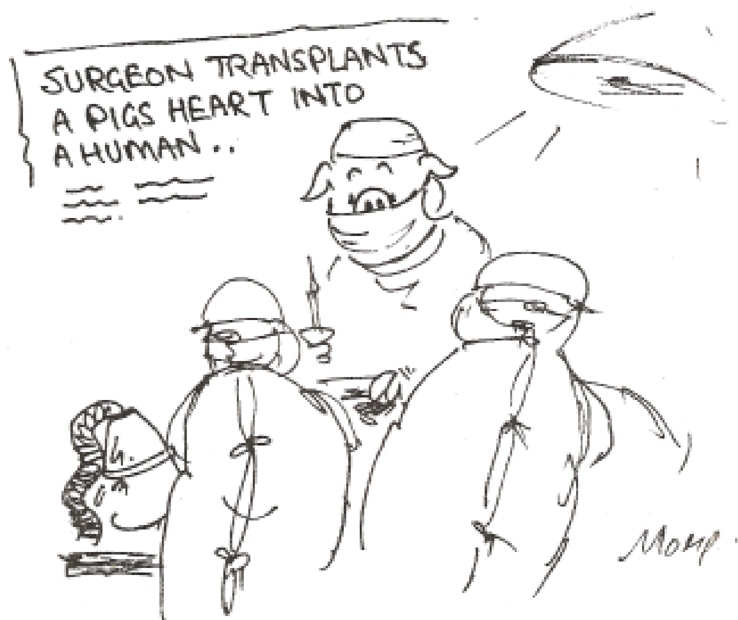
Medical technology and social justice

No longer are advancements in science and technology viewed as unqualified benefits. Technology is inextricably linked with money and markets, and we must examine the social dimensions of technology as it is applied in medicine. In general, in market-driven economies such as India, the poor have benefited very little from high-tech medicine. It has also become an instrument of perpetuating social biases and economic inequities. In this section we present discussions of two such technologies – organ transplantation and sex selection – and the differing views as they have been reflected in the journal. The debates continue but it is evident that high-tech medicine has changed our understanding of basic concepts of life and death, benefit and harm. Technology presents possibilities for both use and misuse, taking ethics into a completely new arena. These essays look at the dilemmas faced by individual practitioners as well as the larger social concerns about the role of medical technology in society and the profession's responsibility to promote the public good.


SURGEON TRANSPLANTS
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Ethical problems in renal transplantation: a personal view

M K Mani

A nephrologist writes on different aspects of renal transplantation based on his own experience. Starting with the specific problems of making decisions about transplantation and seeking informed consent from donors, he discusses the question of giving patients sufficient information to enable them to make an independent choice. He reflects on the larger question of the justice of a technology which creates a deeply exploitative relationship between rich buyers of kidneys and poor 'sellers' of the organs. He speaks specifically of the role of the practitioner, who acts as a broker in this deal.

The golden age of medicine for the individual medical man was the last century. There were few effective drugs available and all the doctor could do was to "cure sometimes, to relieve often, to comfort always." No one expected a doctor to prolong life, and the profession had little responsibility and every opportunity to be noble. Medicine was an art and hardly a science.

The last fifty years have been a golden age of a different sort. There has been a logarithmic increase in our knowledge of diseases and in our therapeutic armamentarium. It has not been an unmixed blessing.

Primum non nocere (First, do no harm)

The power to do good always carries with it the capacity to injure. Effective medicines have horrendous side effects and we often do active harm to our patients in our efforts to help them. Many of us face tortuous decisions day after day. Should I put a patient on cyclophosphamide for glomerulonephritis? Will he suffer some serious infection and die as a result? If I withhold the drug, will he die of renal failure that could have been prevented? Should a surgeon take a patient for an operation that carries risk to life? Is

he sure the patient will die of the disease and cannot recover with conservative treatment?

All these dilemmas pale into insignificance beside the predicament in which transplantation places us. The worst of all is renal transplantation, because the kidney, being a paired organ of which we need only one for life, can so easily be removed from a living person. This leads us to perpetrate the ultimate in horrors, a hazardous operation on a healthy person, and grievous hurt by the 'healing profession'. A few of us have been catalysts in the development of renal transplantation in this country. I do not know whether to pride myself on this, or to hang my head in shame.

The patient with chronic renal failure: options and costs

Let me begin by stating a few basic facts. The patient with chronic renal failure has three options, each with subdivisions. First, he can receive a renal transplant, which could be from a relation, a live unrelated donor, or a cadaver.

The main difference between these is that he has a good chance of success with a related donor even if he uses azathioprine, which would cost him approximately Rs 5,000 a year, but the unrelated kidney from a live or cadaver source will be successfully grafted only if he uses cyclosporine for a period, and this drug costs Rs one lakh a year. Many doctors claim to have successfully weaned their patients off the drug after some time, usually a year, but that still means an additional cost of Rs one lakh.

What must be stressed is that cyclosporine has only made a difference to short term survival of the graft. Long-term survival depends on the degree of matching between the donor and the recipient. A full-match sibling-graft has a half-life of 25 years. Any other half-matched relation has a half-life of 12 years. The unmatched cadaver or unrelated live donor graft has a half-life of 6.5 years, even if cyclosporine is the immunosuppressive used.

Second, the patient can stay on dialysis. This could be haemodialysis, which he could take in hospital for a cost of Rs 1.2 lakh a year, or at home for a cost of Rs 2.5 lakh to buy a machine, and then Rs 50,000 a year for its running. He could go on Continuous Ambulatory Peritoneal Dialysis for a cost of Rs 1.3 lakh a year and could carry out this treatment at home.

Both these modalities are now available in some centres in India, and the long-term survival is good, with a reasonable quality of life.

Third, the patient could quietly go home and die. From the point of view of the family, this is often the best option. Whatever the treatment, it is expensive, and usually the family is poorer for it. Treatment often requires the sale of property or the need to take large loans, and only a few people in our country earn enough to repay them and leave the family richer than it was before the illness struck them.

The only option at least a few Indians can manage on their own income is a related donor transplant with azathioprine. I have seen gold chains disappearing from the necks of ladies and being replaced by a yellow cord to hold the mangalsutra, and silks yielding to faded cottons and I have been left with the guilty feeling of having pushed a family into poverty. Ethical dilemma No.1.

The kidney donor

Let us now turn our attention to the donor. We always reassure him or her that the donation of an organ is quite safe and that life can be carried on safely with one kidney. True, but the kidney is removed by a major operation and all major surgery carries a definite though small risk to life, perhaps 1 in 1,000.

The newspapers carried reports of two donor deaths in Madras during the last few years and there might have been others that did not come to the attention of the public. Hospitals and transplanting doctors do not publicise their failures, especially donor deaths. If the donor of a kidney gets a renal disease himself later in life, he has a smaller renal reserve and will go into renal failure much faster than if he had both kidneys available. It is mandatory that we should stress the risks when we talk to the prospective donor, and that our conversation should be confidential and that he should be given the option of telling the doctor that he does not wish to donate the organ. The doctor should then invent a medical reason for not accepting the donation, so that the family should not be aware of the reluctance of the donor designate. This is ethical dilemma No.2.

I have always regarded a medical certificate as a sacred document and think poorly of doctors who attest to falsehoods and yet I have

to tell a lie to preserve harmony in the family. I have done this on at least three occasions. Once, the prospective donor told me, three days before the operation, that she had changed her mind. I hurriedly ordered a test and in collusion with the biochemist, had it reported marginally abnormal and therefore declared the donor medically unfit. I had to listen to a well-justified diatribe from the husband of the patient for my carelessness in not having done this essential test earlier and for having put the family to great inconvenience and costly delay.

The unrelated live donor: adequate compensation for risk?

The greatest problem lies with the unrelated live donor. The idea of someone having to sell a part of his body for any purpose is repugnant to us and our reflex reaction is to abhor it. Let us think it over rationally.

There are three parties involved. The donor who sells his kidney, the patient with renal failure who buys it and the medical man who serves as a broker, a commission agent who effects the transfer of ownership. In view of the multitude of active programmes all over the country, it is clear that all three parties are happy about the present situation and are willing and even keen on perpetuating the present practice. What right has any one else to intervene? The patient is a man or woman on the verge of death, clinging desperately to a hope that this operation will bring him or her back to a full life and not necessarily one treacherously exploiting the working classes. The donor is a poor man with the laudable objective of earning some money by the sale of his only asset, perhaps to educate his son, perhaps to get his daughter or his sister married, perhaps to pay for an operation on his wife. He or she is not necessarily a drug addict seeking the wherewithal for the next fix. The doctor is a noble soul, desperately trying to save his patients at great difficulty to himself and not necessarily one who is interested only in the money he can extract from the recipient and in retaining for himself the lion's share of the proceeds. Unless otherwise proved, we have no right to view any of the three as anything other than what they claim to be.

But nagging doubts continue to assail me. Let us begin with the patient. Has he or she been informed that the half life of the kidney

will be only 6.5 years, in other words, that he or she has only a 50 per cent chance of the kidney lasting more than six years? Has the doctor mentioned the fact that there is no certain way of establishing whether the donor has some viral disease which could cost the life of the recipient, that the tests now available are not 100 per cent reliable and that the person intent on selling an organ is not going to release information which would preclude the sale of the organ? Has the patient been told that there are excellent alternatives with fewer such risks, such as the different forms of long-term dialysis?

The biggest source of doubt, of course, is the donor. Would he be as willing to give his kidney if he knew that donors can die as a direct result of the operation? The chances of dying are small, but not negligible. What about the risk of his developing renal failure himself, due to some renal disease developing later? I have seen renal failure years after nephrectomy in three of my donors. Two went into the end stage and needed renal replacement. My donors are all related and the family rallied round and someone else offered each of them a kidney. What is the chance of this happening with an unrelated donor?

We are, of course, exploiting poverty all the time. I do not climb the coconut palms in my garden, but pay someone else to pick the nuts that I enjoy. We pay people to entertain us at the risk of their lives, trapeze artistes and lion tamers, for instance. There is a difference. They are living by their skills; the renal donor is at the mercy of the surgeon. Is he being paid a realistic sum for his sacrifice? Who decides that Rs 5,000 or Rs 10,000 or even Rs 50,000 is adequate compensation for an irreplaceable asset, for life itself? This is a buyer's market, where the buyers are all rich and the sellers are all making distress sales.

Noble medical profession?

The greatest mistake mankind ever made was in describing the medical profession as noble. We now claim nobility in all our actions and doctors doing unrelated donor transplants say they have to do it because they are committed to their patients and have to do it to save their lives, however distasteful the means.

The argument is specious. We do transplants only for some fraction of the people with renal failure in the country, maybe two or three

per cent. Have we no duty to the rest, who are too poor to come to us in the first place? Have we no duty to the donor? We ease our conscience by saying that the donor is well rewarded by being given the wherewithal to pay his debts or to buy a hut or a bicycle. If we were really interested in the donor, would we not organise an international auction for his kidney? Surely the rich Arabs and Chinese who buy our kidneys could pay lakhs for them instead of this pittance. Should not the donor receive more for the transplant than the medical man who is merely a broker in the deal? If a broker helps me to buy or sell a car, he receives only a fraction of the price, not the lion's share.

Kidneys from cadavers

We are told that the country is not ready for cadaver transplantation because it is costly and requires a complicated technological set-up. This is nonsense, an argument raised by vested interests. The set-up in the West today is elaborate and well beyond our means, but so is every aspect of medicine. Even a live related donor transplant in the West is done with a degree of sophistication beyond us, at a cost at least twenty times as much as here. I was involved in a cadaver transplant programme in Australia when transplantation was in its infancy all over the world. The concept of brain death did not exist. We waited for a person to die in the old fashioned way, by entire and continuous cessation of respiration and circulation, and then took the kidneys within an hour of death and got a reasonable 60 per cent one-year graft survival, using only azathioprine. There are units all over the world that are using such donors today, people who die outside hospitals or before they get on respirators and their results are only marginally worse than those with heart-beating donors. In 1968, Australia did not have sophisticated computers and a trans-national movement of organs. All kidneys harvested were used within the city, within eight hours and I see no difficulty in establishing the same system in Madras. The cost would be rather less than that of the unrelated live donor, as we can do without a number of investigations needed to safeguard the life of the donor. We need to have the backing of the public for this, with wholehearted willingness to donate organs after death. The effort that the unrelated donor lobby is using to prevent cadaver

legislation would better be utilised to persuade the public to accept the concept of donating all organs after death.

We have an Act to regulate transplantation now. It is a far-sighted piece of legislation, bringing in the concept of brain death, making it possible for us to decide during life that we wish to donate organs after death, firmly prohibiting commerce in transplantation and introducing some regulation of the whole transplant industry. Of course it has flaws and many people on both sides of the question have spent much time pointing out where the law would be misused. It is up to us to put it to good use and the effort we have spent arguing about it would have been better utilised had we got on with the job of making it work.

The gift of life

Unrelated live donor transplantation should be banned because there is an alternative for the patient with terminal renal failure in the form of dialysis or cadaver transplantation, because the donor will always be a poor and ignorant man who will be exploited by the doctor, the patient and the broker and because we will never have cadaver transplantation unless the easy way of buying a kidney is closed to the rich and influential. They will then turn their efforts to establishing cadaver donation in the country. A time will come when it will seem quite natural for every one of us to give life even as we leave the world, with gifts of kidneys, livers, hearts, lungs and to give sight to the blind. Our organs will live on after us.

This is truly the path to immortality.

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The ethics of organ selling: a libertarian perspective

Harold Kyriazi

In a radically different view, this writer opposes a state ban on trade in organs as an infringement of personal freedom. He argues that a free trade in organs would allow the poor to benefit from selling their organs. He also believes that it would be more effective to move from living donor-based transplants to cadaver transplants through a public campaign. These dilemmas are discussed in the Indian context.

First principles

As a libertarian, I believe that people own themselves. Any alternative would involve some form of slavery. And as owners of themselves, individuals have the right to sell their organs, give them away, and even to allow themselves to be "harvested" of their organs in a productive form of suicide, for whatever reason they choose. (Of course, surgeons and hospitals would be free to denounce, and to refuse to perform, such macabre procedures, and medical societies would be free to expel members who assist in such suicides.) Having said that, I also wish to emphasise that I share the concerns expressed by bioethicist Stephen G Post, of the Case Western Reserve University School of Medicine's Center for Biomedical Ethics:

"...in India, where a huge black market in nonvital body parts provide kidneys for the wealthy, it is the poor who sell. Is this truly freedom, as the libertarian proclaims? Or is it a forced choice made in destitution and contrary to the seller's true human nature? I see such a market as the most demeaning form of human oppression, as unworthy of any valid human freedom..."(1)

But one could make the same argument for coal miners and others with dangerous jobs who risk life and limb to support their families. Certainly such people are better off having these additional choices. But while it is a pernicious paternalism that would seek to deny the

poor these choices, it is also a sterile libertarianism that would stop the inquiry here, hailing the enlarged freedom of the destitute, and looking no further.

Margaret Radin, professor at the University of Stanford Law School, reached a similar conclusion:

"If people are so desperate for money that they are trying to sell things we think cannot be separated from them without significant injury to personhood, we do not cure the desperation by banning sales.... Perhaps the desperation is the social problem we should be looking at, rather than the market ban. Perhaps worse injury to personhood is suffered from the desperation that caused the attempt to sell a kidney or cornea than would be suffered from actually selling it. The would-be sellers apparently think so. Then justice is not served by a ban on "desperate exchanges."... We must rethink the larger social context in which this dilemma is embedded. We must think about wealth and power distribution."(2)

And so we are led to consider the larger societal question of basic economic justice. But before discussing the world as it should be, I wish to make a few comments about the ethics of the world of organ transplantation as it is.

Comparing the Indian and US situations

Both India (three of the key states in 1994, and others subsequently) and the US (nationally in 1984) have banned monetary compensation for human organs. The ban has been effective in the US, while it is routinely circumvented in India. But which system is the more ethical? In India, at least, those upper class Indians and wealthy foreigners who need organs are getting them, while some of the poor are afforded more financial opportunity than they would otherwise have. In the US, however, over 5, 800 people - rich and poor alike - die every year while waiting for donor organs that never arrive. And with most such deaths are associated years of waiting, years of debilitating sickness, and years of mental anguish not only for the ill, but for their families and friends. Against this horrendous backdrop, is a ban on market activity ethically sound? Another professor of law, Lloyd R Cohen, of the George Mason University School of Law, thought not: "People are dying while the organs that could restore them to life, and that a market (3)

would provide, are being fed to worms. Were more to suffer and die for want of organs that a market would provide, the high minded pieties that support the prohibition would be revealed for the vacuous moral posturings that they are."(4)

Finally, on this issue, Professor Radin insightfully notes that the US position-that altruism shall be the only permitted motivation for organ donation-may simply be a convenient way of shutting its eyes to the desperation of its own poor. "To preserve organ donation as an opportunity for altruism is also one way of keeping from our view the desperation of poor people."(2)

Let us now proceed to the heart of the matter – poverty and economic justice.

Economic justice

The essence of economic injustice, as it is currently instituted – essentially worldwide – is no longer chattel slavery, as it was in the 19th century and before, but wage slavery. And wage slavery is made possible by land policies that allow a small portion of mankind to monopolise the land on which and from which all must live.

Said 19th century American economic and social philosopher Henry George, "…the 'iron law of wages'…which determines wages to the minimum on which labourers will consent to live and reproduce…is manifestly an inevitable result of making the land from which all must live the exclusive property of some. The lord of the soil is necessarily lord of the men who live upon it. They are as truly and as fully his slaves as though his ownership in their flesh were acknowledged." (5)

I cannot here go into detail about economic justice, but I refer those interested to my recently published book on the subject (6). The short answer, however, is that those who 'own' land and natural resources should pay to the community a yearly rental fee, based on the market value of their holdings (irrespective of buildings or other improvements). Such a fund will guarantee landless citizens at least a minimal income, and also pay for the valid expenses of government. More importantly, the community's act of charging market prices for land and natural resources will help ensure that the latter are put to their highest and best use, generating more jobs and wealth for all. Additionally, no taxation should exist on

productive human activity (such as working, via wage and income taxes; buying, via sales or value added taxes; saving and investing, via income and capital gains taxes; giving, via gift and inheritance taxes, etc.), as that punishes – and hence lessens – good behaviour, while robbing people of the fruits of their labour. From what I understand of recent Indian history, efforts at land reform in the various states have been economically counterproductive, aimed at forcibly subdividing the land itself (7) rather than merely its economic rent. My impression of the Indian economy in general is that central planning and control have effectively stymied individual initiative. But all that is necessary for people to thrive economically is for them to have free and equal access to the earth (or its equivalent in rent) and the rights to free action and free association (i.e. to engage in entrepreneurial and free market activity), with the only proviso being that they do not violate the equal rights of others.

The US has, of course, long championed the latter freedoms, but has ignored the injustice inherent in its monopolistic system of land tenure. It was able to escape most of the harmful consequences of the latter for much of its history by virtue of its frontier, which provided a safety valve for oppressed labourers, who could escape wage slavery by homesteading frontier land, thus becoming their own masters. That avenue of escape was gradually eliminated, and the US then took the indirect route of wealth redistribution (via income, estate, and other forms of taxation) to attempt to redress the situation, rather than eliminating the injustice at its root.

As Winston Churchill said, "Land monopoly is not the only monopoly that exists, but it is by far the greatest of monopolies. It is a perpetual monopoly, and it is the mother of all other forms of monopoly" (8). Thus, while many forms of monopoly now exist, and many people make money in partly unfair ways in many fields other than real estate and natural resource utilisation, these other forms would not be possible without the primary monopoly of land and natural resources. The US and most other countries have thus allowed the privileged to retain their immoral means of subjugating their fellow men. (Not that I believe the privileged are, in general, aware of the partly immoral nature of their means of attaining wealth. If they could perceive the basis of the injustice, so also

would most others.) But perhaps the day is coming when the masses will understand the true nature of their plight, and will take proper remedial action.

A proper ethical focus

A primary ethical focus throughout the world must be the establishment of true economic justice, along the lines discussed above. Only in that way will the question of the exploitation of the poor be properly addressed and satisfactorily answered – by the elimination of poverty.

Additionally, most of the world needs to adopt something like the *de facto* (but not *de jure*) system now in place in India, by permitting monetary compensation for organs. Said Henry Hansmann, of Yale Law School: "...this prohibition may be overly broad... It appears possible to design suitably regulated market-type approaches to the acquisition and allocation of cadaveric organs (and perhaps of organs from living donors as well) that will be neither unduly offensive to ethical sensibilities nor easily abused…" (9)

For most of the world, cadaver tissues and organs should be adequate to meet demand. This seems a reasonable assumption, given that Belgium – which has a policy of 'presumed consent', in which people are presumed to be willing organ donors unless they have indicated otherwise – has such a surplus that it is able to supply many foreigners with needed organs (10). And data from the US on accidental deaths, where the death itself occurs in a hospital setting, suggest a potential surfeit of transplantable organs (11). The laws against monetary compensation thus need to be repealed, allowing organ procurement organisations the freedom to use whatever financial incentives are required to bring the supply up to meet demand. (From an ethical standpoint, it would be wrong to use live donors when cadaver organs are available, assuming that cadaver organs are equally as effective and safe as those from the living. If this is not the case, i.e. if cadaver organs stand a greater chance of failing or infecting their recipients than those from living donors, it would require careful consideration and balancing of the risks to donor and recipient to decide the proper course of action. Nevertheless, it is the individuals involved, and not legislators and bureaucrats, who should make such decisions.)

For most of the world, then, the question of the ethics of living donation will be a peripheral concern, arising only in cases of extreme time urgency, when one simply cannot wait for a cadaver with the proper tissue match to become available. In those cases, live donation, in which the pool of potential donors is much larger, will continue to be the only viable option. For India, however, for a variety of reasons, any large-scale use of cadaver organs is not currently feasible. Thus, for India, live donation will continue into the foreseeable future.

Summary

Given the above considerations, were I a transplant surgeon in India, I would have five relevant ethical concerns: 1. Economic justice: support the establishment of genuine economic justice. 2. Cadaveric vs. living donors: support a transition from a system emphasising living donors to one relying mostly on cadaver organs from those who have suffered brain death. 3. Fair compensation: try to ensure that donors are paid as much as possible (since the current market contains some degree of exploitation, due to the entrenched economic injustice). In practice, this would entail dealing only with organ brokers who treat donors fairly. 4. Do no harm: over and above the usual concerns expressed in the Hippocratic Oath, take all reasonable steps to ensure that patients have adequate follow-up care and legal options for redress of grievances. 5. Legalise organ selling: because the above-mentioned legal options are unlikely to be feasible under a black market system (lawbreakers rarely wish to attract legal attention to their own ‘criminal’ behaviour), one must seek to remove the laws banning organ selling. Their existence in an atmosphere in which black market activity nevertheless thrives not only places those involved outside the protection of the law, but engenders disrespect for law and law enforcement in general, to the detriment of society. More importantly from an immediate standpoint, removing the ban will free the operations from the clutches of organised crime, and make transplants less expensive for recipients, less exploitative of poor donors, and less dangerous for all involved (12).

For anyone seeking further libertarian perspectives on this issue, especially as it relates to US policy, a good source is my website, at www.organselling.com

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The case against kidney sales

George Thomas

This article was written in response to the argument supporting a regulated organ trade. The author views the organ trade from the perspective of the seller, whose problem of poverty is not necessarily resolved by the sale of an organ. It describes organ selling as a new form of slavery. The essay stresses the importance of ethical means as opposed to a utilitarian concern for ends. This essay and the preceding one by Harold Kyriazi were published as part of a collection on ethical issues in organ transplant.

> "The philosophers have only interpreted the world in various ways; the point is to change it."
>
> – Karl Marx: *Theses on Feuerbach*

I am one of those who, according to Radcliffe-Richards et al oppose the practice of buying kidneys from live vendors from a feeling of "outrage and disgust" (1). These feelings are by no means irrational. They are based on a bedrock of moral principle: that no human being should exploit another. The opponents and proponents of the trade in human organs are divided by this (perhaps unbridgeable) chasm. The one side is wedded to the belief that not only are all human beings born free, they should also stay free. The other is not so sure. The evolution of human civilisation has witnessed several periods of gross exploitation of human beings. Slavery, the extermination of six million Jews, and today the transfer of body parts from one living human being to another for a financial consideration, are part of a continuum of values which sees some human beings as less valuable than others. It is this value system that those of us who oppose the sale of kidneys seek to change. All arguments in favour of the trade are attempts to clothe, in the garb of reason, the concept that it is all right to remove a body part from a poor person and put it into a rich one. But even these arguments will not bear scrutiny and I will deal with them below. First, the argument that the prohibition of organ sales worsens the position

of the poor because it removes an option in their already deprived lives: Here the authors (1) of the paper have cleverly stated the most potent contrary argument themselves: the solution is the removal of poverty. They, however, appear to consider this a distant possibility, and in the meantime advocate the selling of kidneys as one option available to the poor to better their circumstances. It would have been useful if the authors had adduced material to show how and how long this so-called option works. In the absence of any sustained means of livelihood, it is quite probable that the money obtained by the sale of one organ will soon be gone. What shall the seller do next? Sell another organ? An eye? A lung? And when all the paired organs are gone?

Let us accept that the risk involved in nephrectomy is not high. But is it not a fundamental tenet of medicine that the risk must be in the medical interest of the patient? What medical advantage does the donor obtain? Undoubtedly the risk is the same for those who sell and those living donors who do not sell but donate out of regard for the recipient. Radcliffe-Richards et al move from this fact to the inference that therefore there should be no difference between the two groups with surprising facility. What matters here is motive: the implicit coercion in the case of the poor who sell out of financial compulsion. Radcliffe-Richards' equating of the motives of the better-off, and comparing the risks of nephrectomy with the risks of dangerous sports, can only be described as callous. No one prevents them from campaigning against these sports if they are so moved, but for us activists in the Third World there are more pressing matters than looking after the well-being of the jet-set. A profile of the sellers would be revealing. It will come as no surprise that they all belong to the third world. And it will also come as no surprise that besides the wealthy in the third world, the potential buyers will be from the rich, white, First World and from the petroleum-driven *nouveau riche*. No wonder a veritable industry of philosophers has risen in these countries to justify this horrible practice. And in the honourable tradition of colonialism there will always be locals ready to aid and abet the conquerors. He who pays the piper calls the tune.

Radcliffe-Richards et al (1) seem fixated on the belief that legalising and controlling the trade in human organs will protect the exploited. The situation in other fields shows that this is naïve indeed. In Hamburg, legal commercial sex workers throng the glittering Reeperbahn, while in the sad, sordid, shadowy bylanes the illegal commercial sex workers have no shortage of clients. This, in a country where social conditions ensure much closer adherence to the rule of law than is the case in most developing countries, which are the main source of people willing to sell their organs. In India, child labour is a reality. Poverty is the main reason for its existence. The efforts of numerous groups have succeeded in making it illegal. Have they removed an 'option' for the poor? After all, the poor consciously send these children to work. Would it be a good idea to legalise the practice and control it on the theoretical basis that it would improve the lot of these unfortunate children? There are many reasons why such trades will always be open to exploitation. The most potent one is that the victims are poor and voiceless while the beneficiaries are generally rich and powerful.

The argument that organ selling is acceptable because some services are available to the rich, that are not available to the poor, is extremely strange. Do the authors believe that the presence of undesirable practices justifies adding a few more? What will the limit be? Who will decide how many more are to be allowed? No prizes for getting it right. The answer is: the rich and powerful permit whatever is in their interest. They can always hire a motley crew of philosophers and technicians to justify it and make it possible. Why is altruism necessary in organ donation? It is because it will ensure the absence of exploitation. It is nobody's case that unless some useful action is altruistic it is better to forbid it altogether. Altruism removes the profit-making element. It will help ensure that organ transplantation is done in the best possible way and thereby achieve the best possible medical result. It will also ensure that no vital organ is removed from a living person. On the other hand, a trade in kidneys definitely puts one on the slippery slope to selling vital organs as documented elsewhere (2). Here, the authors utilise the familiar stratagem of positing and demolishing

imaginary weak arguments against their stated position, while ignoring the real and powerful argument.

The authors end with an emotional appeal that feelings of repugnance among the rich and healthy cannot justify removing the only hope of the destitute and dying. A powerful statement indeed, but on whose behalf? Is the only hope for the destitute the sale of body parts? Is this modern form of slavery where one sells oneself piecemeal, as opposed to the old form where the entire person was sold, the only hope for the poor of the 21st century? Or are the authors unaware that there is enough for all if only the rich were not so greedy (3)? Although they themselves state that the real solution to selling is the removal of poverty, they quickly move on to the reasons why selling is acceptable today. The entire tenor of their article suggests that they are not interested in this, the real option. Perhaps it is difficult to push this idea in the West where the dominant paradigm is to maintain the current wasteful level of living, never mind that it is at the direct cost of millions of other human beings living elsewhere. How much easier to go for the soft option of buying kidneys from the poor and making this appear as good for both the seller and the buyer. As for the dying, it is clear that the authors are not concerned about the poor who are dying, as they cannot afford transplantation and all the costs after transplantation. As for those who can afford transplantation, is the transfer of a kidney from a poor person really the best option? People who have undergone dialysis do not seem to think it such an unpleasant experience as the authors would have us believe (4). Let us not forget also that transplantation is not the end of the story but that the patient has to be on lifelong immunosuppression, which is quite an expensive proposition.

However, it is true that many who would be helped by transplantation are unable to get an organ. The real solutions lie in popularising cadaver transplantation, increasing the donation rate from the brain-dead, and working on technology to make dialysis cheaper and more tolerable. Radcliffe-Richards et al state that a vendor will never be a potential donor even after death. This is by no means certain. Methods can be found to increase donation rates from the brain-dead and from cadavers. One has only to see the amazing success of the Sri Lankan eye donation programme to

understand what can be achieved. This is the difficult option but the only sustainable one. Nothing can justify using one human being as an organ farm for another.

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The ethics of sex selection

Ruth Macklin

Women's groups and health groups in India led a campaign forcing the government to ban sex selection. They did so because they believed it was important to use modern institutions like the democratic state and the legal system in the fight for women's rights. In this context, it is interesting to read an American ethicist's analysis of sex selection from a sociological perspective. The writer admits that sex selection may have harmful consequences in the long run but suggests that it also serves the immediate purpose of preventing the abuse of unwanted girl children. She argues for social reform instead of a ban on the practice. Written before the publication of 2001 census data established the impact of sex selection on the sex ratio, the article focuses on gender discrimination, rather than the misuse of technology.

The thought of women having abortions in order to choose the sex of their future children fills many with revulsion. To think clearly about this issue, it is necessary to separate arguments about the ethics of sex determination (SD) from those pertaining to abortion. People who find abortion ethically problematic will want to see its incidence reduced. We must contemplate SD carried out by pre-conceptional means rather than abortion following prenatal diagnosis as it is only a matter of time before techniques of sperm separation are perfected.

The premise of this article is that whilst SD is not a desirable practice, prohibiting it by law is likely to do more harm than good. This conclusion is clearly consequentialist – the only form of ethical argument that is plausible in this context. It is hard to provide persuasive reasons why SD is intrinsically unethical. No rights are violated when SD is allowed by law. Legal prohibition of SD will infringe upon the reproductive rights of women.

The consequences of legally permitting or prohibiting SD are bound to vary from one society to another. This analysis is limited to India and China, where SD is widespread and consequences are

more palpable than in North America. In these two countries, the methods currently used are post-conceptional and abortion is legal, without the religious and ethical abhorrence common among Christians, orthodox Jews and most Muslims. SD will probably never reach the proportion in the United States that it already has in these two Asian countries because the factors contributing to a strong preference for sons, so prevalent there, are absent here.

Preference for sons in India and China

In India, where abortion for the purpose of SD is widespread and shows no sign of waning, opponents refer to the practice as female foeticide or femicide (l, 2). A strong feminist movement in India condemns SD. The Forum Against Sex Determination and Sex Pre-Selection has engaged in political activism to promote a legal ban. In May 1988, largely as a result of the work of this group, legislation was passed in Maharashtra banning the use of medical techniques for prenatal diagnosis except in cases where the mother is at high risk of foetal abnormality (3). In 1994, the Indian Parliament passed a law that provides penalties of three years in prison and a fine of about $320 for those found guilty of administering or taking prenatal tests for the sole purpose of determining the sex of the foetus (4).

The social and cultural basis for preference for sons in India and China is long standing and deeply entrenched. Religious traditions and economic circumstances drive the preference for sons beyond that in most other countries. In both India and China, the family name is passed down through sons, who are also financially responsible for supporting their parents in old age. In India, a precept of the Hindu religion holds that a sonless father cannot achieve salvation and a significant Hindu funeral rite for fathers can only be performed by male children. An analogous tradition in China stems from ancient Confucian precepts that require a son to perform ancestral worship ceremonies.

The most striking determinant of son preference in India is probably the dowry system. According to one account, in the last two decades, fuelled by a consumer boom among the new Indian middle class, dowry has spread like an epidemic to communities that never practised it before. And its purpose has changed. No longer is it seen as a collection of wedding gifts to help a couple

start a new life; instead, it is a way for the groom's family to elevate its economic status (5).

These demands continue even after marriage. The consequences of failure to meet them can include ejection of the woman from the marriage and even murder by her husband's family

Economic factors evidently provide a major incentive for aborting female foetuses but the underlying cultural tradition of preference for a son remains a strong factor. A middle-class Indian woman, pregnant with her third child, underwent prenatal diagnosis for the purpose of sex selection. She already had two daughters and planned to abort if the foetus was another female. The family was reasonably well off and could afford another girl. They loved their daughters. The motivating factor was the social attitude. The woman told an interviewer: "Our society makes you feel so bad if you don't have a son... People say, 'How many children?' and I say, 'Two girls, ' and they say, 'Oh, too bad, no boy.' And I feel very bad." Interestingly, this Indian woman and her husband were Roman Catholics. She said, "Being a Catholic, it's the only sin I commit." But she added, "When this test is here and everybody is doing it, why shouldn't we have what we want?" (4)

In China, ancient Confucian ideology continues to influence the strong preference for a son, especially as the first-born child. In addition to the need for sons to maintain the family line and to perform crucial ancestral rituals, males are held to be smarter and stronger than females. Despite a law in modern China dictating that parental support is the duty of all children, males are still held responsible for the support of parents in old age. Women are not available for the care of their own elderly parents once they are married. Their productive and reproductive labours benefit their husbands' family (6).

Arguments opposing sex determination

The leading arguments in opposition to SD are: the practice devalues the female sex; it reinforces current attitudes and practices that discriminate against girl children and women; and it results in an imbalance in the sex ratio.

Each of these will be examined in turn.

Devaluing the female sex

Although it is no doubt true that a practice reinforcing the already existing preference for a son devalues the female sex, the question remains whether that is a sufficiently strong reason to institute legal prohibition. Who, if anyone, is harmed or wronged by the practice of SD? Surely not the female child who will not be born as a result of SD, since this is the child who does not know and will never exist. What about existing female children and women? Does SD harm or wrong them? This is where the debate begins and empirical evidence is needed to supply answers.

Some argue that women as a class are demeaned by a practice that seeks to avoid the birth of females. This avoids the critical question of whether girls and women are made worse off as a consequence of this practice than they are anyway or than they would be if SD were eliminated. The first possible consequence to consider is female infanticide.

A report published in June 1986 in *India Today* (5) estimated that 6,000 female babies had been poisoned to death during the preceding decade in the district surrounding the town of Madurai in Tamil Nadu. Methods of infanticide include feeding the baby the sticky white milk of a poisonous plant or cow's milk mixed with sleeping pills. One mother of a day-old baby who had been killed thus was reported as saying: "We felt very bad... But at the same time, suppose she had lived? It was better to save her from a lifetime of suffering."

The mother of another couple who had their second daughter killed said: "Abortion is costly... And you have to rest at home. So instead of spending money and losing income, we prefer to deliver the child and kill it."

Infanticide is viewed as an alternative to aborting female foetuses and, in the case of the second woman quoted, appeared to be the preferable alternative. It is not clear whether legal prohibition of SD produces an increase in the number of girl babies being killed after birth. Yet it is undeniable that from any ethical perspective other than an extreme right-to-life persuasion, aborting pre-viable foetuses is ethically preferable to killing full-term infants after birth.

A second, well-documented consequence for girl children in poor families is their being neglected in favour of their male siblings. Whether SD is legally allowed or legally prohibited, girl children are often denied adequate food and medical treatment in favour of their brothers. So if a family has one or more girl children and then uses SD to produce a male child, it is likely that the girls in that family will be harmed by inadequate food or medical attention. But the same consequences would result if a boy is born into the family without the assistance of SD. It is difficult to determine whether the practice of SD produces more harm to identifiable girl children than they would suffer in the absence of the practice. Nevertheless, it is clear that when SD is practised, the total number of girl children who can be harmed in this way is decreased.

Some of the consequences for women of legal prohibition in India have already become evident. Women for whom SD is less readily available as a result of its being outlawed are made worse off because:

(a) they have more children than they want or than is healthy for them until they have the desired number of sons; (b) some will go to private doctors who perform SD despite legal prohibition and the procedure will cost considerably more than when it was performed in public hospitals before the prohibition, and (c) those who do not bear sons risk having their husbands leave them without any means of support. Even affluent Indian families desire sons. Women in these families are threatened with divorce if they produce only female children. Following a divorce all property belongs to the husband, so these women may be left destitute.

The fact that the practice of SD contributes to devaluing the female sex is a good reason for judging it to be undesirable, but not a sufficient reason for legal prohibition. If women and their girl children in India and China are made worse off in other ways as a result of prohibiting SD than they would be if the practice is legally tolerated, an assessment of these consequences leads to the conclusion that SD should not be banned by law.

Reinforcing discriminatory attitudes

The second general argument opposing SD is that it reinforces current attitudes and practices that discriminate against girls and women. Evidence from Maharashtra, the Indian state that has had a legal prohibition of SD since 1988, suggests that prohibiting SD has not changed the preference for sons, nor has it done anything to enhance the position of women. Although it is surely desirable to increase respect for women and try to improve their status, there is little evidence that prohibition of SD does or will have those desired consequences. According to Madhu Kishwar, a fellow of the Centre for Study of Developing Societies in Delhi: "Statist measures such as banning the test and punishing those who go for it are likely to be both ineffective and counterproductive. Female foeticide is a symptom of devaluation of female lives, unless we are able to deal with all those social and economic factors that are going into the culture of son-preference and daughter-aversion, we cannot effectively combat the killing of unwanted female foetuses."(3)

Of course, it is not evident how these cultural attitudes can be changed. Professor Kusum, a scholar at the Indian Law Institute in New Delhi, contends that laws banning SD will not change the attitudes of the Indian people toward women. Instead, efforts must be made to try to change such attitudes by education rather than by law (7).

Thus, although it may well be true that SD reinforces current attitudes and practices that discriminate against girls and women, the converse does not appear to be true: prohibiting SD does not have the effect of eliminating attitudes and practices that discriminate against members of the female sex. Furthermore, legal prohibition in India does not seem to have succeeded in lowering the number of SD tests. The practice has simply been driven underground, with no way of monitoring the numbers or seeking to maintain quality control. After the ban, doctors who do the procedure have become unwilling to talk or provide information(3).

A physician in Bombay who formerly practised SD contends that enacting the law in Maharashtra has played into the hands of unethical people. Physicians who do amniocentesis sometimes do

it unscrupulously, telling women that the foetus is a girl when it is not. Financial motivation conjoined with legal prohibition has worsened the situation. The doctor in Bombay stated his own belief: "You can't violate the law of the land." He says that it was wrong to enact the law, but now that it is there, it must be respected (8).

In China, the return in the 1980s to family-based labour has led to the rise of patriarchal authority and discrimination against women. The immediate effect of this radically altered economic policy in a formerly centralised economy has been the desire or need for children, especially sons, to provide hands for work. Sons are thought to be better workers than daughters, and the demand for more children becomes a demand for sons (6). Conjoined with the state policy of a one-child family, the ultimate result has been a reinforcement of the traditional preference for sons. SD following prenatal diagnosis is therefore the consequence, not the cause, of discriminatory attitude and practices.

If the practice of SD reinforces current attitudes and practices that discriminate against girls and women, that is a good reason for judging it to be undesirable but not a sufficient reason for legal prohibition. It is hard to see how further restricting the options for women who already have limited choices in their lives can benefit them.

The danger of an imbalance in the sex ratio

Demographic figures from both countries reveal that a significant imbalance in the sex ratio has already occurred. In China, the 1990 census showed that of a total population of 1.2 billion, about 205 million Chinese over the age of 15 are single. Of those, there are nearly three men for every two women. Among people in their 30s, men outnumbered women by nearly 10 to 1 (9)

In India the ratio of men to women in the population, which has been widening throughout the century, has been tipping even more sharply toward men. Census counts show a trend: from 971 females for every 1,000 males in 1901, to 930 in 1971, and 929 in 1991 (10). In Haryana, a populous northern state that surrounds Delhi, the figure in 1991 dipped to 874 females for every 1,000 men, a disproportion said to be virtually unprecedented in similar counts around the world (4). Yet some have argued that the prenatal tests for SD cannot be viewed as

primarily responsible for the growing imbalance in the sex ratio. That ratio continued to decline sharply in the period between 1901 and 1971, when there were no tests. And between 1971 and 1991 the number dropped by only one point – from 930 in 1971 to 929 in 1991 (10).

As Jonathan Glover notes: "To refer to an imbalance between the sexes as a 'danger' may seem to beg a question. The traditional pattern is of a roughly equal number of men and women in any generation. Is it so clear that to depart from this would be disastrous?" (11) The answer, once again, can only lie in an assessment of the actual or probable consequences of an imbalance in the sex ratio. Some recent evidence has begun to emerge in China but at present such assessments are more speculative than based on empirical evidence.

Glover speculates that if two-thirds of a generation were male, a real problem could result. Men would feel that they are at a substantial disadvantage since many of them would be deprived of a partner. This, in turn, could result in a growth in prostitution and pressures towards polyandry (11). Kusum notes a similar fear about polyandry and adds to that the prospect of an increase in crimes like rape, incest and kidnapping. She also mentions the fear that "the reproductive burden on women will increase because the same burden of bringing forth progeny will then have to be shared by fewer women." (10)

Are there any possible positive consequences? One argument would be that an imbalanced sex ratio would ultimately benefit women. As women become scarcer, their value would increase. Women would then become valued in the way that rare jewels or one-of-a-kind art objects are revered. Glover rejects this argument on the grounds that it depends on an excessively economic view of relationships and of why people are valued...The argument is essentially that scarcity drives up the value of any commodity. But people are not commodities, and so the benefit to women from the imbalance is at least highly speculative (11).

The presumed negative and positive scenarios resulting from an imbalance in sex ratio are potential rather than actual consequences. The trouble with consequentialist arguments is

that they rely on projections or assumptions and they tend to stress those consequences that fit their authors' value predilections. Fortunately (or unfortunately), there is some reported experience from China.

One lonely 30-year-old man lamented, "Women are so hard to find now, and I just want one." (9) A government-sponsored computer dating service in Beijing reports that at least 70 per cent of the young people who come for the service are men. A social worker at the service observed that women have a good chance of finding a man who meets their standards, while men who ask for beautiful girls are told they must be realistic. Young men are reported to be dejected and pessimistic about their prospects. A 22-year-old engineering student despaired of ever finding a mate, while his friend speculated that "Without enough women, may be we will become monks." (9)

One rather cynical conclusion that might be drawn from these figures is that in these traditional, male-dominated societies, men are finally getting what they deserve. A more favourable outlook is one that envisages the benefits to women. Glover's rejection of people as commodities notwithstanding, a *New York Times* editorial cited market forces as a factor that has led to a new and higher value being placed on women. As a result of the current predominance of men, "suddenly young women are finding themselves valued in the society that once shunned them. They are being treated with new respect, and...have been rescued from disdain and oblivion by a highly impersonal and newly potent principle in Chinese life: market forces." (12) Guo Daofu, a senior economist for the State Statistical Bureau, speculated that the current shortage of women will play a positive role in improving the status of women: "I think this will lead to changes in society. Men will have to become more open-minded." (9) This prediction, though, is more speculative than it is based on any empirical evidence.

A darker picture is painted by Wang Wei, a professor of ethics at the People's University in Beijing, who noted a series of kidnappings of city women who were abducted by bounty hunters and delivered to rural farmers who were desperate for brides. "You could see more of that," Professor Wang said.

Conclusion

SD is an undesirable practice for the reasons stated by its opponents. Yet legal prohibition would restrict reproductive rights, hardly a desirable feature in countries like India and China that have both experienced serious violations of the rights of women by forced sterilisation and administration of state-imposed long-term contraception. Moreover, as already demonstrated in India, legal prohibition is likely to produce more harm than benefit to women and girl children in societies with strong preference for sons.

This conclusion must be tempered by the potential negative consequences of a severe imbalance in the sex ratio, as is already occurring in India and China. In both countries, social reforms rather than prohibition of SD are more likely to achieve desirable effects. Efforts should be made in all societies to increase respect for women and to enhance their status. An additional step in India is reform of the dowry system, which not only commodifies the marital arrangement but also oppresses the parents of girl children. In the end, it is social and cultural change not legal prohibition that can enhance the position of women in traditional societies.

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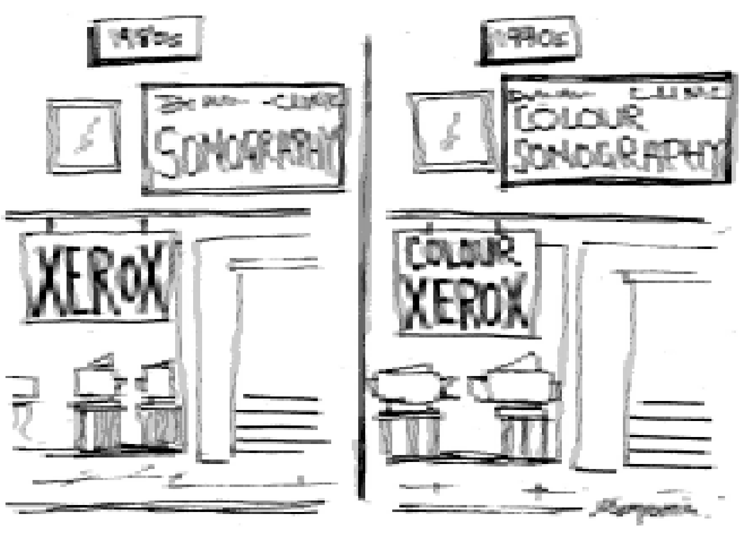

Sex selection: ethics in the context of development

Neha Madhiwalla

Data of the 2001 census show a clear relationship between the expansion of prenatal testing clinics and the skewing of the sex ratio. There is already a fairly widespread consensus that sex selection is unethical and unjust. This author writes against the background of the renewed campaign against sex selection following public interest litigation asking the government to implement its ban on sex determination as well as sex selection. The campaign is now clearly focused on the role of the medical profession in misusing medical technology. This article emphasises the need to develop a consensus within the profession to eliminate the practice, using self-regulation as well as legal provisions.

All too often we reduce 'son preference' to a crude caricature of starving, harassed and tortured girl children. However, the reality is much more complex. In the same society where sex selection is used as a new means to perpetuate an old bias, education levels are rapidly rising, floods of girls are going to school and college, there are more women working in offices and in factories, in panchayats and in Parliament.

It is actually not surprising that sex selection is highly co-related to development. After all, modernisation has made abortion available, accessible and morally acceptable to thousands of otherwise conventional families. And development itself brings new pressures. The cost of rearing children rises with the social imperative of educating them and providing health care. Some families may feel that such money and effort are better spent on boys rather than on girls; also girls are less needed in the new urban household, with small families and little need for unpaid labour.

It is in this context that sex selection must be understood. The movement towards more equal gender relations is, in a sense, inextricably embedded in the development process. However, the

resistance to it is stiff and takes new forms such as sex selection. Thus, on the one hand, middle-class families can allow their daughters to study after marriage, girls get sent to the best available schools, and women with 'girls only' families see older couples in the extended family managing without sons, buying houses for their married daughters, or sending them abroad. On the other hand, women still feel the pressure to have sons, and mothers of daughters find their children are not fawned upon as their sons may have been.

And this is the danger that sex selection poses. With one sweep, it threatens to reverse a process that has taken many decades to evolve. The power of technology can overwhelm the slow reflective process of change set in motion by millions of girls going to school and starting to work.

For a young urban woman such as myself, sex selection can never be an issue of mere academic interest. It is the lived experience of several friends, relatives and acquaintances. But I must address the question: how does one presume the availability of technology to make abortion and childbearing safe and accessible, and in the same breath ask for restrictions on its use? The Centre for Health and Allied Themes (CEHAT) is one of the co-petitioners in a Supreme Court writ petition calling for implementation of the Prenatal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994. And as a member of CEHAT's team, I feel the need to situate the campaign against sex selection in its proper context. Almost a decade of advocacy by CEHAT for more liberal abortion laws and services is obscured when we get clubbed with religious and quasi-religious political organisations holding diametrically opposing views on women and on sexual and reproductive rights.

The proponents of sex selection have various arguments. Sex selection is a personal choice, they say, and the state should not interfere in it. Intervening in matters of individual choice is a step towards greater state scrutiny and control. Rather than curbing the use of technology, we should spend our energies on educating the public and changing social norms. Some people also accuse us of imposing a western ideological perspective on people with a very

different value system. It is also argued that doctors should not be expected to play the role of moral police and reform their clients.

This perspective ignores the fact that the preference for sons is not personal, but completely socially determined. Second, the phenomenon of sex selection would never have existed without modern medical technology and is directly linked with the expansion of modern western medicine. In India, sex selection has risen along with the penetration of technology into semi-urban and rural areas. This is what distinguishes sex selection from other forms of neglect and discrimination that girls may face; it is not merely a manifestation of gender discrimination that households resort to. It is intimately connected to another phenomenon of development: the health care market. Doctors, as professionals, do not participate in infanticide or wife abuse. But they not only participate in sex selection, they benefit materially from it. And that explains the rapid proliferation of sex selection: it is good business.

Doctors and technicians know that sex determination for sex selection (without any medical reason) was never the intended use of diagnostic tools like amniocentesis and ultra-sound. However, because of the wide publicity that sex selection has received, many people are unaware of any other use for this technology. According to a recent study on abortion in villages of Pune district, while 75 per cent of the women (39 women) were aware that sonography could be used to determine sex, only four women knew that this technology was used to detect foetal anomalies (1).

Doctors represent society's elite, and what they say and do significantly affects public opinion. They lend legitimacy to the practice of sex selection by the very fact that they do not oppose it. Therefore, they will have to accept the challenge of reforming their own fraternity and influencing public opinion. No doubt, social reform has an important role to play in bringing about gender equality. What better group to begin with than one in which every member has at least five to seven years of college education and an income many times higher than the national average?

There is need for a law as well as a commitment from the profession to condemn and isolate those providers who engage in sex selection. The only real and lasting strategy to eliminate this practice is by building consensus within the profession. Only when

the option of sex selection ceases to exist will the coercion of women to abort female foetuses stop. As long as providers are willing to offer such services, women will remain vulnerable to such exploitation within their households.

Having said all this, ethical providers today may face dilemmas in individual situations.

Is sex-selection justified if the doctor is certain that the woman will come to harm if she bears a girl?

The doctor may indeed worry that a woman will be deserted or tortured if she bears a girl. However, the pressure to bear sons is only one aspect of the oppression that women suffer. In fact, as the family has no control over the doctor, the professional may be the only influential person who can argue against sex-selection without fear.

What if the woman herself requests it?

If the woman has been coerced by her family to ask for a sex-selective abortion, then by refusing one, the doctor is in fact acting in her interest. If she has really made an autonomous choice, it may be more useful for her to know that this act is illegal (many do not know) and that the doctor considers it unethical.

Is it all right if the couple already has one or more daughters?

How often do couples request an abortion because the foetus is male and they have too many sons? Only parents of girls have an urge to 'balance' the family, indicating that the whole process is discriminatory. Children lend variety to a family by their personalities, not by their sex. If family balancing was such an important issue for households, the sex ratio would never be so skewed. Many families voluntarily limit family size after they have had one or two sons, even when they do not have daughters. Significantly fewer families with only daughters do the same.

If you refuse to provide services, some untrained provider will.

Sex selection reduces even the qualified ethical provider to the same level as the unethical or unqualified provider: both are guilty of violating the law. In this way, professionals lose their moral

authority to demand the elimination of both unqualified as well as unethical providers.

Second, the influential urban middle class will not risk safety beyond a point and this will eliminate the largest and most lucrative market for sex selection.

How is sex-selective abortion different from the abortion of foetuses with serious genetic abnormalities?

When parents opt to abort a foetus with genetic abnormalities, they are concerned about the poor quality of life of the child that would have been born. A girl's disadvantages are not biological but social, and social change is more rapid and unpredictable than the improvement of prospects for the severely disabled.

This is not to claim that eugenic abortions are without ethical dilemmas.

Is the ban on sex-selective abortion not in conflict with the unrestricted right to abortion?

Through the anti sex selection campaign, right wing anti-abortion groups have suddenly discovered a love for the girl child. The unsaid message is that abortion itself is unethical and immoral.

Nonetheless, the opposition to abortion, and the ethical issues surrounding it, must be discussed by anyone serious about campaigning against sex selection. It is necessary to separate the two issues and yet see how they connect. The opposition to abortion is based on two arguments; the sanctity of life (including that of the foetus), and the fear that abortion will lead to promiscuity and the breakdown of the institution of the family. Often these two arguments enter each other's territory. One cannot challenge the personal views of those who would not opt for an abortion or conduct one themselves. We must respect a woman's freedom of choice to have a baby. We must also respect the choice of those professionals who would not like to participate in abortion. But the right to abortion, as a woman's right and without restriction, must exist. This is because women are often coerced to have sex, whether within or outside marriage. Second, contraception when available is not fool-proof and has its own risks. Third, women must bear the burden of the responsibility for contraception, of

childbearing itself, and of rearing children as well. Finally, the risks of childbearing are borne by women alone although women hardly ever have exclusive rights over the children born. Thus, access to abortion is a substitute for the rights denied to women otherwise by society (the right to have or not have sex, the right to ask a partner to use birth control or to look after the child).

Wherever safe abortion is available, women have used it judiciously. Freedom for women has strengthened families, not weakened them. What it has weakened is men's control over women – and in any case this ought not to be the basis of the institution of the modern family.

Thus the demand that women should have a right to their bodies and unconditional access to abortion is not in conflict with the claim that sex selection and sex-selective abortions are unethical. It is not the abortion that makes the act unethical, but the idea of sex selection. For one, the family that opts for the abortion of a female foetus is no different from the family that determines it is a male and therefore goes home happy. The ban on sex selection, like the right to abortion, is a proactive step; it gives a woman protection from coercion by the family and the right to respect, whether she bears a girl or a boy.

Reference

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