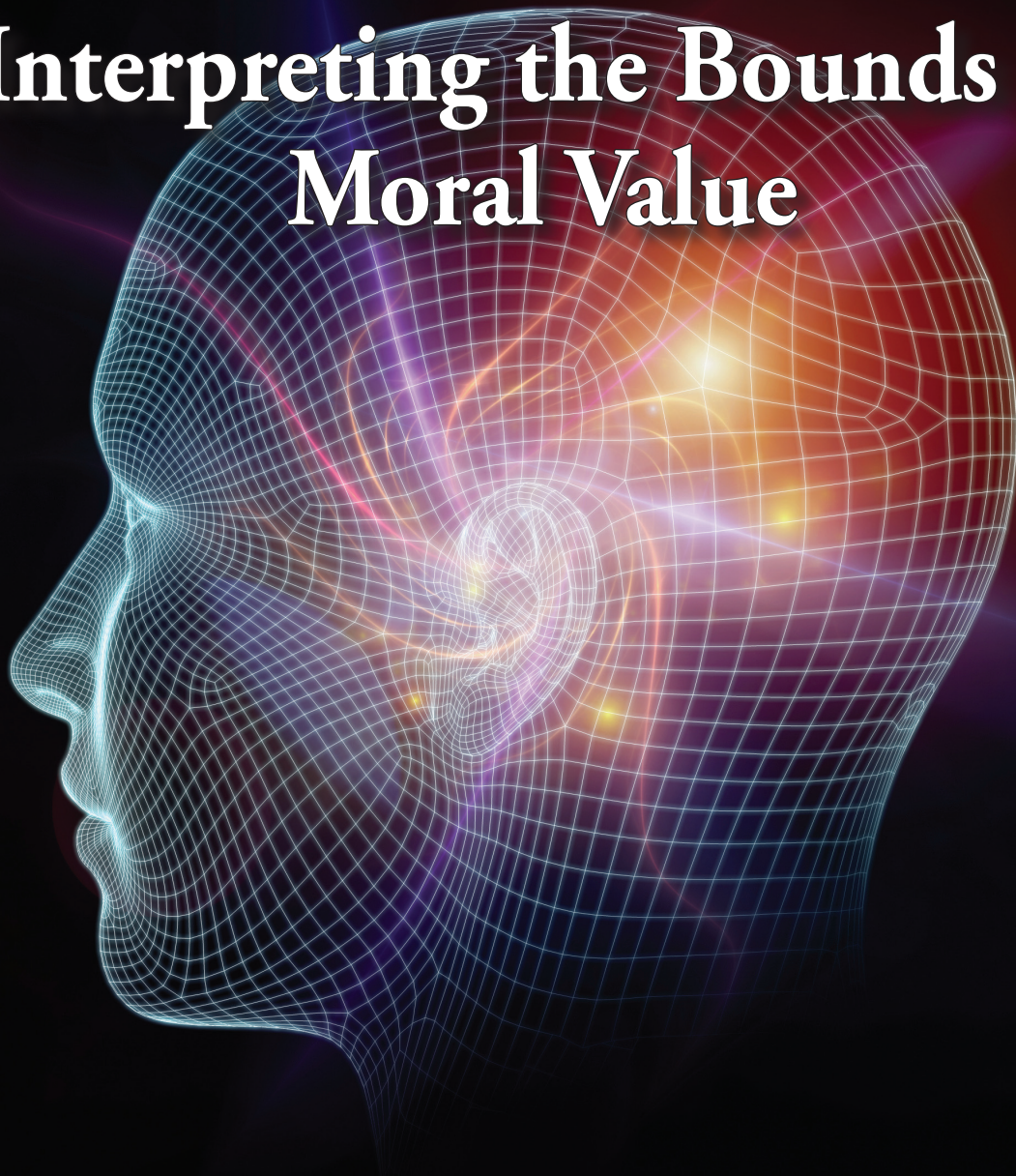


Volume XII Issue i

**PBJ**

**PENN BIOETHICS JOURNAL**

**STATUS AND SELECTION:  
Interpreting the Bounds of  
Moral Value**



**Non-Medical Sex Selection, Cognitive Capacity in Animals,  
and a Conversation with Dr. Lance Wahlert**

# PENN BIOETHICS JOURNAL

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*Editor-in-Chief*

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# Letter from the Editor

Darby Marx  
*Editor-in-Chief*

Dear Readers,

It is my pleasure to present you with Volume XII, Issue i of the Penn Bioethics Journal, titled “Status and Selection: Interpreting the Bounds of Moral Value.” In this issue, you will find two articles that explore moral value from different perspectives, an interview with professor and bioethicist Dr. Lance Wahlert, and a Bioethics-in-Brief section.

The first article, titled “A Unique Way of Thinking? Cognitive Capacity and Moral Status in Humans and Animals,” argues that humans should not necessarily have higher moral status than all non-human animals. In this paper, author Eitan Sapiro-Gheiler of Princeton University considers the implications of assigning moral status based on the possession of morally relevant traits and category membership.

The second piece, titled “From Cradle to the Womb: Arguments against Non-Medical Sex Selection and the Principle of Dignity,” approaches questions of status and value from a different perspective. Author Anastasia Rykova of the University of Toronto adamantly argues that non-medical sex selection is impermissible. In her argument, she addresses three related concerns: preference, balance, and protection. She goes on to explore how the principle of dignity plays into the ethicality of sex selection in non-medical settings.

For this issue, the Penn Bioethics Journal also had the opportunity to interview Dr. Lance Wahlert, an Assistant Professor of Medical Ethics & Health Policy at the University of Pennsylvania. Dr. Wahlert, who is also the Director of the Project on Bioethics, Sexuality, and Gender Identity at Penn, offers a unique perspective on non-medical sex selection and its connection to LGBTQ and disability ethics.

Additionally, the Bioethics-in-Brief section, which can be found in the next few pages, includes news briefs covering several recent developments in the field of bioethics. The first brief is about the first “BodyHacking Con,” which was in Austin, Texas in February of 2016. At this conference, body hackers from around the world convened to learn more about the newest body-implantable technologies. The second news brief discusses the first attempted uterine transplant in the United States, which occurred in February of 2016 at the Cleveland Clinic. While these events are different in nature, they both draw attention to ethical questions that will likely arise as technological advancements enable us to “modify” the human body in ways we never have before.

The last two news briefs address government recommendations regarding public health. Specifically, the third news brief is about the recommendation from El Salvador’s government that couples avoid pregnancy until 2018 due to the Zika virus outbreak, and the fourth brief is about the CDC’s February 2016 recommendation that sexually active women not using birth control avoid alcohol consumption.

In other news, it is my pleasure to announce that Dr. Harald Schmidt, Assistant Professor of Medical Ethics & Health Policy at the University of Pennsylvania, is the Journal’s new Faculty Advisor. As an established bioethicist and longtime faculty member at Penn, Dr. Schmidt is aware of the unique niche that the Journal occupies within the field of bioethics, and is committed to helping the Journal expand its reach on local, national, and international levels.

I would like to thank the entire editorial staff and Dr. Schmidt for their hard work and dedication that made this issue possible. I encourage you to explore the following content, and hope that you find these bioethics topics both engaging and thought-provoking.

Darby Marx  
*Editor-in-Chief*  
University of Pennsylvania C’17

## Body Hacking Movement Gains Momentum



Body hackers displaying their Northstar LED light implants.

In February 2016, the world's first "BodyHacking Con" took place at the Austin Convention Center in Texas, where several hundred body hackers gathered to share their mission to improve the human body through implantable technologies. At the convention, body hackers lined up to receive implantable radio frequency identification chip devices, called RFIDs, that have encrypted information to open doors or contact personal smartphones. Others opted for more visible gadgets, such as the Northstar, which is implanted into the hand through a gory procedure and mimics bioluminescence when its five LED lights flash in response to a magnet (Peralta 2016).

As evidenced by the convention, the body hacking movement has a host of followers, called "grinders," who intend to push the boundaries of what constitutes human improvement. Many body hackers also self-identify as "cyborgs" because of their combined biological and artificial traits. Cyborgs believe that modern technology is capable of improving the human body beyond medical fixes, and often use their own bodies as experimental platforms for innovation. Experiments like the bio-safe chip and the Northstar utilize technology to augment the human body and give it capabilities beyond those we are born with.

Body hackers have even cited eyeglasses—which enhance natural human capabilities—as primitive evidence and reason to expand beyond traditional means of enhancement. In one famous case, a colorblind artist from Barcelona, Neil Harbisson, was persuaded by a physician to implant a camera in the back of his head. He now uses an antenna that detects the dominant color in front of him and translates it into musical notes, creating a relationship between color and sound—an awareness of his surroundings that he would lack otherwise (Peralta 2016).

Though the recent convention brought body hacking into the limelight, this movement is not new. Generally recognized as the birthplace of the biohacking movement, England gave rise to two main figures, Kevin Warwick and Lepht Anonym, who served as inspiration for the modern generation of grinders. Warwick, an academic in the Department of Cybernetics at the University of Reading, and Anonym, a DIY punk, were two of the earliest body hackers to garner attention. While Warwick relies on a trained staff of medical technicians for his implants, Anonym spurred a radical movement by implanting the machinery herself.

Because of them, body hackers over the past decade have formed a loosely-organized culture through online forums, such as biohack.me (Popper 2012).

Biohacking is closely connected to transhumanism, a broader movement that underwent a transformative shift in 1990, following events including the first gene therapy trial. Transhumanists advocate for the enhancement of the human condition through sophisticated technologies, and many believe that overcoming human mortality can be a reality by 2045. Other modern trends, such as DIYbio, emphasize the accessibility of research biology to the greater public through self-experimentation (Popper 2012).

Despite its expanding popularity, the movement has raised ethical and moral concerns from multiple communities. For bioethicists and experts in the medical field, justifying medical need for these implants is of immediate concern. These considerations make it difficult for body hackers to find physicians willing to carry out these invasive and personally-motivated procedures (Popper 2012). Additionally, although the Food and Drug Administration and American Medical Association have released recommendations on RFID devices, many healthcare providers are concerned about the safety of body hacking (Bacheldor 2007 and "Guidance" 2004).

Others are concerned about the potential implications biohacking could have for socioeconomic structures, arguing that the divide will only widen as society continues to create technologies that are not widely accessible (Geoffrey 2015). On a more theoretical level, ethicists are also examining how biohacking could negatively impact social identity. Some believe that through an obsession with enhancement, we will have no "discrete, persistent selves, no 'real' me, and that we will come out on the other side of biohacking as some homogenized, bland, and sterile form of humanity" (Woo 2015). Others have even argued that the entire transhumanism movement perpetuates the ideology of the eugenics movement through "self-directed human evolution" (Jotterand 2010).

Despite differing points of view in the ethics field, drawing the line between human and cyborg—that is, if there is a line to draw—will become increasingly important as the once under-the-radar collection of body hackers becomes a more dominant force around the world.

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# Cleveland Clinic's Attempted Uterine Transplant: An Ethical Perspective



On February 24, 2016, a medical team at the Cleveland Clinic performed the first uterine transplant in the United States as part of a clinical trial to help women suffering from uterine factor infertility (Cleveland Clinic 2016a). Although the attempt was unsuccessful, this event marked a significant step toward making uterine transplants safer and more widespread.

Uterine transplants are unlike many other organ transplants in that they are not life-saving (Rettner 2015). Instead, they enable women who have damaged or missing uteruses to experience natural pregnancies and births. Sweden is currently the only country in which there have been successful transplants, with five successful pregnancies resulting from nine procedures. In these cases, patients kept the uteruses only long enough to have one or two children, after which they were removed (Fox 2016a).

A significant risk of uterine transplantation is due to the immunosuppressant drugs given to recipients to prevent rejection of the organ. There is little evidence on how these drugs can affect a developing fetus, and side effects of the drug include an increased risk of preterm delivery and infection (Rettner 2015). Furthermore, other complications may result from this operation, as illustrated by the failed transplant at the Cleveland Clinic.

Initially, the transplant appeared successful. However, on March 9, the Cleveland Clinic released an update explaining that the uterus had to be removed due to a complication. Upon further investigation, it was found that the recipient had a yeast infection (Fox 2016b). According to a statement by the clinic on April 8, "...The infection appears to have compromised the blood supply to the uterus, causing the need for its removal," (Fox 2016b). The severe impact of the yeast infection on the success of the transplant reveals that there are still significant issues to be addressed with this procedure.

As uterine transplantation is still new and experimental, it must be viewed in this context of research. According to an article published in *Transplant International*, "Research differs fundamentally from clinical care in that clinical care concerns itself only with the welfare of the patient, whereas research aims to aid all persons for whom the findings will benefit and inform" (Lefkowitz, Edwards, and Balayla 2012). Efforts to conduct uterine transplants, therefore, should be judged not only on the basis of individual costs and benefits, but also societal ones.

In order to examine the bioethical implications of this procedure on an individual level, positive outcomes of the procedure's success must be weighed against the myriad complications and harm that could result. A salient bioethical principle to consider in this discussion is non-maleficence (Lefkowitz, Edwards, and Balayla 2012). Physicians should not perform medically unnecessary and exceedingly risky procedures on their patients. Safer alternatives to having children certainly exist, such as adoption or surrogacy, although they do not grant the experience of pregnancy and childbirth to the mother.

For some women who seek to raise children, however, childbirth is integral to their identities as mothers. The principle of autonomy, in this case, conflicts with the principle of non-maleficence. Assuming that she fully understands the risks and potential complications of the procedure, a woman's choice to receive a uterus transplant should be upheld and respected by physicians (Lefkowitz, Edwards, and Balayla 2012).

Currently, uterine transplantation is far from a commonplace procedure. The numerous risks and complications involved not only with the transplantation but also the subsequent steps leading to a healthy birth are significant hurdles to overcome before this procedure can be more readily available. Following the failure of the first uterine transplant, the Cleveland Clinic announced there will be no changes in its plan to enroll ten women in its clinical trial (Cleveland Clinic 2016b).

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## Exploring El Salvador's Zika Virus Pregnancy Ban

This past year, the Zika virus has become a global health scare. Since high rates of the disease were first identified in northeastern Brazil in early 2015, the disease has spread to over 30 countries in South and Latin America and infected an estimated 1.5 million people (Schuler-Faccini 2016; Kirk 2016). Though the mosquito-borne disease rarely causes serious health issues, experts have noticed a correlation between pregnant women infected with the virus and increased rates of infants born with microcephaly, a neurological condition characterized by an underdeveloped brain and an abnormally small head (Ahmed 2016). Because of this risk, governments in countries such as Colombia, Jamaica, and Honduras have issued statements asking women to delay pregnancy until the outbreak has passed (Partlow 2016).

In late January 2016, the government of El Salvador issued a recommendation for couples to avoid pregnancy until 2018 (Ahmed 2016; Garsd 2016). This recommendation shows significant governmental concern regarding the disease, despite how little is truly known about it. The recommendation also comes, however, in the context of a strongly Roman Catholic country in which abortions and contraception are illegal under all circumstances and sexual education programs are not prioritized (Ahmed 2016; Miller 2016; RT 2016). The country also has one of the highest teenage pregnancy rates in the world due to the prevalence of sexual violence, especially in impoverished areas (RT 2016).

In such a country, the poor, who lack access to reproductive technologies, are disproportionately affected by unplanned pregnancies. Zika compounds on this issue of inequality, since poor women are at a greater disadvantage, lacking the resources to properly protect themselves from mosquito vectors transmitting the disease (Jordan 2016). Thus, the government recommendation for pregnancy avoidance brings up significant bioethical questions that can be explored through a historical lens.

In the 1960s, an outbreak of rubella in the United States changed the rhetoric around abortions, emphasizing a woman's ability to work directly with her physician to make decisions about reproductive health (Berman 2015). Like Zika, the symptoms of rubella are frequently insignificant for the individual. However, infection of pregnant women causes devastating birth defects, including microcephaly in 85% of fetuses infected in the first trimester (Garsd 2016; Berman 2015). The 1960s rubella outbreak occurred in the context of a strongly anti-abortion American public.

At the time, illegal abortions were associated with the poor, but the increased rates of rubella pushed upper-class women toward the procedure as well. As a result, abortion became less strongly tied to issues of race and class while gaining the acceptance of a much larger American society (Garsd 2016).



In Recife, Brazil, Pediatrician Danielle Cruz checks on a child born with microcephaly.

Like the socio-cultural response to the rubella outbreak, El Salvador's ban on childbearing has important bioethical implications. The similarities of the current outbreak to the American rubella case suggests that Zika presents an opportunity for these strongly anti-abortion countries to reconsider their stances on abortion and contraception, especially when it comes to protecting children from preventable developmental defects. Already, the Pope has issued a statement easing the ban on contraceptives for women infected with the disease (West 2016).

Zika virus also brings up ethical questions of the extent to which the state can issue control over reproduction. When this intersects with poverty and gender, it asks whether the state must ensure that all members of a population are treated equally. In such a situation, the current ban on childbearing in Zika-infected countries must reconcile government imposition onto bodies—and poor women's bodies in particular—with the goal of maximizing the “common good” of the state.

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## CDC's Recommendation on Women's Alcohol Consumption Stirs Controversy

On February 2, 2016, the Centers for Disease Control and Prevention (CDC) released a statement urging women between ages 15 and 44 to refrain from the consumption of alcohol “because they are drinking, having sex, and not using birth control to prevent pregnancy” (CDC 2016). The statement followed the recommendations by the American Academy of Pediatrics stating that “no amount of alcohol intake should be considered safe, there is no safe trimester to drink alcohol, and all forms of alcohol, such as beer, wine, and liquor, pose similar risk” to developing fetuses (Williams 2015). The range of developmental disorders associated with drinking during pregnancy fall under the umbrella of fetal alcohol spectrum disorders (FASD), including physical, behavioral, and psychological abnormalities (Williams 2015).

Following the CDC's statement, an explosion of feminist news outlets protested the alcohol restrictions, labeling them as sexist and unrealistic. *Slate's* Ruth Graham quipped, “It's the kind of swath-yourself-in-bubble-wrap thinking that has turned modern pregnancy into a nine-month slog of joyless paranoia” (Graham 2016). According to Graham, defining pregnancy as a state of purity and innocence results in enormous social and psychological pressures on expecting women to restructure their lives and behaviors. *Jezebel's* Jia Tolentino wrote that “to extend this idea to women who might become pregnant just because they are alive and unmedicated—or to phrase the recommendation with a basic disregard for the facts of how women live—suggests the same old idea that all women are either future, current, past or broken incubators, and that is their body's primary use” (Tolentino 2016). According to Tolentino, centering a pregnant woman's worth on a fetus treats her as a means to an end. *Washington Post* writer Alexandra Petri took a satirical approach to the situation, claiming she “had no idea that drinking eight beverages a week could result in a baby. I always thought, somehow, that there were other activities involved. But the CDC knows best” (Petri 2016).

With the spread of the Zika virus and women's access to healthcare remaining a point of contention in the 2016 presidential election, questions surrounding pregnancy and women's reproductive rights continue to be a major issue. Many feminist groups view impositions on women's healthcare as puritanical and representative of government over-regulation, while many rightwing republicans feel upholding the moral values of the nation is a job of the legislature (GOP 2016).

Two days after the original press release, CDC Principal Deputy Director Dr. Anne Schuchat stated, “We weren't as clear as we had hoped to be,” and further asserted that the effects of alcohol on developing babies are “completely preventable” (Victor 2016). In an interview with *New York Times* contributor Daniel Victor, Dr. Schuchat said the goal of the CDC's recommendations was to raise awareness of the risks involved in drinking while pregnant, rather than to suggest that women “plan their entire lives around a hypothetical baby” (Victor 2016). Although the CDC's recommendations regarding pregnancy and alcohol consumption elicited a wide range of responses, their purpose was to merely warn the public of possible health risks. In the future, the CDC will likely take extra precaution in evaluating the social and personal implications embedded in their statements.

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The above infographic was previously published on CDC's website, but has since been taken down due to the backlash addressed in this brief.



# Interview

## A Conversation with Dr. Lance Wahlert

Dr. Lance Wahlert, PhD, is an Assistant Professor of Medical Ethics & Health Policy, Program Director of the Master of Bioethics (MBE) in the Perelman School of Medicine, Core Research and Teaching Faculty Member in the Department of Gender, Sexuality, and Women's Studies at Penn, and Director of the Project on Bioethics, Sexuality, and Gender Identity. He has a wide breadth of research interests, including queer studies, the history of medicine, English, cinema studies, and bioethics. Currently, Dr. Wahlert is writing his first book on the history of 20<sup>th</sup> century appreciations of homosexuality in cinema and medicine.



*Photo courtesy of Dr. Wahlert*

**Penn Bioethics Journal (PBJ): In your opinion, what are the main bioethical issues facing the LGBTQ community?**

**Dr. Lance Wahlert (LW):** I think a lot of them have to deal with, obviously, representation in the medical profession, whether or not there are more or less LGBT persons who are clinicians. I think inclusivity has a lot to do with how these communities feel. There is a long history and legacy of seeing medical discourse as being predisposed to think pathologically about people's queerness, or to be gun shy about doing that. So a lot of clinicians and physicians who are doing good work are wary to ask questions about one's gender non-normativity or sexual non-normativity, for fear of making people feel singled out. There's a very precarious relationship that comes from legacy.

Queer people have their closest brethren in the community of disability studies. Most of the language that surrounds disability has been around notions of pathology and illness. Terms like "homosexual," "transsexual," "transgender," "bisexual," came out of medicine, so the intimidation of medicine that's present for anybody who feels marginalized is particularly heightened for queer persons, because [their] whole history [has been] been pathologized.

**PBJ: You mentioned that the closest brethren to LGBTQ persons are disabled individuals. Could you comment on how that statement applies to the topic of non-medical sex selection?**

**LW:** The connection between queerness and disability has to do with a history of pathology on the one hand, but on the other, it has to do with how families are forged and how communities are built. That condition, whether it be disability or queerness, in many cases causes individuals to found families and build fraternity, sorority, and fellowship, laterally, not just vertically between parents and kids. So the question about, say, non-medical sex selection, is a lot like thinking about non-medical disability selection. This is what conversations about disability preservation are basically couched around; to say, how

dangerous is it to start thinking about using certain calibers to wipe out certain kinds of persons.

I can tell you that when it comes to non-medical sex selection, a lot of bioethical discourse has tended to surround a couple of major conditions. First of all, the discussion of sex selection becomes particularly contentious when there is not just the one variable, but also another variable that says you can only have one kid and you can select the sex of that child. That is one example where the bioethics of non-medical sex selection has really taken off in the last 20 years.

The other two topics of bioethical discourse in non-medical sex selection actually speak to queer communities, even though one of them is not necessarily queer. For example, when it comes to gender-specific conditions that are congenital, like hemophilia, this is where non-medical sex selection gets talked about a lot. It's a congenital condition and it is contracted particularly in boys because of the fact that it's carried on the Y chromosome. Queer people take a lot of alarm there because we feel very protective of hemophiliacs. The question of eradicating hemophilia or avoiding hemophilia in your offspring is something that borders very closely to a very serious queer population, which are people with HIV.

And the third topic would be something in terms of congenital conditions, such as the condition of congenital adrenal hyperplasia. The intersex community is one that is often included under LGBTQI discussions. Interventions for intersex kids, if discovered after they're

born, usually occur because of some anatomical difference. Congenital adrenal hyperplasia is one of these conditions and therefore, the question about whether to have—in this case, it could be described as medical or non-medical sex selection—is one that queer people would also have hesitation with.

Interventions on behalf of gender anomaly is something that a lot of people in queer theory and bioethics are wary of. This question of what is medical and what is non-medical intervention is a moving gray line.

**“There is a long history and legacy of seeing medical discourse as being predisposed to think pathologically about people's queerness, or to be gun shy about doing that.”**

**PBJ:** When evaluating the ethics of a non-medical sex selection decision, what factors come into play?

**LW:** It depends on the case, and it depends on the intention. I'm very wary of jurisdictions in the United States and other countries that want to dictate whether one can have the right to get an abortion. They want to make that mandate based upon whether or not the intention involves family welfare, economics, or whether or not you think your happiness or your mental health is at stake. In fact, in a lot of countries throughout the world, the barometer to determine whether or not you can get an abortion is whether or not you can prove that either the life of the mother or the life of the child is at stake. In that case, sometimes the life of the mother just means her happiness. In the United States, in most jurisdictions, abortion

is just on demand if you want to have it. And so, questions about non-medical sex selection become unethical when we start to look into the minds of persons to figure out why they want or don't want the child. The hard part is that whether we're talking about abortion, whether we're talking about sex selection, whether we're talking about any kind of termination or extension of a pregnancy, how do you get inside somebody's psyche to determine what their motives are? One hopes that there isn't a discriminatory or eugenic agenda at hand, that there isn't disfavor that's fueling a particular solution or selection.

On the one hand, I don't want people to be having abortions; I don't want people to be terminating pregnancies because they don't want a baby of color, a queer child, or a boy or a girl or what have you—on the other hand, I don't want to infringe on anybody's rights to determine whether or not they can make reproductive choices on their own. So it's very difficult. This is why it's a very good bioethics question. Bioethics, ethics, really means values, but according to an Aristotelian definition, it means choices. You get to a moment and you have to make a choice and good ethics is hard ethics, which is to say you get to that fork in the road and I can see two or three good choices or I see two or three awful choices or I can see two or three things or principles that I want to honor—unfortunately I can't honor them all.

In fact, for people who want to talk about theories like principlism, the principle of do no harm, the principle of benevolence, etc., the hard part is that a lot of times, those principles are in competition with one another. I want to honor people having reproductive freedom and choice to determine whether or not they want to terminate pregnancy, yet I also want to protect diversity and disabled bodies and queer bodies, and sometimes, I can't honor both things at the same time, so that's why it's person-to-person, decision-to-decision, soul-to-soul; the right side to honor varies.

**PBJ:** When would non-medical sex selection be ethical?

**LW:** A classic example of that would be if you're using IVF, you often have to impregnate and cultivate multiple zygotes. Let's say, for example, that there are twelve zygotes that are ready to be used, but there's a strategic choice to select however many from there. Does one need to cover one's eye

“Questions about non-medical sex selection become unethical when we start to look into the minds of persons to figure out why they want or don't want the child.”

and just pick the four or can one actually say “Well, we can determine the future of these particular sets of cells here—do I get to take my hand off my eyes and pick the ones I want to put in?” Whether or not one argues for one case or the other is totally based on whatever your own particular values are, as a lot of bioethics conversations are, but the fact of the matter is that half of those tissues are going to

be destroyed regardless. This is where, basically the way to put this is—how far do we take family planning? Is it wise to draw a line where there shouldn't be family planning? I have a hard time trying to think of a moment where non-medical sex selection strikes me as comfortable, and yet, suggesting that there is a limitation on how much you get to be a with-eyes-wide-open participant in how you choose to get pregnant or how you choose to have a child worries me only because someone is going to start to move that line back. That's what I'm afraid of.

**PBJ:** Would you say that fertility specialists have an obligation to offer non-medical sex selection and should they be able to refuse it?

**LW:** I definitely don't think they have an obligation to offer it, that's for sure. Do they have an obligation to refuse it? Probably. Just in the same way that any OB/GYN has the right to not offer abortions if they don't want to. Any medical practitioner, if they have a moral objection to a particular procedure, has a right not to provide it, so long as it is not life-saving or affecting the health of their patient. Having said that, they have an obligation to refer somebody to another practitioner for said services. In most cases, medical standards on whether there's an obligation to perform a particular procedure—if the life is at stake, you must perform whatever you're medically capable of and trained to do. Short of that, you can refuse as long as you're willing to get that person the care they have asked for in another venue ASAP. The moral objection comes if you're trying to keep somebody from something they have a legal or ethical right to.

*Interview by Jake Morse and Olivia Webb*

# A Unique Way of Thinking? Cognitive Capacity and Moral Status in Humans and Animals

Eitan Sapiro-Gheiler\*

In 1871, Charles Darwin theorized in *The Descent of Man* that *Homo sapiens* was, like any other nonhuman animal, a product of evolution from common ancestors. Yet despite these shared origins, most humans exhibit traits that appear unique—consciousness, complex reasoning, and long-term preferences. Possession of these traits, integral to ethics, leads many to automatically grant all humans a higher moral status than any animal. To show why this is unjustified, I will not seek to prove that equal moral status between humans and animals is a consequence of a shared property, a view reflected by Peter Singer's position that "the ability to feel pain...gets animals into the moral community." Nor will I deal with constructing a complete hierarchy of moral status that defines the comparative status of humans, animals, and, as in Dario Ringach's example, "a rock, a dead cat, or human remains." With one final assumption—that moral status is a consequence of morally relevant traits, not a direct consequence of species membership—I will seek to show that three common arguments which put all humans in a category of moral status higher than that containing animals are flawed. The arguments I will address are: (1) by granting moral status as a consequence of possessing certain traits, some animals are necessarily excluded, (2) valuing the potential to possess these traits means that at least some non-human animals must be denied moral status, and (3) valuing membership in a category that naturally possesses those traits necessarily denies moral status to some animals.

In 1871, Charles Darwin theorized in *The Descent of Man* that *Homo sapiens* (henceforth humans), shared common ancestors with nonhuman animals (henceforth animals), making humans a product of evolution like all other species rather than a unique entity (Darwin 1981). Yet despite these shared origins, most humans do exhibit traits that appear to point to uniqueness—such as consciousness, complex reasoning, and long-term preferences. Possession of these traits, which are integral to ethics, leads many to automatically grant all humans a higher moral status than any animal (Singer 2015). In our discussion, we will define moral status according to the Stanford Encyclopedia of Philosophy, which states that an entity has moral status if "its interests morally matter to some degree for the entity's own sake" (Jaworska and Tannenbaum 2013). A higher moral status for humans means that when a human and an animal have equal and opposing interests, the human's are preferred (Singer 2015).

The goal of this paper is not to explain why certain animals ought to have the same moral status commonly accorded to humans, but rather to show that not all humans merit higher moral status than all animals. Thus I will not seek to prove that equal moral status exists because of a shared property, a view reflected by Peter Singer's position that "the ability to feel pain...gets animals into the moral community" (Frey 2009). Likewise, constructing a complete hierarchy of moral status that defines the comparative status of various entities as Dario Ringach compares "a rock, a dead cat, or human remains," is beyond the scope of the paper, as I am not attempting to classify all entities by moral status, but rather merely to show that there is overlap between humans and animals (Ringach 2011). The arguments I will address are:

(1) by granting moral status as a consequence of possessing certain traits, some animals are necessarily excluded, (2) valuing the potential to possess these traits means that at least some animals must be denied moral status, and (3) valuing membership in a category that naturally possesses those traits necessarily denies moral status to some animals.

### Possession of Morally Relevant Traits

The first way to assign moral status is by whether an entity possesses a particular set of morally relevant traits. This includes traits that may not always be manifested—for example, a sleeping human is not self-aware while asleep, but still possesses the trait of self-awareness. A trait is usually categorized as morally relevant if it is necessary for moral thought, leading us to grant an entity the highest possible moral status if it possesses sophisticated cognitive capacities, or SCC (Jaworska and Tannenbaum 2013).

Included in this broad category is the ability to reason, hold preferences, make choices, and be self-aware, traits vital for being able to, as Carl Cohen puts it, "lay down moral laws [which make the entity] self-legislative, morally autonomous" (Cohen 1986). An exact definition of SCC is beyond the scope of this paper, but the arguments that follow could be made valid for any definition that excludes all animals.

Yet as Bonnie Steinbock points out, a select few humans lack SCC and "have less capacity for moral choice and responsibility" than some animals (Steinbock 1978). This view would thus exclude human infants, often compared in cognitive capacity to intelligent animals, as well as those suffering from dementia, individuals born with mental handicaps, or those with brain injuries who lose self-awareness

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or recognition of the future (Koren 2013; “Alzheimer’s Disease Fact Sheet” 2015). Expanding the definition of SCC would almost certainly include some animals, as Lori Gruen notes that “work on animal behavior suggests that many of the activities that are thought to be distinct to humans occurs in non-humans.” For example, animals have been shown to form long-lasting relationships with kin, sacrifice their safety to care for the ill or elderly, and to “to suffer terribly from the death of their partners” (Gruen 2014). According to Marc Bekoff, grief is apparent in a range of species: “Dolphins also have been observed struggling to save a dead infant. Elephants have been observed to stand guard over a stillborn baby for days with their head and ears hanging down, quiet and moving slowly as if they are depressed” (Bekoff 2000).

Thus, the attempt to assign moral status based on these uniquely human, morally relevant traits excludes some humans, while any attempt to include all humans includes some animals. However, SCC serves as a valuable trait because it distinguishes a majority of humans from a majority of animals. Thus the remaining arguments will still use SCC as a classifier to define differing categories of moral status.

### Potential Possession of Morally Relevant Traits

Broadly, there are two definitions of potential that are commonly used when dealing with moral status: “direct potential” and “average potential.” An entity has direct potential if, given a normal course of life, free of injuries or other interruptions, it can develop the traits needed to be accorded a certain moral status. Charles Camosy explains that, “[a] snail can only develop as a snail does...never able to have projects of its own, never able [to] self-consciously wonder about its place in the universe...The fetus, if she is permitted to actualize her potential, will experience all of these things,” meaning a fetus would have direct potential to develop SCC and would be accorded the highest moral status, while a snail would not (Camosy 2012). However, under this definition, an elderly person with Alzheimer’s disease, or someone with permanent cognitive disabilities, would not have direct potential, as their impairment is currently considered permanent.

The second type of potential is “average potential”—whether an entity is a member of a category which, given a “natural” course of life, would possess moral status—to highlight an issue with the definition of a natural course of life. This is a variation on what Camosy terms “active potential,” a potential which is part of the very nature of an entity (Camosy 2012). Here, both the infant and the elderly person could, if they were to live a natural life, possess SCC and thus the same moral status as a healthy human, whereas a snail, even if it were normal and healthy, could not develop SCC and thus would have a lesser moral status.

We look first to direct potential, which struggles with the same types of situations as the possessed trait argument. While it does expand the category of beings given higher moral status to include infants, direct potential still excludes the cognitively disabled, who have no ability to develop SCC. Peter Singer notes that the impairments that prevent those humans from displaying these traits are

usually permanent and thus serve as a counter to the direct potential argument as well (Singer 1993). One could argue that this is merely a result of technological limitations. Perhaps in the future, the development of treatments for cognitive disabilities will render them an unimportant distinction. However, by that same logic, technology could enhance animal cognitive capacity sufficiently to grant certain animals SCC, at which point they would merit equal moral status regardless of the process used.

Furthermore, the direct potential argument creates a higher chance that animals will merit the same moral status as humans due to the possibility of inaccuracies when assessing the cognitive capacities of animals. Kristin Andrews notes that “[g]iven the lack of theoretical consensus on the nature of rationality, empirical research projects are not designed to examine rationality directly. Instead, researchers investigate various capabilities that may be associated with rationality” (Andrews 2014). This opens the possibility that what researchers are seeing in animal research projects is not reflective of an animal’s potential cognitive capacity, only the capacity that exists under human-created conditions. Because it still excludes some humans and has a higher probability of including animals, the direct potential argument does not suffice to give all humans higher moral status.

The average potential argument seeks to circumvent the issues of direct potential by defining potential in terms of the natural course of a particular category of entities. There are two main difficulties with this argument: choosing a category and defining its natural potential. We look first at the latter issue, which John Fisher explains requires us to “view the development of an organism as an ineluctable progression towards a specific predetermined goal,” which the organism can meet to varying degrees (Fisher 1994).

For the purposes of this analysis, we will consider the human species as our category, though the average potential argument is applicable to other chosen categories, such as United States citizens, mammals, or living beings. It is common to assume that there is a normal or expected level of overall cognitive capacity for all humans, though theories like Howard Gardner’s idea of “multiple intelligences” suggest that some humans naturally possess certain cognitive abilities associated with SCC in greater or lesser strength (Gardner 2006).

In the case where illnesses or injuries cause cognitive impairments, the average potential argument, which assigns moral status based on the average course of life, grants impaired individuals the same moral status as healthy humans, since these illnesses or injuries are not normal or average. The case of genetic differences, however, is not as unambiguous.

One significant challenge to the argument that average potential grants those with genetically-based cognitive disabilities equal moral status would be questioning the idea that those born with disabilities are severely impaired or abnormal at all; as Harriet Johnson writes, “the presence or absence of a disability doesn’t predict quality of life” (Johnson 2003).

Given this perspective, we can imagine two extreme cases. In the first, anyone with below-average cognitive

capacity is considered “abnormal”—one could imagine a society in which everyone who does not receive the average IQ score is labeled as cognitively impaired. In the second, any level of cognitive capacity, including those now considered evidence of an impairment, is accepted as normal.

Clearly the first case is overly inclusive in that too many people are categorized as impaired, while the second is exclusive and prevents any kind of recognition or treatment of diagnosable cognitive impairments. The middle ground is thus a case where on the full range of possible cognitive capacities, an interval around the median is considered normal, while anything outside that interval is considered abnormal. The average potential definition would include individuals within the interval who possess SCC as well as all those outside the interval. However, some individuals may be within the interval but lack full SCC. This highlights another difficulty with average potential—it is nearly impossible to find a well-known set of “normal” traits around which to define an average.

### Category Membership

Even if traits are assumed to have a natural state, the second problem that arises with the average potential argument is the choice of category. Overly restrictive categories, such as race or sex within the human species, provide insufficient ground for differentiation. As Peter Singer notes, “[w]e can admit that humans differ as individuals, and yet insist that there are no morally significant differences between the races and sexes” due to the high degree of overlap between members of different categories (Singer 1993). Overly broad categories, such as mammals, or even animals, do not allow differentiation of moral status between humans and nonhuman entities, and are thus an ineffective argument in favor of higher moral status for humans. To avoid this, the human species itself can be used as a category, remembering that SCC was constructed to show a significant, morally relevant difference between humans and other species. The criterion for moral status has thus progressed from possession of SCC, to the potential to possess SCC, to membership in some group possessing SCC, to membership in a species possessing SCC. But categorization by species raises a problem noted by Agnieszka Jaworska and Julie Tannenbaum: while species membership is dependent on certain biological traits such as mating ability, those traits are not themselves morally relevant, while the traits that compose SCC are (Jaworska and Tannenbaum 2013).

While the human species may be a morally valid category since humans typically possess morally relevant traits, including SCC, granting moral status based on species membership rather than possession of those traits would imply that biological determinants of species, not SCC, define moral status. For example, categorizing a human and a chimpanzee with equal cognitive capacity as differing in moral status makes that status a question of species, not SCC. We already began by assuming that moral status is not a consequence of species. However, a strong argument in opposition of the species-based average potential argument can be made based on the fact that species categorization makes basic biology, not SCC, the determinant of moral status.

### Conclusion

To show that if moral status is assumed to be a consequence of morally relevant traits, it is not justified to give all humans a higher moral status than any animal, we examined three common traits-based criteria for moral status: possession of SCC, direct potential, and average potential. Although traditional utilitarian arguments related to suffering were not addressed in this paper, these three arguments provide a comprehensive background on this subject.

Other than average potential, all criteria failed to include all humans, while average potential rested on the uncertain assumption that a natural state existed and created a definition of moral status that depended on biological determinants of species instead of morally relevant traits. The flaws of these three arguments means we might not be justified in giving every human higher moral status than any animal. But this determination leaves open a key question: should some humans possess lower moral status than others, or should some animals possess the highest possible moral status, along with all humans?

Even that answer does not resolve the issue of moral status, as the specific privileges and treatment guaranteed by various levels of moral status are often as difficult to determine as the status itself. Clearly, an incompatibility exists between the moral status certain entities are assumed to have and the moral status that is philosophically justifiable. Correcting this justification has ramifications from the laboratory to the dinner table and affects the way we consider and define the uniqueness of the human species itself.

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# From Cradle to the Womb: Arguments against Non-Medical Sex Selection and the Principle of Dignity

Anastasia Eugenia Rykova\*

“From Cradle to the Womb” analyzes non-medical sex selection from the perspectives of discrimination, balance, and protection. A common thread—the principle of harm—runs through this discussion; helping draw the conclusion that medical sex-selection for non-medical purposes is, by an overwhelming amount of reasons, unethical. Although this principle is sufficient, it lacks the fundamental strength required to axiomatically make this practice unethical. The principle of dignity, differing from the principle of harm in its foundational nature, achieves this very purpose. With final reference to dignity, “From Cradle to the Womb” concludes that non-medical sex selection can never be ethically justified.

From inherited family secrets about what foods to eat, to medical interventions for the implantation of a specific-sexed fetus, sex-selection has long been a reality of human reproduction. Given its history, sex selection will likely remain a reality, but the question of whether sex selection is ethical or not still persists. This paper will argue that sex selection—for non-medical purposes—is ethically indefensible by addressing three different, but related, concerns: preference, balance, and protection.

Although the concern is not with the ethics of the methods by which the sex-selection is achieved, it is important to understand, generally, how it is performed.

### What is Sex Selection?

Sex selection can be broadly defined as anything which conceiving individuals do to affect the sex of their unborn child. For the purposes of this article, sex selection will refer strictly to medically accepted or proven interventions that seek to affect the sex of an unborn child. In particular, this article is concerned with using abortion as a means of sex selection.

Medical sex selection is when sex selective services are performed for the purposes of identifying sex-linked genetic diseases. Such is the case when a conceiving pair has a disorder or a family history of a disorder that is known to be passed down to certain sexed children. For instance, a sperm donor affected by Coffin-Lowry Syndrome, a disorder characterized by small stature and intellectual disability, will pass their condition onto a female fetus 100% of the time (Castriota-Scanderbeg 2005; Rovensky 2009).

By contrast, Hunter Syndrome, a condition that commonly causes skeletal deformities and neurological decline, is X-linked recessive, meaning an egg donor who is a carrier of Hunter Syndrome will always pass the disorder to any male offspring. Depending on the carrier status of the parents, a given genetic disorder has a different chance of being passed on to the next generation. Coffin-Lowry

Syndrome, for example, is 50% likely to express in a male fetus if his biological mother carries it and 0% likely if the biological father is the carrier. In cases where the sex of the child directly impacts the probability of inheriting a serious genetic disorder, knowing the chromosomal makeup of a fetus can be crucial. Even when a test does not guarantee—as many do not—that a fetus has indeed inherited a particular genetic disorder, conceiving individuals can make informed decisions about continuing with the pregnancy based solely on the sex of the fetus.

Non-medical sex selection, on the other hand, uses sex selective techniques for purposes other than the detection of genetic diseases or their probabilities. These are often healthy conceiving individuals who do not carry sex-linked disorders, but desire to implant and carry a particularly sexed child to term. Although an ethical analysis of pre-conception sex selection is much needed, this paper will largely focus on the consequences of post-conception sex selection that is non-medical in nature.

### Strong Concerns Against Non-Medical Sex Selection

This section examines arguments against non-medical sex selection in an attempt to understand how the principle of harm aids or hinders the act in question.

#### *Preference*

Individuals who desire certain sexed children due to no other reason than preference are often criticized as sexists, for such vehement preference can be viewed as a statement of value. The only natural way for one to want a female over a male, or vice versa, is if one believes that such a factor would change or influence the child. The origin of personhood appears to be confounded because the assumption is that a certain sex will lead to a certain type of individual. Even if it were the case that sex created personhood, there is an assumption of heteronormativity.

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However, that which is feminine does not necessarily belong to only females and what is masculine does not necessarily belong to only males. It is not sex or the gender that dictates what “can” and “cannot” be done with our children, it is social convention. Non-medical sex selection on the basis of preference is discrimination and, therefore, unethical.

### *Balance*

Some pregnant couples could, theoretically, desire a female or male because they already have a child of the opposite sex. If this desire wasn't discriminatory, wouldn't statistics reflect the facts? If parents just wanted to have balanced families, there should be equal choice for female and male fetuses during the sex-selection process. Yet statistics on these procedures reflect that these techniques are exclusively used for the birthing of sons rather than daughters (Renteln 1992). There is a clear preference for the male sex across many countries—China and India in particular—and, in considering this, it becomes clear that “balance” is just another form of discrimination (Renteln 1992; Courtwright 2008).

Furthermore, the fundamental question of what is balance continues to persist (Blyth 2008). One could easily say that balance is having each person from one of the possible hair or eye colors. Or, that balance is achieved when you have a certain combination of personality types across the family. Can we, then, commit to the stance that it is ethical to allow sex selection and by extension, the aborting of a fetus that would have otherwise lived, on the basis of this arbitrary principle of balance? In my opinion, the answer is a clear and profound no.

### *Protection*

Arguments for “protection” claim that sex selection is necessary for the welfare of the child due to geographical location. For instance, if the community is deeply sexist, then the principle of harm justifies the procedure in question.

Yet in selectively aborting female fetuses, the community itself exacerbates the problem of sexism by promoting the ideas that sex carries personality and that men and women are different because they are men and women, not because they are individuals (Milliez 2007). Additionally, by having less females in the population, perceptions of women will likely remain unchanged and the status of women will continue to decline (Renteln 1992).

Parents do not necessarily have to consider this grand image, just the welfare of their future child. What if lives are at stake because the only chance to the necessities of life (i.e., food, water, currency, shelter) is to have male children because female children are not allowed into the workforce or to have an education? Why should individuals in these particular situations concern themselves with fifty years from now, when tomorrow is not secure? To this, there is only one answer; in the matter of life or death non-medical sex selection is ethical.

However, in the western world—for, unfortunately, I do not fully explore non-Western cultures here—this is rarely the case. Furthermore, in situations where non-medical sex selection is an actual matter of life or death, it is typically

true that real medical sex-selection is not an option; there is no active medical interference for sex selection. Therefore, although these topics do deserve inquiries of their own, they are outside the scope of this paper, and are irrelevant in the discussion of what makes non-medical sex selection ethically unjustifiable.

Strong concerns against non-medical sex selection pave the way towards a foundational and unifying principle against the act in question. The principle of harm operates in the positive for concerns based on preference and balance; showing that neither fetus, parent, nor future community should be harmed for the sake of folly desires.

In appeals to protection, the principle of harm acts in the negative. Save for certain rare scenarios, non-medical sex selection cripples the future lives of children. These arguments

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“The principle of dignity concerns itself with the moral and ethical implications of non-medical sex selection. In particular, it questions the ethical status of the parties seeking the procedure and of future generations.”

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and conclusions are satisfactory in fully making the practice of non-medical sex selection unjustifiable. Yet the principle of harm itself alludes to a concept more unifying and primary; a concept that calls into question morality and ethical behavior in general. This concept is the principle of dignity.

### **The Principle of Dignity**

The principle of dignity concerns itself with the moral and ethical implications of non-medical sex selection. In particular, it questions the ethical status of the parties seeking the procedure and of future generations.

### *Seeking the Procedure*

This facet can be simplified as the question of moral worthiness and ethical status of individuals who want children, but with added stipulations (which are, more often than not, shallow). Our most basic and oldest notions of dignity intuitively tell us that people should be worthwhile in and of themselves. Are people who want children, but only if they are female or male, treating potential life with dignity?

The definition of dignity may cause difficulty here since there is no exact consensus in regards to it and some even go as far as to deem the concept useless (Mitchell 2014). However, Jordan (2010) provides a thorough definition of human

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dignity in his paper, Bioethics and 'Human Dignity' and this will be the view employed here:

"Human dignity" refers to a collection of intangible, distinctively human goods. To affirm that there is such a thing is to affirm that genuine human flourishing requires at least the following; moral virtue, appreciation of beauty, awareness of oneself as a unique individuals, participation in human community, receptivity, and personal agency" (Jordan 2010).

This is the foundation to which we return in every instance of disagreement; how do you affect your own, your child's, and the future generation's dignity (i.e., the moral virtue, uniqueness, receptivity, personal agency, etc.) by choosing to sex-select for non-medical reasons?

There is, for instance, moral virtue in wanting your children to be happy, but there is no moral virtue in desiring a certain sex for them. It has been consistently shown—in this paper and otherwise—that sex does not equate to characteristics, personalities, or even happiness.

Even if taking into account how sex affects gender and our expectations for certain individuals, it has to be noted that the interaction between these concepts is losing its strength. This asks the question further: how will the moral virtue of future generations change if the current generation refuses to accept that sex is arbitrary? In the end, treating a possible life as undesired because of an organization of genes which have almost nothing substantial to do with the resulting individual (e.g., personality, characteristics) is a grotesque violation of human dignity; your own, the child's, and that of future generations.

The contradiction of human dignity occurring here should be addressed at this point. Do people not have reproductive rights? Isn't the infringement of these rights a violation of the very dignity being discussed in this very paper? Humanity—as an organization—has been in the business of controlling the desires of their population since the beginning. This is done informally, through socialization, and formally, through law. Although we may be unable to change or control immoral and unethical thoughts or desires, we can change the effects these desires may have by creating legal regulations. There is a limit to how much human "nature" can run amok and unregulated. This limit is, often, the occurrence of harmful, immoral, and/or unethical behaviour.

Thus, we are justified in claiming what kinds of desires for children are ethical and unethical—just as we are justified in claiming which reasons for murder are ethical and unethical. Secondly, reproductive rights have never been an absolute (Ethics Committee 2004). No one is required positive support for their every reproductive decision. One can see this, intuitively, if they consider their own feelings about an individual using abortion as birth control, or tricking someone into impregnating them and paying child support.

As a collective, we have the right to curb desires and actions that violate the dignity of the population. Not everything can be controlled, but guidelines for action can nonetheless be set. Given that reproductive autonomy is limited and not an absolute right, it would not be a violation of dignity to question the desires underlying the choice for children when individuals turn to the system for goal actualization. Non-

medical sex selection is a perfect instance of a case where guidelines are violated and the right to question is present.

### *Compliant Parties*

This consideration takes into account the children and their resulting environment should non-medical sex selection be performed. This does not mean that these children are necessarily born into harmful environments. However, it does mean that there might be ramifications to having your sex selected or knowing about it.

Conceiving individuals who want children of a certain sex operate from some—either conscious, unconscious, big, or small—base ideology rooted in sexism. Their happiness with their sex-selected child will likely be affected by whether that child fulfills certain gender roles (Renteln 1992). As such, the one who comes short of this role might find themselves in a hostile environment.

A lot of money and time was spent on ensuring that a child of the "right" sex be born. Having a son or daughter that are distinctly not male or female (e.g., masculine or feminine) would be undoubtedly disappointing. The future parent-child relationship may become so broken that the dignity of each party is put at stake.

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“As a collective, we have the right to curb desires and actions that violate the dignity of the population.”

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Consider, in addition to the above, the apparent “ambiguity” of non-medical sex selection. The distinct lack of stance on non-medical sex selection sends the message that children are things which one gets to pick and choose; something which can be completely fashioned and molded in respect to individual images and desires (Blyth 2008). The lack of firm legal rule on this matter implies that picking traits of one's future child might not be a violation of human dignity and that, therefore, it is ethical for children to become commodities. We, as a human community, should not sit back and allow for the abortion of fetuses on the basis of improper genitalia.

The final consideration is in regards to children who may know or find out that their parents selected their sex. Imagine a daughter knowing that she was wanted only second to her brother. Already treated as a second citizen, she would be faced with a fundamentally ground-breaking realization; that her own parents thought so much of something so little that they took on enormous stakes to prevent its occurrence.

To have one self knowingly be desired for some other purpose—especially a purpose so miniscule and inconsequential—than oneself, would have untold consequences on your dignity (e.g., your sense of uniqueness and personal agency). The questions of identity that would

ensue would be heartbreaking. Does one have to maintain constant vigilance and act according to certain gender roles, will one's parents be enormously disappointed if they do not, is one only wanted because of the gender roles they could fulfill?

In the end, although the principle of harm is effective in invalidating non-medical sex selection, it is not primary. When we construe human dignity as the basic and foundational principle from which to carry out all considerations, non-medical sex selection is easily unjustifiable. This is a necessary step when it comes to sensitive and consequential topics such as reproductive rights and bioethics. What this shows, then, is that non-medical sex selection violates the basic dignity of parents, children, and future generations.

### Conclusion

Various defenses for and against non-medical sex selection exist in the current literature. Most arguments stem from a consideration of the principle of harm; which claims that as long as the child in question will not be harmed by being conceived (e.g., have a life debilitating disease), then the behaviour is ethical.

This fundamental principle, after much discussion, sheds light on the fact that non-medical sex selection is discrimination. Although this analysis is sufficient, it is

lacking and unsatisfactory; for how can a singular principle lead to so many different answers upon its application?

The principle of dignity, on the other hand, performs perfectly: it is primary, foundational, and basic. It allows for exceptions to the rule, justifies medical sex-selection and, upon all application, unequivocally adjudges non-medical sex selection as unethical, unjustifiable, and inexcusable.

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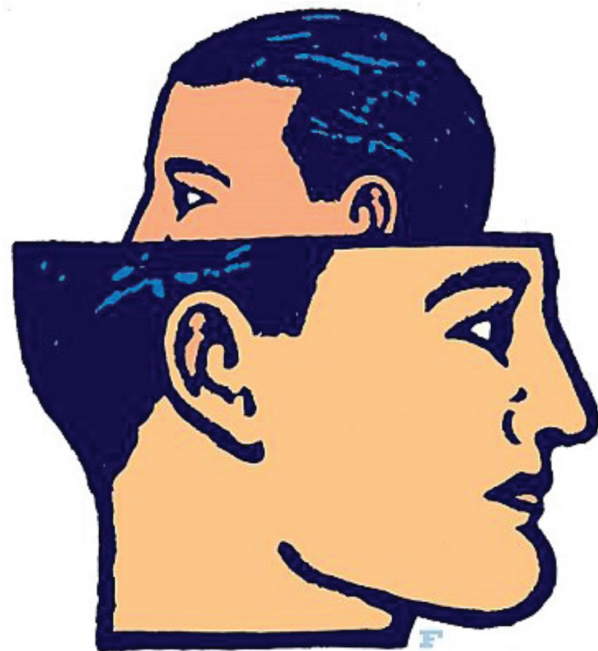
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