

results of prospective trials regarding the use of corticosteroids to treat poison ivy dermatitis.

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**Reference**

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## Preconceptional sex selection

In their excellent article on assisted reproductive technologies,<sup>1</sup> one controversial area that Laura Shanner and Jeffrey Nisker did not discuss is the use of preimplantation genetic diagnosis or sperm sorting for preconceptional gender selection for family balancing.

Some people are worried that the use of these technologies for preconceptional gender selection may affect the sex ratio in countries like India where most families want to have boys. I feel that couples should be free to select the sex of their babies. We have been offering preimplantation genetic diagnosis for sex selection for family balancing in our clinic in India since April 1999 and have treated 28 patients.

Thirteen of these patients have conceived, and 8 have given birth so far. I believe that if we allow people to choose how many babies to have and when to have them and even to terminate pregnancies if they wish, then we should allow them to select the sex of their child if they wish.

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**Reference**

1. Shanner L, Nisker J. Bioethics for clinicians: 26. Assisted reproductive technologies. *CMAJ* 2001; 164(11):1589-94.

**[The authors respond:]**

Like most bioethicists, we reject sex selection except to prevent serious sex-linked medical disorders. Our primary ethical guide remains unchanged: assisted reproduction creates new relationships and must always be understood in that context.<sup>1</sup>

Choosing which child to have is very different from choosing whether to have children at all. The US President's Commission observed that sex selection "seems incompatible with the attitude of virtually unconditional acceptance that developmental psychologists have found to be essential to successful parenting."<sup>2</sup> All children deserve respect regardless of their sex. Children must never be treated as custom-ordered commodities to satisfy our personal or social preferences.

Effects on third parties matter enormously. How do existing children perceive their parents' desire for the "right" (opposite) sex of child? Sex ratio imbalances are already causing social disturbances in parts of India and China where young men cannot find partners. Because sex selection most often prevents the birth of female children, the practice devalues women as a group.

For a medical procedure to be considered as ethical, the benefits must outweigh the risks. Subjecting fertile women to in vitro fertilization with preimplantation genetic diagnosis to choose the baby's sex is bad medicine,

both clinically and ethically. In vitro fertilization carries potentially life-threatening risks of ovarian hyperstimulation syndrome, deep vein thrombophlebitis and surgical complications. There is no evidence that "balanced" families are better families, or that "family completion" requires children of the opposite sex. Using physicians for preferential sex selection — even by less invasive sperm sorting techniques — misdirects scarce medical resources and, in our view, demeans the medical profession.

Ethics is never one-sided; the interests of everyone affected must be considered. We hope that pending Canadian legislation will discourage the provision of medical procedures for selecting nondisease traits such as sex. The medical risks of in vitro fertilization with preimplantation genetic diagnosis, and especially the social risks of eroding respect for children and women, must not be underestimated.

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1. Shanner L, Nisker J. Bioethics for clinicians: 26. Assisted reproductive technologies. *CMAJ* 2001; 164(11):1589-94.
2. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. *Screening and counseling for genetic conditions*. Washington: US Government Printing Office; 1983. p. 57.

## Mandatory vaccination of health care workers

In a commentary on mandatory vaccination of health care workers, Elizabeth Rea and Ross Upshur state that the burden involved for health care workers to accept vaccination "can be eased by providing free vaccine, [and] compensation for vaccine-related adverse

effects ... .<sup>21</sup> Compensation for vaccine-related adverse effects is an interesting suggestion, but it is important to note that Health Canada acknowledges that “currently, Quebec is the only jurisdiction in Canada to have a compensation plan [for vaccine-associated adverse events].”<sup>22</sup> Many health care workers in Ontario have been promised by their employers that they will not dispute any compensation claims. This is misleading, for it suggests that compensation is actually available.

Offering vaccination as an option to our health care workers may be supportable, but coercion, whether financial or emotional, truly constitutes a violation of both ethical and legal rights. Perhaps a better solution would be to review infection control procedures, to prevent mass transmission and to reconsider attendance management policies that effectively prevent ill workers from taking necessary time off.

**Catherine Diodati**  
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#### References

1. Rea E, Upshur R. Semmelweis revisited: the ethics of infection prevention among health care workers [commentary]. *CMAJ* 2001;164(10):1447-8.
2. Immunization in Canada. In: Canadian National Report on Immunization. *MMWR Morb Mortal Wkly Rep* 1996;23S4.

#### [The authors respond:]

As Catherine Diodati rightly points out, Quebec is currently the only province with a compensation program for severe vaccine-associated adverse effects. In Manitoba, a law commission recently recommended that the province institute a compensation program.<sup>1</sup>

Society has an obligation to balance burdens imposed on individuals for the communal good with public programs and policies to care for those individuals should they suffer an adverse consequence. Although we made this argu-

ment with regard to vaccination,<sup>2</sup> we agree with Diodati: the same principle applies equally for health care workers who stay off work to avoid infecting their patients. They should not be made to suffer adverse economic consequences for doing so. Putting this into practice has long been a thorny management issue. It has been particularly topical over the past few influenza seasons in Ontario, where there has been a concerted effort to improve staff vaccination rates in hospitals and nursing homes. Managers may be concerned about potential abuse of policies that pay staff to stay home when ill. Whatever implementation and monitoring procedures are developed to address this concern, the best infection control solution when staff contract influenza despite vaccination seems to be paid sick leave. Another useful option may be to reassign workers who are more mildly ill but may still pose a risk to patients to duties that do not involve patient contact. These approaches are relevant for many other communicable diseases and health care situations (the transplant ward, for example).

However, the obligation to do no

harm is not coercion. It is a fundamental ethical principle for those of us who provide health care. We believe that it can and should be extended to nonprofessional staff who provide direct patient care. The obligation to do no harm — given the balance of potential risks and benefits — includes one's own vaccination for influenza. Influenza is a highly contagious airborne disease; rigorous handwashing and good sanitation are not enough.

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1. Manitoba Law Reform Commission. *Executive summary of report on compensation of vaccine-damaged children*. Winnipeg: The Commission; 2000. Available: [www.gov.mb.ca/justice/mlrc/pubs/vaccine.html](http://www.gov.mb.ca/justice/mlrc/pubs/vaccine.html) (accessed 2001 Nov 22).
2. Rea E, Upshur R. Semmelweis revisited: the ethics of infection prevention among health care workers [commentary]. *CMAJ* 2001;164(10):1447-8.

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