BMA) maintained that sex selection should only be used for medical problems, namely “to avoid major genetic problems [for the child] in the future.” The British Infertility Counselling Association (BICA) expressed that it is mainly concerned with the child’s welfare when it comes to sex selection, urging that couples seeking out sex selection receive counseling to increase their awareness of the implications of the procedure prior to treatment. The licensed Assisted Reproductive Technology (ART) clinics surveyed took positions on both sides of the issue—some sympathized with couples and condoned the use of sex selection for family balancing purposes, while others disapproved of sex selection for any nonmedical reason.

\[143\] Id.
\[144\] Id. ¶ 80, at 21.
\[145\] Id.
\[146\] Id. The BICA responded that such counseling “should be an essential requirement for anyone contemplating [sex selection] treatment.” Id.
\[147\] Id. ¶ 82, at 22. The consulted ART clinics that approved the use of sex selection for family balancing explicitly disapproved of it for any purposes that could be categorized as moving toward designer babies. Id. One such HFEA-licensed ART clinic supported the use of PGD over sperm sorting for family balancing sex selection because it is more reliable, but other HFEA-licensed clinics openly opposed the use of sex selection for non-medical reasons. Id.
The British people and their government seem to agree that sex selection should be available for medical reasons like preventing a genetically linked disease. However, the government’s ban on the use of sex selection for nonmedical reasons like family balancing is at odds with that of members of the British population who believe they should have the right to choose the sex of their child or because they have been suffering psychologically and emotionally due to their desire for a child of one particular sex for personal reasons. Despite the differences of opinion, there appears to be a general concern for both the child and the parents when it comes to the possible psychological, physical, and social harm to both as a result of using reproductive technology for sex selection. As evidenced by the absence of strict regulation of sex selection in the United States, having the right, or even the option, to use sex selection for both medical and nonmedical reasons does little to ease the debate.

B. United States

1. Current Legal Treatment of Sex Selection in the U.S.

In contrast to the United Kingdom, there are currently no laws in the United States expressly restricting the practice of sex selection. On the contrary, existing legislation and case law related to marital privacy, reproductive autonomy and abortion impliedly permits sex selection for both medical and nonmedical reasons.

In the 1960s and 1970s, the U.S. Supreme Court decided a line of cases defining an individual’s constitutional right to privacy. In 1965, a landmark case in the realm of reproductive rights, Griswold v. Connecticut, established that a husband and wife have a right to privacy in the context of their marriage. Two Connecticut statutes were at issue in the case: one of which criminalized the use of birth control, and another, which treated “[a]ny person who assist[ed] . . . another to commit any offense” in the same manner as the “principal offender.” The defendants in the case, who were the Executive

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149 See generally id. at 529 (citing Roe v. Wade to demonstrate a woman’s right to control her own pregnancy).
151 Id. at 480.
152 Id.
Director of the Planned Parenthood League of Connecticut, a licensed physician, and a medical school professor, had assisted married couples in selecting a method of birth control and were subsequently convicted under the second statute as accessories to the violation of the first statute. The Court noted that these statutes directly impacted “an intimate relation of husband and wife and their physician’s role in one aspect of that relation.” Determining that a marital relationship falls “within the zone of privacy created by several fundamental constitutional guarantees,” the Court held that the government cannot interfere with a married couple’s choice to use contraceptives.

After its holding in *Griswold* that a married couple has a constitutional right to privacy as to whether or not it has children, the Supreme Court extended this right of privacy to unmarried individuals in *Eisenstadt v. Baird*. *Baird* was convicted under a Massachusetts statute for demonstrating contraceptive products while giving a college lecture on birth control and for giving one of the contraceptives to an unmarried female student after his lecture. The statute imposed one to five years of imprisonment for anyone distributing contraceptives who was not a licensed physician or licensed pharmacist filling a valid prescription for a married couple. Similarly to *Griswold*, the Court determined that the statute “materially impair[ed] the ability of . . . persons to obtain contraceptives.” As opposed to the statutes addressed in *Griswold*, the statute in *Eisenstadt* made a distinction between married and unmarried individuals. The Court found no rational explanation for

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153 *Id*.
154 *Id.* at 482.
155 *Id.* at 485. The Court likened marriage to other rights of privacy that are not explicitly mentioned in the Constitution, but are implicitly included therein as a penumbra of constitutional rights free from governmental intrusion. *Id.* at 482.
156 Concerning the zone of privacy surrounding a marital relationship, Justice Douglas, writing for the majority, asked, “Would we allow the police to search the sacred precincts of marital bedrooms for telltale signs of the use of contraceptives? The very idea is repulsive to the notions of privacy surrounding the marriage relationship.” *Id.* at 485–86.
158 *Id.* at 440.
159 *Id.* at 440–41.
160 *Id.* at 446.
this unequal treatment, and held that the right of privacy protects both married and unmarried individuals from governmental interference with their choice of whether or not to have children.

A year after *Eisenstadt*, the Supreme Court granted certiorari on what would become the seminal case for abortion in the United States: *Roe v. Wade*. In *Roe*, the Court addressed the constitutionality of Texas statutes that criminalized abortion for reasons other than the medical purpose of saving the mother’s life. The plaintiff in the case was a single pregnant woman who wanted to have an abortion “performed by a competent, licensed physician, under safe, clinical conditions,” but was unable to do so legally because she did not qualify for the medical exception to the Texas statute. She sought to have the relevant Texas statutes—as well as similar statutes in other states—ruled unconstitutional on the basis that they violated a woman’s constitutionally protected right to personal privacy, which included the right “to choose to terminate her pregnancy.” The Court concluded that the implied constitutional right of privacy “is broad enough to include a woman’s decision” to terminate or not to terminate her pregnancy. However, the Court also determined that this right should be subject to regulation due to states’ interest in “safeguarding health, . . . maintaining medical standards, and . . . protecting potential life.”

The crux of the issue hinged on the “personhood” of the fetus: if a fetus were the equivalent of a person, the Constitution would afford it protection. On the ground that states have “a compelling . . . interest in protect[ing] prenatal life from and after conception,” the

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161 Id. at 447. Among the State’s arguments for upholding the statute were deterring premarital sex, protecting purity and chastity, and minimizing a health hazard, but the Court found none of these to be a permissible purpose in justifying the distinction between unmarried and married individuals using contraceptives. Id. at 448, 451.
162 Id. at 453.
164 Id. at 118.
165 Id. at 120.
166 Id.
167 Id. at 129.
168 Id. at 153.
169 Id. at 154.
170 Id. at 156–57.
171 Id.
Court held that the mother has a right to privacy with regard to her pregnancy until the fetus reaches viability, at which time the state may regulate abortion to promote its interest in the protection of potential human life.

While *Roe v. Wade* affords women a measure of reproductive freedom and privacy in one respect, it also limits that freedom in a manner that is directly applicable to the issue of sex selection. If a woman hopes to employ abortion as a means of sex selection pursuant to *Roe*, she is only permitted to do so up until the end of the first trimester. Although *Roe* opened the door for modern sex selection by establishing that couples have the right to make reproductive decisions privately, it also subjected that right to government regulation on the ground that it involves compelling state interests. It is clear that when the Supreme Court made its decision in *Roe*, it did not contemplate the use of reproductive technologies for sex selection because parents-to-be did not discover the sex of their child until long after the first trimester. Today, it is common to learn the sex of a fetus during the second trimester, and the first is easily within reach. If this had been the case when the Supreme Court decided *Roe*, it is likely that the Court would have placed a time limitation on using reproductive technology as it did with abortion, which would have a significant effect on today’s sex-selective practices. Furthermore, the Court would have been compelled to contemplate the point at which the fetus attains a personhood status so that genetic manipulation of the fetus becomes not only morally reprehensible, but also legally objectionable.

The collective effect of *Griswold*, *Eisenstadt*, and *Roe* is to firmly establish an individual’s right to privacy and autonomy over his or her reproductive decisions in the United States. By implication, these rights include the freedom to engage in sex

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172 *Id.* at 160 (defining viability as the potential for the fetus “to live outside the mother’s womb, albeit with artificial aid”).

173 *Id.* at 164–65. The Court holds that the point of viability is approximately at the end of the first trimester; and prior to viability, the State only has an interest in protecting the life of the mother and can only regulate abortion “in ways that are reasonably related to maternal health.” *Id.* at 164.

174 *Id.*


176 *Id.*
selection for both medical and nonmedical reasons. However, attempts have been made to limit sex-selective practices in the U.S. in recent years. In 2012, Republican Representative, Trent Franks, introduced the Prenatal Nondiscrimination Act (PRENDA) in the House of Representatives.177 Though it was voted down in the House, PRENDA proposed a complete ban on abortion in the U.S. for purposes of sex selection.178 Referring to sex selection as “[d]iscrimination against the unborn on the basis of race or sex,” PRENDA provided for a fine, a maximum five-year term of imprisonment, or both on anyone who knowingly performed an abortion, forced a woman to have an abortion, accepted funds to perform an abortion, or transported a woman into the U.S. to have an abortion for the purpose of sex or race selection.179 The bill also included civil remedies for women—as well as for the unborn child’s father or maternal grandparent—forced to have selective abortion based on sex or race in the form of actual and punitive damages.180 Opponents of PRENDA point out that sex-selective abortions are simply not as big a problem in the United States as in other countries.181 On the other hand, proponents of the measure argue that banning sex-selective abortions is an essential means to “combat gender bias.”182

On January 24, 2013, Senator David Vitter re-introduced PRENDA in the Senate, where it was assigned to a congressional committee for consideration before going to the full House or Senate.

177 Prenatal Nondiscrimination Act (PRENDA) of 2012, H.R. 3541, 112th Cong. (2d Sess. 2012) (“To prohibit discrimination against the unborn on the basis of sex or race, and for other purposes.”) [hereinafter, PRENDA].

178 The final vote on PRENDA in the House of Representatives was 246 votes for the bill and 168 against it, which failed to meet the two-thirds requirement. House Rejects Sex-Selection Abortion Ban, supra note 2. For a discussion of a recent controversy involving Planned Parenthood arranging sex-selective abortions, see Steven Ertelt, Is Planned Parenthood Arranging Sex-Selection Abortions?, LIFE NEWS.COM (Apr. 23, 2012), http://www.lifenews.com/2012/04/23/is-planned-parenthood-arranging-sex-selection-abortions/.

179 PRENDA, supra note 177, § 3(a).

180 Id.

181 Rachael Larimore, PRENDA Shows Just How Far Apart We are on Abortion, XXFACTOR: WHAT WOMEN REALLY THINK (May 30, 2012, 5:39 PM), http://www.slate.com/blogs/xx_factor/2012/05/30/the_prenda_debate_shows_just_how_far_apart_we_are_on_abortion.html.

182 Id.
for a vote. On February 1, 2013, Representative Franks re-introduced PRENDA to the House of Representatives, where it was referred to a House committee for consideration. To date, no further action has been taken in either the House or Senate regarding PRENDA 2013. Nevertheless, until such legislation is passed, or the Supreme Court reconsiders its position, sex selection remains legal in the United States for both medical and nonmedical reasons.

2. SEX SELECTION IN AMERICAN SOCIETY

   a. Medical Ethics Committees

   While U.S. lawmakers continue to debate sex selection in the legislatures and courts, it also remains at the heart of an ethical and moral debate in the field of medicine. The Ethics Committee of the American Society for Reproductive Medicine (ASRM) generally approves of sex selection, but discourages its use for nonmedical reasons. In its report on “Preconception Gender Selection for Nonmedical Reasons,” the ASRM stated that nonmedical sex selection carries a number of risks and hardships, including “gender discrimination, inappropriate control over nonessential characteristics of children, unnecessary medical burdens and costs for parents, . . . inappropriate and potentially unfair use of limited medical resources, . . . sex ratio imbalances, . . . and reinforcement of gender bias in society . . . .” It also cautioned that parents of children born as a result of sex selection might expect them “to act in certain gender-specific ways,” which may lead to unwarranted disappointment if the

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187 Id. at 862 (quoting ASRM Ethics Comm., Preimplantation Genetic Diagnosis and Sex Selection, 72 FERTILITY & STERILITY 595–98 (1999).
child fails to conform to the gender-specific behavior the parents desire. Furthermore, the ASRM expressed its concern that widespread use of sex selection could commodify children by placing emphasis on a child’s genetic characteristics rather than “his or her inherent worth.” Similarly, it pointed out that the practice could dilute the effectiveness of the medical field to some extent if doctors increasingly allocate their skills and resources for nonmedical purposes. In sum, ASRM recommended that couples considering sex selection for nonmedical reasons:

[1] . . . [be] 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 behavior of children of the preferred gender, and [4] are offered the opportunity to participate in research to track and assess the safety, efficacy, and demographics of preconception selection.

In a similar vein, the Ethics Committee of the American College of Obstetricians and Gynecologists (ACOG) has stated that it “supports the practice of [sex selection] for the purpose of preventing serious sex-linked genetic diseases,” but it opposes sex selection for nonmedical purposes like family balancing “because of the concern that such requests may ultimately support sexist practices” by devaluing women. The ACOG also recognized that because couples in the U.S. have a legal right to learn the sex of their baby, it is extremely difficult for doctors to avoid unknowingly participating in sex selection.

b. Government Organizations

In the government sphere, the Centers for Disease Control and Prevention (CDC) gives its Division on Reproductive Health

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188 Id. at 862.
189 Id.
190 Id.
191 Id. at 863–64.
193 Id. at 477–88.
The Division conducts surveillance of Assisted Reproductive Technology (ART), which includes “fertility treatments in which both eggs and sperm are handled.” The Division has concluded that ART carries multiple risks, including early delivery, low birth-weights, and increasing rates of multiples. Though the CDC has not made its policy clear on the issue of sex selection, its main concern seems to be ensuring that reproductive technologies and procedures available in the U.S.—including those associated with sex selection practices—are medically safe.

The Food and Drug Administration (FDA) has explicitly denounced one particular method of sex selection. In 2011, the FDA banned a sex-selection procedure called MicroSort, which utilizes a device to facilitate sperm sorting, at the Genetics and IVF Center (GIVF) in Fairfax, Virginia. Although the FDA concedes that MicroSort is “safe and effective,” it barred the procedure on the ground that there is “no ‘public health benefit’ [to] offering gender selection for nonmedical purposes.” On the other hand, the FDA has not banned IVF or PGD, which are generally more effective methods of sex selection than sperm sorting. Due to the FDA ban,

195 Assisted Reproductive Technology (ART), CDC, http://www.cdc.gov/ART/index.htm (last updated Nov. 27, 2013). According to the CDC’s 2011 preliminary ART Fertility Clinic Success Rates Report, “the use of ART . . . has doubled over the past decade.” Id.
196 Id.
197 E.g., Edgar Dahl, FDA Bans Gender Selection Procedure, INST. FOR ETHICS AND EMERGING TECH. (May 17, 2011), http://ieet.org/index.php/IEET/more/4753. Since the FDA banned MicroSort, the Virginia-based GIVF Center has not pursued further FDA approval of the procedure. See What MicroSort Tells Clinical Trial Participants, CHR BLOG (July 6, 2012), http://www.centerforhumareprod.com/blog/what-microsort-tells-clinical-trial-participants/. The GIVF Center has had to cease accepting “new participants in the clinical trial for . . . ‘family balancing,’” but it could continue offering MicroSort for “‘genetic disease prevention for families with [an] increased risk . . . [of] sex-linked diseases.”’ Id.
198 Dahl, supra note 197.
the GIVF Center had to cease accepting “new participants in the clinical trial for . . . family balancing,” but it has continued to offer MicroSort for “genetic disease prevention” for families with “an increased risk of a sex-linked disease.”

c. Religious Organizations

In addition to medical and scientific organizations, various religious organizations in the U.S. have released official statements regarding gender selection. In general, these religious organizations disapprove of the use of reproductive technologies for purposes of gender selection. The Roman Catholic Church vehemently opposes abortion, and states that sex-selective practices “are contrary to the personal dignity of the human being and his or her integrity and identity,” and further, cannot be justified by any “possible beneficial consequences for future humanity.” In a similar manner, the National Catholic Bioethics Center has described sex-selection techniques as “chilling,” and categorically denounces their use. For its part, the United Methodist Church takes the position that

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reproductive technologies “that intentionally generate ‘waste embryos’ that will knowingly be destroyed when the medical procedure or the research is completed” should be banned.202

In contrast, the Seventh-Day Adventist Church (Adventist Church) supports the use of reproductive technologies to aid procreation to the extent that they are used “within the bounds of the fidelity and permanence of marriage.”203 While the Adventist Church declines to address the issue of sex selection directly, it affirms that “[h]uman reproduction is part of God’s plan,” and concedes that “[m]edical technologies that aid infertile couples, when practiced in harmony with biblical principles, may be accepted in good conscience.”204

Additionally, even though the Presbyterian Church U.S.A. (PCUSA) generally opposes abortion, it takes the position that there are instances in which a woman’s decision “to terminate a pregnancy can be morally acceptable,” such as for a legitimate medical reason or when the pregnancy is the result of rape.205 However, PCUSA clearly states that “[a]bortion is not morally acceptable for gender selection.”206 Based on PCUSA’s stance on abortion, it is likely that it would find sex selection through reproductive technologies to be morally acceptable for medical reasons but unacceptable for nonmedical purposes.

202 Marvin W. Cropsey, The Book of Resolutions of the United Methodist Church 2012, at 306 (2013), available at http://umc-gbcs.org/resolutions/new-developments-in-genetic-science-3181-2008-bor. However, the Methodist Church does provide for one exception to the general ban on reproductive technologies: IVF: “A woman is at risk for complications each time drugs are given to stimulate ovulation and ova are removed. Obtaining and fertilizing multiple ova may be justified to avoid the necessity of multiple attempts to obtain ova.” Id.


204 Id.


206 Id. para. g.
d. Public Opinion

The American public appears split over the use of reproductive technology for nonmedical sex selection. On one side, many Americans believe they should have the freedom to employ sex selection for nonmedical reasons. Some reason that sex-selection procedures are generally invasive, and it is unlikely that couples willing to undergo such procedures lack the justification for choosing to do so. Many in the U.S. support the nonmedical use of sex selection for family balancing, particularly for a family that already has multiple sons or daughters and wants a child of the opposite sex, or one that has lost a child, and hopes that another child of the same sex will make their family feel whole again. On the other side, many Americans find sex selection immoral. Those who cite their religious values often believe that couples should accept their children exactly as they are given in the natural order of things. While a 2006 survey on abortion showed that most Americans oppose abortion for purposes of sex selection, a more recent study revealed that Americans are split over whether sex selection should be allowed for family balancing. Many of those in favor of sex selection for the purposes of family balancing pointed out that it was particularly appropriate in cases where a medical purpose came into play. On the other hand, many of those surveyed had moral

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208 See id. at 302–03.
209 See id.
210 Id.; Savulescu & Dahl, *supra* note 5, at 1879.
211 McCarthy, *supra* note 207, at 303.
213 Kalfoglou et al., *supra* note 212, at 2734. But see, e.g., Poll: Americans Incorrectly Believe ‘Pro-Choice’ Dominates US Abortion Views, CBS DC (May 15, 2013), http://washington.cbslocal.com/2013/05/15/poll-americans-incorrectly-believe-pro-choice-dominates-us-abortion-views/ (The same Gallup poll produced vastly different results with the first indicating that 51% of Americans think the public is pro-choice and 35% think it is pro-life, and the second indicating that 48% of Americans call themselves pro-life and 45% call themselves pro-choice.).
214 Kalfoglou et al., *supra* note 212, at 2733–34 (finding that most participants of the study believed using sex selection for medical reasons was ethical).
objections to the practice of family balancing for nonmedical reasons and believed that couples engaging in the practice were being selfish, commodifying their children, and “[going] against God’s will.”

Moreover, many Americans disapprove of sex selection because they believe it to be a misallocation of the nation’s medical resources. Others argue that the practice of sex selection is comparable to that of cosmetic surgery as couples are using their own private funds to pay for it, and although these procedures are expensive, those who can afford to, will pay for it.

Finally, some have expressed concerns that the widespread use of sex selection for nonmedical reasons will result in an imbalanced sex ratio not only in the United States, but also throughout the world. It is likely that these concerns stem from the tangible effects of widespread sex-selective practices in China and India on those nations’ sex ratios. Critics of this view argue that such fears are unfounded, due to the procedure’s invasiveness, cost, and the fact that most people will continue to leave the sex of their child up to nature.

\[\text{Id.} \]
\[\text{McCarthy, supra note 207, at 304.} \]
\[\text{Id. at 305. Participants in an American study on sex selection for family balancing expressed concern that “only the wealthy would be able to afford to use the technology” to engage in the practice; Kalfoglou et al., supra note 212, at 2734.} \]
\[\text{McCarthy, supra note 207, at 305; PRENDA, supra note 177, § 2(a)(1)(E); Kalfoglou et al., supra note 212, at 2731.} \]
\[\text{See infra Part I.} \]
\[\text{McCarthy, supra note 207, at 305. It is disputed as to whether the U.S. exhibits a preference for sons or daughters when it comes to sex selection for non-medical reasons. See PRENDA, supra note 177, § 2(a)(1)(E) (claiming there is a son preference due to immigrants from countries exhibiting a son preference bringing their cultural practices with them to the U.S.); Douglas Almond & Lena Edlund, Son-biased Sex Ratios in the 2000 U.S. Census, 105 Proc. Nat’l Acad. Sciences 5681–82 (Apr. 15, 2008); Gender Preference in the U.S., INGENDER.COM, http://www.ingender.com/XYU/Gender-Preference/ (last visited Feb. 9, 2014) (claiming there is a daughter preference). If most couples were using sex selection for family balancing, then the preference would exist on a case-by-case basis. See id.} \]
An emerging area of the sex selection debate is that it could lead society down a “slippery slope” by which genetically enhanced “designer babies” become the norm. Proponents of nonmedical sex selection argue that because sex selection does not constitute a genetic enhancement, the two issues are completely separate. Selecting sex is distinguishable from selecting a trait like height, hair color, or eye color because, for the most part, males and females are treated equally in the U.S. Proponents of nonmedical sex selection take the position that genetic enhancements like these are more likely to lead to the commodification of children because society views them as material characteristics. The widespread selection of traits that are determinative of a child’s appearance could cause social harm and could have a significant emotional impact on children and their parents. By way of example, if a child’s parents could not afford to genetically enhancement their child, and that child became the subject of harassment by peers at school who were genetically enhanced, the child might ultimately resent his or her parents and blame them for the psychological pain the child was experiencing.

It does not appear that it would be out of the question for the U.S. government to regulate, or even prohibit, the use of reproductive technologies for selection of genetic characteristics other than gender. However, a distinction must be made between the effects of couples selecting the gender of their child versus other characteristic like hair or eye color. When viewed in this light, using reproductive technologies for the selection of genetic characteristics other than sex is comparable to human cloning. Currently, there is no federal law banning human cloning in the U.S., but fifteen states do have laws explicitly prohibiting human cloning for reproductive purposes. Much like PRENDA, the proposed legislation that would ban sex-selective abortion, the Human Cloning Prohibition Act (HCPA) would ban human cloning in the U.S.

221 McCarthy, supra note 207, at 305; Robertson, supra note 83, at 213.
222 McCarthy, supra note 207, at 306.
223 Id.
224 Jennifer Steinhauer, House Rejects Bill to Ban Sex-Selective Abortions, N.Y. TIMES, June 1, 2012, at A20; see supra notes 185–86.
225 E.g., ARIZ. REV. STAT. ANN. § 13-3603.2 (2011); see also Sujatha Jesudason & Susannah Baruch, Race and Sex in Abortion Debates: The Legislation and the Billboards, GENERATIONS AHEAD, 1, 4–6,
It is relatively easy to argue that selecting a child’s sex still falls within the realm of family planning and reproductive autonomy, which are protected from intrusion by the U.S. government. However, it is much more difficult to argue that selecting a child’s hair or eye color relates to family planning as protected by the law. Any benefits of selecting these non-gender characteristics are likely substantially outweighed by the negative effects on the child.

As the law currently stands, it is not feasible for the U.S. to emulate the U.K.’s legal framework of the regulation of sex selection in the U.K as it stands in the HFE Act. Although many people consider practices like abortion and sex selection to be morally wrong, they are not willing to limit American liberties and privacy rights that individuals have and will continue to enjoy. On the other hand, it may be feasible for the U.S. to regulate the use of reproductive technologies for selecting genetic characteristics other than gender. One concern is that the widespread use of sex selection for nonmedical reasons would lead society down a slippery slope to the point that parents would be able to manufacture children into designer babies by choosing other genetic characteristics, such as hair color, eye color, or height. Although not banned in the U.S. yet, human cloning helps to clarify the difference between using reproductive technologies for selecting sex and using them for selecting other genetic characteristics and the more likely classification of the latter as the manufacturing of humans.

Ultimately, despite diverse viewpoints among Americans about using sex selection for nonmedical purposes, many support the status quo because they fear regulation “could lead to an erosion of reproductive rights” and the individual autonomy established by


In sum, while it is evident that many Americans believe it may be morally wrong to select the sex of their children, they may not necessarily support an outright prohibition on the practice due to concerns for how it might affect their other reproductive rights.

IV. THE FUTURE OF REPRODUCTIVE TECHNOLOGIES IN THE UNITED STATES

As reproductive technology continues its inevitable advance, the issue of sex selection will remain a widely debated topic. In the coming years, it is likely that the U.S. government will be forced to make legislative decisions regarding the use of reproductive technologies for sex-selective practices. While legislators have already attempted to ban sex-selective abortion, they have not been successful in convincing a majority that sex selection is the underlying purpose for a nonmedical abortion. It is just as difficult to prove that a couple is using reproductive technologies for nonmedical sex selection for some reason other than family balancing, which likely falls within the constitutionally protected realm of family planning. As such, the U.S. should treat the use of reproductive technologies for both medical and nonmedical sex selection as it does abortion. However, it should prohibit, or at least regulate, the use of reproductive technologies for the selection of genetic characteristics other than gender that are not linked to any genetic disease or serve some other viable medical purpose as it does not fall under the constitutionally protected area of family planning.

While a few states have passed laws or introduced legislation prohibiting sex-selective abortions, a federal law on sex selection has yet to be passed. Given the current state of U.S. law, it seems unlikely that the federal government will choose to regulate the use of reproductive technologies for sex selection to the extent that they are regulated in the United Kingdom.

228 Kalfoglou et al., supra note 212, at 2734; see supra Part III.B.1.
229 Steinhauer, supra note 224; see supra notes 185–86.
230 See supra notes 185–86.
231 E.g., ARIZ. REV. STAT. ANN. § 13-3603.2 (2011); see also Jesuadason & Baruch, supra note 225.
232 See supra Part III.B.1.
In one sense, it would be very difficult to restrict the use of sex selection for certain purposes—as the U.K. has done through the HFE Act—without infringing upon other well-established constitutional rights, including the right to privacy within the confines of marriage, reproduction, and family planning. Banning nonmedical sex-selection in the United States would almost certainly mean banning nonmedical sex-selective abortion as well. Such restrictions would essentially overturn well-established case law permitting abortions, marital privacy, and reproductive autonomy by imposing limitations to those rights and freedoms that Americans currently enjoy.

Furthermore, if family balancing indeed falls under the constitutionally protected right to privacy regarding the intimate aspects of reproduction and family planning, a restriction on sex selection for nonmedical purposes would infringe on that right as well. If abortion remains legal in the U.S., it will be almost impossible to discern whether a couple chooses not to have a child for purposes of family planning or the sex of the fetus. Consequently, if the American government is willing to allow its people to choose to terminate a pregnancy, it would be contradictory for it to disallow them to choose the sex of their child with reproductive technologies.

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233 Id.
234 Id.