LET GIRLS BE BORN ELSEWHERE: SEX SELECTIVE ABORTION IN INDIA AND THE NEED FOR SELF-REGULATION WITHIN THE MEDICAL PROFESSION

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I. INTRODUCTION

> Let girls be born elsewhere, let boys take birth here. Son is wealth. Son is a blessing. The son will be the father's strength in old age. The father will go to heaven if the son lights his funeral pyre. It is the son who will rescue the father from hell.[1]

This Indian saying is indicative of a pervasive societal preference for sons. In India, the desire for sons is so strong that half a million girls per year are killed via sex selective abortion in the hopes that a future pregnancy will produce a son.[2] Prenatal medical technology like the ultrasound is so widely available and cheap that even the poorest of Indian families can determine the sex of a fetus and decide if they want to allow it to live.[3] This has resulted in an increasingly skewed sex ratio that has dangerous consequences for India's future.[4] Despite efforts to curb these statistics, the latest Indian census in 2011 revealed that the sex ratio of the number of girls born per 1000 boys had dropped yet again from past censuses.[5] A natural sex ratio at birth is an average of 105 boys born for every 100 girls.[6] In 1981, the ratio in India was 962 girls

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[1] *Discrimination Against Women: Millions of Girls Aborted in Recent Years in India*, BUDDHIST BROADCASTING NETWORK (Oct. 16, 2013), http://www.bbncommunity.com/discrimination-women-millions-girls-aborted-recent-years-india/ (quoting Taslima Nasrin, *"It's a Girl!" "Kill Her"*, FREETHOUGHTBLOGS.COM (Apr. 30, 2012), http://freethoughtblogs.com/taslima/2012/04/30/its-a-girl-kill-her/).

[2] Kristi Lemoine & John Tanagho, Note, *Gender Discrimination Fuels Sex Selective Abortion: The Impact of the Indian Supreme Court on the Implementation and Enforcement of the PNDT Act*, 15 U. MIAMI INT'L & COMP. L. REV. 203, 204–05 (2007).

[3] *Id.* at 205.

[4] *Id.*

[5] OFFICE OF THE REGISTRAR GEN. & CENSUS COMM'R, INDIA, *Final Population Totals*, CENSUS INFO INDIA 2011, http://censusindia.gov.in/2011census/censusinfodashboard/index.html (last visited Oct. 22, 2014); *see also Sex Ratio in Indian Population - 2011*, MED INDIA, http://www.medindia.net/health_statistics/general/sex-ratio-in-india-2011.asp (last visited Oct. 22, 2014) [hereinafter *Sex Ratio in Indian Population - 2011*].

[6] MARA HVISTENDAHL, UNNATURAL SELECTION: CHOOSING BOYS OVER GIRLS, AND THE CONSEQUENCES OF A WORLD FULL OF MEN xiii (2011).

for every 1000 boys.[7] In 1991, that dropped to 945 and in 2001, continued its descent to 927.[8] In 2011, the ratio dropped to an all-time low of 914.[9]

Traditionally, Indian culture has valued sons and systematically discriminated against girls.[10] Infanticide of girl children has been documented for centuries, but the introduction of ultrasound technology in India opened a floodgate of prenatal sex determination followed by sex selective abortions.[11] To combat the dropping ratio of girls, the Indian Parliament enacted the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act (PNDT) in 1994, which criminalized sex determination and sex selective abortion.[12] Sadly, however, society and medical professionals alike generally ignored the PNDT Act.[13]

In 2001, the Indian Supreme Court responded to a 1998 report regarding the lack of enforcement by issuing directives for more vigorous enforcement.[14] Since those issuances, awareness and advocacy for the rights of the girl child have slightly increased, but as evidenced by the continuous drop in sex ratios, the current course of action is not effective.[15] In order for there to be a significant drop in sex selective abortions and an evening out in the sex ratio, the medical community must take responsibility for its role in sex determination and abortion.[16] The Indian Medical Association (IMA) and the Medical Council of India (MCI) must enforce the PNDT Act and the MCI's Code of Medical Ethics, so that doctors who have direct control of these technologies are held responsible for their actions.[17]

This Note discusses the historical discrimination against girl children in India, societal motivations for sex determination, and the effects of the introduction of prenatal medical technology as well as the projected consequences of sex selective abortion. This Note then discusses the current state of the law in India and the PNDT Act. Finally, this Note analyzes the role of the medical community in sex

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7 OFFICE OF THE REGISTRAR GEN. & CENSUS COMM'R, INDIA, *Gender Composition*, CENSUS OF INDIA, http://censusindia.gov.in/Census_And_You/gender_composition.aspx (last visited Oct. 22, 2014).

8 *Id.*

9 *Sex Ratio in Indian Population - 2011*, *supra* note 5.

10 *See* Lemoine & Tanagho, *supra* note 2, at 218.

11 *See* Vineet Chander, Note, *"It's (Still) a Boy . . . ": Making the Pre-Natal Diagnostic Techniques Act an Effective Weapon in India's Struggle to Stamp Out Female Feticide*, 36 GEO. WASH. INT'L L. REV. 453, 453, 457 (2004).

12 Lemoine & Tanagho, *supra* note 2, at 206.

13 *Id.*

14 *Id.*

15 *Id.* at 206–07; *Sex Ratio in Indian Population - 2011*, *supra* note 5.

16 Chander, *supra* note 11, at 466.

17 *Id.*

determination and sex selective abortion and emphasizes the necessity of enforcing the Code of Medical Ethics in a way that is self-regulating.

II. BACKGROUND

A. Historical Discrimination Against Girl Children

1. Causes of Female Discrimination and Sex Determination in India

Dominant patriarchal family structures in Asia have traditionally placed great value on producing a male heir.[18] "Property rights [are] passed down hereditarily from father to son."[19] The son not only "carr[ies] on the family name and caste," but also "care[s] for his parents in their old age," while a daughter is considered "part of her in-laws' family" once she marries.[20] Because a son receives the family inheritance, he is perceived as a critical source of stability and wealth and as such is a better "investment" than a daughter.[21] In India, a son's birth raises the social and economic standing of a family, while the birth of a daughter does not.

Not only are girls perceived as not bringing money into a family, but they are also perceived as taking money away from the family in the form of a dowry.[22] An Indian proverb demonstrates the prevailing cultural bias against daughters: "Grooming a girl is like watering a neighbor's garden."[23] When a daughter marries, she leaves her family and spends the rest of her life working for her in-laws' family.[24] In addition, the custom of dowry in India demands that the family of the bride pay the family of the groom.[25] Though this custom has deep roots in Hindu law and historically was voluntary, the current practice is not voluntary and requires a significant amount of money and goods whether or not the bride's family has the financial ability to pay.[26] The demanded dowry can amount to up to five years' income for some families because it is calculated to be proportionate to the groom's

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[18] Monica Sharma, *Twenty-First Century Pink or Blue: How Sex Selection Technology Facilitates Gendercide and What We Can Do About It*, 46 FAM. CT. REV. 198, 200 (2008).

[19] Chander, *supra* note 11, at 455.

[20] *Id.*

[21] Sharma, *supra* note 18, at 200–01.

[22] Sharma, *supra* note 18, at 200–01.

[23] *Id.* at 200.

[24] Alison Wood Manhoff, Note, *Banned and Enforced: The Immediate Answer to a Problem Without an Immediate Solution—How India Can Prevent Another Generation of "Missing Girls,"* 38 VAND. J. TRANSNAT'L. L. 889, 899 (2005).

[25] *Id.* at 900.

[26] *Id.*

potential earning capacity.[27] Despite the Dowry Prohibition Act that was passed in 1961 outlawing dowry payments, the practice continues.[28] If a groom's family is not satisfied with the dowry payment, there can be serious repercussions for the bride, including abuse and even death.[29] These deaths are often called "bride burning"[30] in reference to the "accidental" kitchen fires that kill these young brides.[31] Since 1947, when India became independent, 72,000 brides "between the ages of fifteen and twenty have been burned to death."[32] Dowry is only one example of a culture that devalues girls to the extent that it is seen as merciful to selectively abort or kill them to prevent them from experiencing bride burning or other discrimination.[33]

Beyond dowries, women in Indian society have severe economic limitations because of a lack of education and a lack of freedom and economic mobility.[34] Women are seldom literate, at a percentage of fifty-four compared to seventy-six percent of men, leaving them unable to obtain high-paying work.[35] Even women who are literate and educated are often dependent on male family members to support them because they do not have a separate source of income.[36] Indian women are viewed as an economic burden to the family because of their lower wage-earning capacity in addition to the economic pressures that the dowry system places on families with daughters.[37]

Population control measures instituted by the Indian government are also to blame for the skewed sex ratio caused by sex selective abortion.[38] The government first championed sex selection as a population control method and instigated selective abortion as part of a family planning method.[39] Because of India's large population of over one billion people[40] and its population concerns, the Indian government tried

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[27] Andrea Krugman, Note, *Being Female Can Be Fatal: An Examination of India's Ban on Pre-Natal Gender Testing*, 6 CARDOZO J. INT'L & COMP. L. 215, 224 (1998).

[28] Manhoff, *supra* note 25, at 901.

[29] *Id.*

[30] Krugman, *supra* note 28, at 224.

[31] *Dowery Deaths and Bride Burnings*, VDAY, http://www.vday.org/bride+death#.VAzmz2PCevk (last visited Oct. 30, 2014).

[32] Krugman, *supra* note 28, at 224.

[33] *See* Manhoff, *supra* note 25, at 905; *see also* Varsha Chitnis & Danaya Wright, *The Legacy of Colonialism: Law and Women's Rights in India*, 64 WASH. & LEE L. REV. 1315, 1339 (2007).

[34] Lemoine & Tanagho, *supra* note 2, at 220.

[35] *Id.*

[36] *Id.*

[37] Sharma, *supra* note 18, at 201.

[38] Lemoine & Tanagho, *supra* note 2, at 220.

[39] *Id.* at 221.

[40] *Sex Ratio in Indian Population - 2011*, *supra* note 5.

to convince women to give birth to male children as a way to slow population growth.[41] The government's attempts have generally been successful, as it has become "unfashionable" to have a large family.[42] Especially in higher socioeconomic levels of society, fewer children are deemed better, with two being the supposed ideal.[43] When a couple only plans to have a few children, there is considerable pressure to know the sex of the fetus to ensure that at least one of those children is a boy.[44] These population control methods have fueled a fire that already existed because of deeply ingrained cultural values and have led to an increase in sex selective abortion.

2. Female Infanticide

Female infanticide and the discrimination against girl children is not a recent development or cultural fad.[45] The killing of female children has been a practice in existence for centuries.[46] One author wrote that "[b]ecause sex historically has been linked to economic entitlement, social privilege, and personal status in most societies, attempts to control or predict the sex of one's offspring also date back to ancient times."[47] Historically, families who did not want their baby girl resorted to traditional methods like poisoning, sedative overdose, strangulation, and asphyxiation.[48] Sometimes, baby girls are just neglected so they die in early childhood from disease or malnutrition, which is sometimes referred to as "extended infanticide."[49] Commonly, girls are breastfed for a shorter time period than boys and receive less healthcare when sick.[50]

In 1871, the Indian census exposed a sex ratio of 940 women to 1000 men,[51] providing further proof that female infanticide was more than just a cultural practice, but was widespread enough to cause real damage to India. The British enacted the Infanticide Act of 1870, which criminalized infanticide, but the Act was ultimately unsuccessful in overcoming a cultural practice that was so widely accepted.[52]

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41 Krugman, *supra* note 28, at 216.

42 Lemoine & Tanagho, *supra* note 2, at 221.

43 *Id.*

44 Krugman, *supra* note 28, at 216–17.

45 *See* Manhoff, *supra* note 25, at 892.

46 *Id.*

47 Jodi Danis, Recent Development, *Sexism and "The Superfluous Female": Arguments for Regulating Pre-Implantation Sex Selection*, 18 HARV. WOMEN'S L.J. 219, 223–24 (1995).

48 Krugman, *supra* note 28, at 221.

49 Lemoine & Tanagho, *supra* note 2, at 208.

50 *Id.*

51 *Id.*

52 *Id.* at 208–09.

B. Introduction of Prenatal Medical Technology in India

Because Indian families perceived female children as a burden and were already concerned with having male children, the introduction of prenatal medical technology that could determine the sex of a fetus only exacerbated the skewed sex ratio and allowed families to avoid the inconvenience and difficulty of infanticide.[53] Amniocentesis, which involves inserting a needle through a pregnant woman's abdomen to retrieve amniotic fluid, was first introduced in India in 1975.[54] Though the technology was intended to detect fetal abnormalities, it quickly came to be used to determine the sex of the fetus.[55] By the early 1980s, it was so widely used that Indians referred to it as simply the "sex test."[56] However, the procedure is invasive and lacked mass appeal.[57]

By the mid-1980s numerous clinics began offering prenatal ultrasounds, which is a noninvasive technique that allows a doctor to determine the sex of the fetus, and the technology spread at a surprisingly quick rate.[58] In commenting on the resulting increase in skewed sex ratios in East Asia following the technology's introduction, demographers Chai Bin Park and Nam-Hoon Cho wrote: "[I]n each country, within a single year the sex ratio has jumped to a high level that has subsequently been sustained. This suggests that people have been anxiously awaiting the availability of sex-control technology."[59]

With the arrival of the ultrasound, private clinics were formed so that even the most remote rural towns had access to the technology.[60] The ultrasound is the most popular of sex determination options in India mainly "because [the] ultrasound machines are widely available."[61] Between 1988 and 2003, "the manufacture of ultrasound machines in India increased thirty-three times" according to government data.[62] Compare the 1000 ultrasound machines produced in India in 1994 with

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[53] Seema Mohapatra, *Global Legal Responses to Prenatal Gender Identification and Sex Selection*, 13 NEV. L.J. 690, 691 (2013).

[54] HVISTENDAHL, *supra* note 6, at 48.

[55] *Id.*

[56] ELISABETH BUMILLER, MAY YOU BE THE MOTHER OF A HUNDRED SONS: A JOURNEY AMONG THE WOMEN OF INDIA 113 (1990).

[57] HVISTENDAHL, *supra* note 6, at 48.

[58] *Id.* at 49.

[59] Chai Bin Park & Nam-Hoon Cho, *Consequences of Son Preference in a Low-Fertility Society: Imbalance of the Sex Ratio at Birth in Korea*, 21 POPULATION & DEV. REV. 59, 79 (1995), *available at* http://www.jstor.org/discover/10.2307/2137413?uid=3739936&uid=2134&uid=2&uid=70&uid=4&uid=3739256&sid=21104746188393.

[60] Manhoff, *supra* note 25, at 893.

[61] Lemoine & Tanagho, *supra* note 2, at 210.

[62] *Id.*

the almost 20,000 produced from 2000–2003.[63] These statistics correlate to the increasingly skewed sex ratio at birth.[64] As families gained easier access to prenatal sex determination, abortions of girl children increased leading to where the ratio is today.[65]

C. Consequences of Sex Selective Abortion and a Skewed Sex Ratio

If sex selective abortion continues uninhibited and the skewed sex ratio is not remedied, India will see anywhere from twenty-eight to thirty-two million young surplus males in the next ten years.[66] This will be a fifteen to twenty percent excess of young men in India.[67] This excess of young men has serious consequences, some already being realized and some a serious threat with yet unrealized implications. Because of the shortage of women, these men will be unable to marry and will be ostracized for that inability.[68] "They will generally 'come from the lowest socioeconomic classes, will be un- or underemployed, [and] will live nomadically,' generally associating with other bachelors."[69]

Because of the scarcity of girls, when the excess of young males reaches marrying age, there are not enough brides.[70] Demographers call this a "marriage squeeze."[71] When this happens, often the surplus men who cannot find wives will marry younger women so the shortage is not apparent.[72] However, when the younger males reach marrying age, all of the women have already married or they are competing with both older men and men their own age for a bride.[73] Often this second generation of men is vastly left unmarried or they turn to more desperate measures.[74]

A scarcity of brides has resulted in an increase in child brides and human trafficking, both for brides and for prostitutes.[75] In India, there

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63 *Id.*

64 *See* Manhoff, *supra* note 25, at 895.

65 *Id.* at 894–95; *Child Sex Ratio At Its Lowest Since 1947: Govt*, HINDUSTAN TIMES (Aug. 12, 2014, 8:31 PM), http://www.hindustantimes.com/india-news/child-sex-ratio-at-its-lowest-since-1947-govt/article1-1251329.aspx.

66 Valerie M. Hudson & Andrea Den Boer, *A Surplus of Men, a Deficit of Peace: Security and Sex Ratios in Asia's Largest States*, 26 INT'L SEC., Spring 2002, at 5, 11, *available at* http://www.jstor.org/discover/10.2307/3092100?uid=3739936&uid=2134&uid=2&uid=70&uid=4&uid=3739256&sid=21104746188393.

67 HVISTENDAHL, *supra* note 6, at 165.

68 Lemoine & Tanagho, *supra* note 2, at 222.

69 *Id.*

70 HVISTENDAHL, *supra* note 6, at 163–64.

71 *Id.* at 163.

72 *Id.* at 163–64.

73 *Id.* at 164.

74 *Id.*

75 Lemoine & Tanagho, *supra* note 2, at 222 & n.147.

has been an increase in child brides, which only further contributes to the lack of education and opportunity that young Indian girls face.[76] Young brides have high-risk pregnancies and are also more likely to die in childbirth.[77] Additionally, matchmaking agencies have sprung up all over Asia, promising brides from countries like Vietnam and Thailand.[78] In India, agents purchase poor brides from tribal communities in Gujarat and Karnataka and then marry them into households where they must provide sexual services to all of the males in the extended family.[79] Abuse is rampant and wives have become a commodity to be bought and sold, to the extent that women have been listed for sale on eBay.[80] Indian men have gone so far as to share a wife, as one Haryana case showed where four brothers shared one wife.[81] The shortage of marriageable women also causes an increase in trafficking and the number of prostitutes, as men who cannot find brides resort to purchasing sex.[82] This has the potential to lead to a rise in sexually transmitted diseases and HIV, in addition to contributing to a lucrative trade where young girls are kidnapped and forced into prostitution.[83]

Another consequence of sex selective abortion, a skewed sex ratio, and an abundance of men unable to marry is an increase in violence.[84] History gives numerous examples like the Wild West in America and insurrections in China during the Qing Dynasty, where there was an abundance of unattached men that led to increased violence and even war.[85] Violence towards women, particularly sexual violence, ensues more frequently in places where men outnumber women.[86] Sadly, a scarcity of women has not resulted in an increase in their societal value in India.[87] In a culture where a preference for sons overrides the severe consequences of a skewed sex ratio, women could be subjected to higher numbers of rape, prostitution, and violence.[88]

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[76] *Id.* at 222–23.

[77] *Id.* at 223.

[78] HVISTENDAHL, *supra* note 6, at 165–66.

[79] Vibhuti Patel, *Sex Determination and Sex Pre-Selection Tests in India*, 2 ASIAN BIOETHICS REV. 74, 76 (2010), *available at* http://www.academia.edu/563961/An_Update_on_the_declining_sex_ratio_in_India_by_Vibhuti_Patel.

[80] HVISTENDAHL, *supra* note 6, at 172.

[81] Lemoine & Tanagho, *supra* note 2, at 223.

[82] *Id.* at 222–23.

[83] *Id.*

[84] *Id.* at 224.

[85] HVISTENDAHL, *supra* note 6, at 209.

[86] Lemoine & Tanagho, *supra* note 2, at 224.

[87] Sharma, *supra* note 18, at 203–04.

[88] *Id.* at 203.

II. CURRENT STATE OF THE LAW

A. Historical Development of the Law

As previously discussed, the British enacted the Infanticide Act of 1870 to criminalize the practice of infanticide, but it was largely ineffective because it was generally unenforced in the face of overwhelming cultural acceptance of the practice.[89] Under the Indian Penal Code, abortion was also prohibited unless it was a "good faith effort to save the life of the woman."[90] However, concerns about population growth made it seem prudent to Indian government officials to re-evaluate the penal code. The Medical Termination of Pregnancy Act was passed in 1972 giving medical professionals wide discretion to determine whether an abortion was justified.[91] Such decisions were made under broad auspices of health or humanitarian reasons.[92] However, because these guidelines were so broad, when the ultrasound and other prenatal technology were introduced in India, there was a large increase in the numbers of sex selective abortions.[93]

To counteract prenatal gender selection and the killing of female fetuses, women's groups and activists lobbied Parliament for over a decade.[94] These campaigns were generally sporadic, but by 1985 these lobbyists had formed an organization called the Forum Against Sex Determination and Sex Pre-Selection (FASDSP), which was key in the fight for legislation and later in monitoring compliance.[95] The first legislation was passed in Maharashtra in 1988 to regulate the use of prenatal sex determination techniques.[96] This legislation was novel and was a precursor to the national government's PNDT Act.[97]

B. Pre-Natal Diagnostic Techniques Act

In 1991, the Indian census showed a decline in the sex ratio to a national average of 945 girls to every 1000 boys.[98] The central government realized the significance of this drop and became aware that something needed to be done.[99] In 1994, the central government drafted the Pre-Natal Diagnostic Techniques Act as the first national law

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89 Lemoine & Tanagho, *supra* note 2, at 208–09.
90 Chander, *supra* note 11, at 457.
91 *Id.*
92 *Id.*
93 *Id.* at 457–58.
94 Krugman, *supra* note 28, at 227.
95 Chander, *supra* note 11, at 458.
96 *Id.*
97 *Id.*
98 Manhoff, *supra* note 25, at 895.
99 *Id.* at 894.

against sex determination.[100] The PNDT Act was officially implemented on January 1, 1996, when all state legislatures had approved it.[101] The stated objective of the legislation is to regulate prenatal diagnostic techniques and to prohibit their misuse "for the purpose of prenatal sex determination leading to female foeticide."[102]

The PNDT Act prohibits conducting prenatal exams for any purpose other than detecting certain abnormalities as listed in the statute, such as chromosomal abnormalities and sex-linked genetic diseases, and further prohibits any communication of the sex of the fetus to any person, including parents and relatives.[103] It additionally requires that only clinics that are lawfully registered provide prenatal diagnostic tests and procedures for proper purposes.[104] The PNDT Act also mandates the appointment of certain authorities for enforcement of the Act's provisions and mandates certain penalties and fines for violation of its requirements.[105] Anyone who violates any provision of the Act is subject to a maximum sentence of three years in prison and a fine of 10,000 rupees.[106]

Other important provisions of the Act include a protection from punishment for pregnant women compelled by relatives to undergo prenatal diagnostic tests for purposes other than those allowed by the Act.[107] The Act creates a rebuttable presumption that any woman undergoing prenatal diagnostic techniques in violation of the Act was "compelled by her husband or any other relative."[108] A key provision of the Act provides that the names of violating doctors are sent to the State Medical Council for necessary action.[109] Under this provision, the offending doctor or medical professional must have his or her name removed from the register of the Council for two years following a first offense and permanently for any subsequent offenses.[110]

A Central Supervisory Board and State Supervisory Boards were established and given numerous responsibilities including monitoring

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[100] Chander, *supra* note 11, at 459.

[101] *Id.*

[102] The Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994, No. 57, Acts of Parliament, 1994 (India), *available at* http://www.liiofindia.org/in/legis/cen/num_act/pdtapoa1994657/.

[103] *Id.* at ch. III-4(2) & ch. III-5(2).

[104] *Id.* at ch. VI-18.

[105] *Id.* at chs. IV, V, VII.

[106] *Id.* at ch. VII-23.

[107] *Id.* at ch. VII-24.

[108] *Id.*

[109] *Id.* at ch. VII-23(2).

[110] *Id.*

the implementation of the PNDT Act.[111] However, many of these duties were neglected and the Act commanded an almost non-existent response when it was first enacted.[112] Despite the numerous monitoring provisions, the government failed to take necessary action to implement the PNDT Act and sex determination and prenatal diagnostic testing continued vastly unchecked.[113]

One of the problems in the structure of the PNDT Act is that the authorities appointed to monitor and implement the Act's provisions were former doctors and were loath to implicate fellow doctors for something that was a lucrative and widespread practice.[114] These authorities had no motivation to fight a deeply rooted cultural issue by investigating and criminally prosecuting their own colleagues.[115] Between 1994 when the Act was passed and 2000, there were no convictions of individuals who violated the prohibition of sex determination.[116] Though the PNDT Act was originally championed as a success, after its passage there was little to no difference in people's actions as evidenced by the fact that it was still possible to obtain an ultrasound for sex determination for as little as $12.42 from numerous clinics in India.[117]

In 2001, the census brought the Indian Supreme Court's attention to the fact that the sex ratio continued to significantly skew in favor of boys because of the rampant sex determination and sex selective abortion occurring all over India.[118] The Supreme Court then ordered the central government and state authorities to begin actively implementing the provisions of the Act "with all vigor and zeal."[119] In 2002, state governments were then required to confiscate ultrasound machines from unregistered clinics that provide sex determination ultrasound testing.[120]

In 2003, the government amended the PNDT Act and renamed it the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, including that persons seeking help for sex selection can face a three-year imprisonment or a 50,000 rupee fine for a first

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111 Lemione & Tanagho, *supra* note 2, at 229–30.
112 *Id.* at 230.
113 *Id.*
114 *Id.* at 230–31.
115 *Id.*
116 Manhoff, *supra* note 25, at 895.
117 *Id.* at 894–95.
118 *Id.* at 895–96.
119 *Id.* at 896.
120 *Id.*

conviction.[121] The 2003 regulations also control sales of ultrasound machines, requiring that any sex determination devices only be distributed to lawfully registered clinics.[122] The Act attempts to prohibit the use of ultrasounds to determine sex, but does not prohibit the use of ultrasounds themselves therefore only attempting to regulate their purpose.[123] Ultrasound machines may only be sold to registered clinics and any kind of sex determination advertising is banned.[124] Despite all of these efforts to further implement the ban on sex determination, Indian families and medical professionals have found ways around the law and the skewed sex ratio has continued to worsen.

III. THE ROLE OF THE MEDICAL COMMUNITY

A. Practices of Doctors Relating to Sex Selective Abortion

The role of the medical community and doctors is key in India to balancing out the sex ratio.[125] A demographer in Mumbai emphatically stated, "If doctors were quite serious about this kind of large-scale distortion and elimination . . . it would never happen."[126] Another claims that the PNDT Act has failed mainly "because of the connivance of doctors in sex determination and selective abortions."[127] The child sex ratio among doctors' families is even more skewed than the national average.[128] Within these families the average was 907 girls per 1000 boys as compared to the national average of 914 per 1000.[129] This reveals the enormous scope of the problem and demonstrates just how deeply social values are embedded in those who have the greatest ability to stop this dangerous practice.[130]

Doctors primarily control ultrasound technology and stand to make the most profit from sex selection. Because they control the technology, doctors add a cover of legitimacy to the practice of sex determination and

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[121] The Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994, No. 14, Acts of Parliament, 2003 (India), *available at* http://www.ncpcr.gov.in/view_file.php?fid=434.

[122] *Id.* at ch. II-3B.

[123] Chander, *supra* note 11, at 459–60.

[124] Prohibition of Sex Selection Act chs. II-3B, VII-22.

[125] *See* Lemione & Tanagho, *supra* note 2, at 210–11.

[126] HVISTENDAHL, *supra* note 6, at 54.

[127] Madhu Gurung, *Female Foeticide*, WOMEN'S STUDIES PORTAL, 37 (1999), http://www.womenstudies.in/elib/foeticide/fo_female_foeticide.pdf.

[128] Umesh Isalkar, *Study Shows Sex Selection Practices in Doctors' Families*, TIMES OF INDIA (May 27, 2013, 1:11 AM), http://articles.timesofindia.indiatimes.com/2013-05-27/pune/39556611_1_indian-medical-association-pre-natal-and-diagnostic-techniques.

[129] *Id.*

[130] *Id.*

sex selective abortion.[131] Dr. Puneet Bedi, a gynecologist in Delhi, says that sex selective abortion caught on in Delhi specifically because it is perceived as a scientific advance.[132] He says, "It's sanitized," commenting that the fact that it is a medical act divides moral responsibility between the parents and the doctor and that "there is a complete lack of shame on behalf of the parents and doctors who do it."[133] Each party reasons that the other is responsible, he states, saying that "parents tell themselves their doctor knows best, while doctors point to overwhelming patient demand for the procedure."[134]

Additionally, because of the huge demand in India for sex determination and abortion, the business is lucrative for doctors.[135] The medical industry has expanded into a business worth $100 million.[136] Though the medical community largely denies any allegations, doctors strongly encourage sex determination to ensure they get patients.[137] Doctors have even posted advertisements positing, "Pay Rs. 500 now rather than Rs. 500,000 later," referring to the cost of dowry when compared to the cost of an ultrasound.[138] Reportedly, some doctors have even resorted to operating ultrasound machines out of their cars and driving to rural areas to provide sex determination services.[139]

Sanchita Sharma, health editor for the *Hindustan Times*, commented that while infanticide would exist minus doctors and ultrasounds, the sex ratio would not be so unbalanced because it is much more difficult to kill a baby than to get an abortion.[140] Hospitals have little incentive to address the problem or regulate doctors because maternity wards bring in significant business.[141] To add to the existing motivations for doctors and hospitals participating in sex selection, some truly believe that sex determination is in the best interest of India as a way to remedy the population problem.[142] One hospital advertisement in Mumbai reads, "In developing countries like India, . . . as the parents are encouraged to limit their family to two offspring, they will have a right

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131 *See* HVISTENDAHL, *supra* note 6, at 46.
132 HVISTENDAHL, *supra* note 6, at 45–46.
133 *Id.* at 46.
134 *Id.*
135 *See* Lemione & Tanagho, *supra* note 2, at 211.
136 Lemione & Tanagho, *supra* note 2, at 211.
137 *Id.* at 213.
138 *Id.* at 211–12.
139 *Id.* at 212.
140 *Id.* at 213–14.
141 HVISTENDAHL, *supra* note 6, at 47.
142 Manhoff, *supra* note 25, at 908.

to quality in these two . . . as far as can be assured," intending "quality" to mean "male."[143]

Though the PNDT Act requires clinics to register in order to conduct genetic counseling, the provisions of the Act do little to prevent doctors from finding alternate ways to communicate the sex of a fetus to their patients via code words or telling an assistant within earshot of the patient.[144] Because of the loopholes in the Act, doctors can simply notify friends who would in turn tell the family.[145] Some doctors will only perform a sex determination test if an agent that the doctor knows accompanies the patient.[146] Doctors have admitted to using code phrases, like "the sky is blue" and "your baby is fine and will play football" (to indicate a boy) or "you are in the pink of health" and "your child is like a doll" (to indicate a girl), to indicate the sex of the fetus to the patient.[147] There is no limit to the methods used by doctors to evade the law, including using pink or blue pens to write prescriptions.[148] Even for registered clinics that have certain reporting requirements, doctors are not required to keep a written record of such actions.[149] Prosecution of doctors who participate in skirting the law is difficult without this record, in addition to the reluctance of the supervisory boards to incriminate fellow doctors.[150]

Those within the medical community have shown a large-scale indifference to the issue of sex selection.[151] In 2002, the Medical Council of India (MCI) revised its ethics code in response to the Delhi High Court's order to amend the ethics code to comply with the law.[152] The Council revised its code to prohibit sex determination tests undertaken "with the intent to terminate the life of a female foetus" unless there are other indications that would make an abortion lawful.[153] Violation of the

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143 HVISTENDAHL, *supra* note 6, at 49.

144 Chander, *supra* note 11, at 463.

145 *Id.*

146 David Rohde, *India Steps Up Effort to Halt Abortions of Female Fetuses*, N.Y. TIMES, Oct. 26, 2003, http://www.nytimes.com/2003/10/26/world/india-steps-up-effort-to-halt-abortions-of-female-fetuses.html.

147 Manhoff, *supra* note 25, at 895.

148 Lemione & Tanagho, *supra* note 2, at 212.

149 Manhoff, *supra* note 25, at 895.

150 *Id.* ("Prosecution of doctors who participate in skirting the law is difficult without this record . . . ."); *see* Lemione & Tanagho, *supra* note 2, at 230–31 (describing the reluctance of the supervisory boards to incriminate fellow doctors).

151 Manhoff, *supra* note 25, at 908.

152 *Id.*

153 Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, Gazette of India, § 7.6 (Apr. 6, 2002), *available at* http://www.mciindia.org/RulesandRegulations/CodeofMedicalEthicsRegulations2002.aspx.

provision includes penalties and criminal liability.[154] Despite this inclusion in the ethics code, the revision does not define sex determination as objectionable unless intent to commit feticide could be proved.[155] Intent to commit feticide is almost impossible to prove and the unresponsiveness of the medical community to this issue is telling.[156]

Prosecutions of doctors who violate the PNDT Act are few and convictions even fewer. Between the enactment of the PNDT Act and December 2003, there were no convictions of medical practitioners for violating the law.[157] By 2007, over 300 doctors had been prosecuted, but convictions were still few, largely because of pressure from the medical community on the government not to prosecute these doctors.[158] Officials at a conference in New Delhi in 2006 said that four doctors had been convicted under the PNDT Act, but that was twelve years after the Act was passed.[159] Government officials also stated that the pressure from the medical community was obstructing action against doctors, agreeing with health activists who had the same concern.[160] These officials have conducted surprise raids on ultrasound clinics to catch violating doctors, but said there has been significant lobbying from the medical community to protect doctors caught on hidden cameras revealing the sex of a fetus.[161]

On a small scale, surprise inspections of health clinics have been successful. Before 2010, fifty-four cases had been filed in the state of Rajasthan for violation of the PNDT Act.[162] Since 2010, the government has been using pregnant women to go undercover and pretend to want an abortion if an ultrasound reveals they are pregnant with a girl.[163] Using this strategy, by July 2013, the number of cases filed had reached 562.[164] According to one source, the "Rajasthan Medical Council has suspended 23 doctors' licenses and brought charges against 153 medical

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154 *Id.*

155 Manhoff, *supra* note 25, at 908.

156 *Id.*

157 *Id.* at 907.

158 Sharma, *supra* note 18, at 205.

159 Ganapati Mudur, *Doctors in India Prosecuted for Sex Determination, but Few Convicted*, 332 BRIT. MED. J. 257, 257 (2006), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1360431/.

160 *Id.*

161 *Id.*

162 Swapna Majumdar, *Pregnant Volunteers Aid India's Fetal Sex Law*, WOMENSENEWS.ORG (Sept. 26, 2013), http://womensenews.org/story/abortion/130925/pregnant-volunteers-aid-indias-fetal-sex-law#.Ulbe3yhD3ww.

163 *Id.*

164 *Id.*

practitioners, the highest of any state in the country."[165] This example demonstrates the importance and necessity of the medical profession itself taking responsibility for its role in sex selection and enforcing the law.

Arvind Kumar, a senior administrative officer who has prosecuted eighteen doctors, commented, "There is confidence, almost arrogance, among some doctors that they can get away with this."[166] Health activists, doctors against sex selection, and government officials all agree that to effectively implement the PNDT Act and to combat the skewed sex ratio in India, guilty doctors must be punished both via criminal liability and prosecution by the government and via more proactive regulation by the Indian Medical Association and the Medical Counsel of India.[167]

IV. ANALYSIS OF MEDICAL COMMUNITY REGULATION

A. Comparison to Legal Community and Self-Regulation of Profession

The current regulation and involvement of the medical community in India by the Indian Medical Association (IMA) and the Medical Council of India (MCI) is largely inadequate to implement the PNDT Act and stop sex selection in India. The IMA is a national voluntary organization that seeks to promote the improvement of public health while seeking to maintain "honour and dignity and to uphold the interest of the medical profession."[168] The MCI is responsible for establishing medical education standards and provides registration and licensing of doctors with recognized medical qualifications.[169] Both of these bodies hold considerable influence over doctors in India, but have been too lax in their mild attempts to implement the PNDT Act and the MCI Code of Ethics.[170] At the time of registration as a licensed physician, doctors must agree to abide by the Registrar's medical oath which includes a provision stating that they will respect all human life from the time of conception, yet sex selection continues largely unpunished.[171] As a whole, the actions of the medical community show an indifference to the issue of sex determination and sex selective abortion.[172] The IMA and the MCI

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[165] *Id.*

[166] Mudur, *supra* note 160, at 257.

[167] Chander, *supra* note 11, at 466.

[168] *About IMA*, INDIAN MED. ASS'N, http://ima-india.org/page.php?page_id=9 (last visited Oct. 23, 2014).

[169] *About MCI*, MED. COUNCIL OF INDIA, http://www.mciindia.org/AboutMCI/Introduction.aspx (last visited Oct. 23, 2014).

[170] *See id.*

[171] *Medical Oath*, INDIAN MED. ASS'N, http://www.ima-india.org/page.php?page_id=21 (last visited Oct. 23, 2014).

[172] Manhoff, *supra* note 25, at 908.

must begin to regulate the medical profession and enforce the current ethics code as the legal community does.

The legal community in the United States is a self-regulated profession, standardized by the American Bar Association (ABA) and a strict ethics code that requires lawyers to report violations of the Model Rules of Professional Conduct.[173] Though each state has its own licensing requirements and rules of professional conduct, each state generally follows the same guidelines and mirrors the Model Rules of Professional Conduct.[174] The ABA is a voluntary professional organization responsible for establishing ethics norms and standards within the profession, while individual state bar associations are responsible for disciplining lawyers and judges who violate the established standards as codified by the Rules.[175] No outside organization or governmental body has control over the set standards for the profession, as it is policed by other lawyers within the legal community. Though a lawyer can be subject to a malpractice lawsuit in a court of law and disciplinary action taken by the bar is appealable to the judicial system, as a whole, the legal community establishes model ethical codes for the profession and disciplines from within.[176]

The IMA and MCI are structured similarly to the ABA, but currently are not enforcing their ethics code and are not disciplining doctors for violations of the code. Though the PNDT Act itself provides for Supervisory Boards to enforce the provisions of the law, the law would be much more effective if the medical community itself sought to follow the example of the legal community in disciplining from within. The IMA and MCI need to mirror the ABA in establishing ethics norms and standards and then strictly enforcing them. For the implementation of the law to be effective, doctors must be subject to discipline, including the revocation of their licenses to practice, and they must be required to report violations of the ethics code. Doctors would still be subject to criminal prosecution for violation of the law, but if sex selection is to be dramatically decreased, the medical community must begin to effectively self-regulate.

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[173] *See generally* MODEL RULES OF PROF'L CONDUCT (2009).

[174] *About the Model Rules*, A.B.A., http://www.americanbar.org/groups/professional_responsibility/publications/model_rules_of_professional_conduct.html (last visited Oct. 23, 2014).

[175] *About the American Bar Association*, A.B.A., http://www.americanbar.org/about_the_aba.html (last visited Oct. 23, 2014); *ABA Mission and Goals*, A.B.A., http://www.americanbar.org/about_the_aba/aba-mission-goals.html (last visited Oct. 23, 2014); *see generally, e.g.*, *History*, VA. B. ASS'N, http://www.vba.org/?page=history (last visited Oct. 3, 2014) (explaining that the Virginia State Bar Association is a licensing and disciplinary agency).

[176] MODEL RULES OF PROF'L CONDUCT Scope ¶ 20 (2009).

Another issue within the medical community that complicates the enforcement of the PNDT Act is the increase of private practice within the healthcare system in India.[177] While the government has more control over regulations in public practice, data shows that approximately two-thirds of abortions are conducted by private providers where regulation is seriously lacking.[178] In India, health is a state subject and there is no existing framework of regulations or institutional mechanisms for the private healthcare sector.[179] Evidence from case studies of medical regulations in India indicates that these regulations and policies have been ineffective largely because of a lack of implementation and enforcement in addition to resistance from private medical providers.[180] As the current rules and mechanisms have not been effective, medical councils and associations must be supported by institutional mechanisms to help enforce legislation and must have the means necessary to create peer pressure in order to better facilitate the self-regulation of the profession as a whole.[181]

Though measures have not been as effective as is necessary to prevent the current birth ratio from skewing even further, in 2006 the IMA partnered with the United Nations Family Planning Association (UNFPA) and other medical associations to develop a campaign called "Doctors for Daughters."[182] The campaign seeks to educate doctors and medical professionals on India's laws against sex selection, challenge deeply-rooted gender norms and values in society, and create "champions of girls' and women's rights" within the medical community.[183] As a part of the campaign, IMA passed a resolution against sex selection and sought to help doctors understand the importance of fighting this problem and their role in implementing the law.[184] This is key to stopping the practice of sex determination and sex selective abortion in India, but must also be combined with harsher punishments and the revocation of licenses for violating doctors as the example of South Korea demonstrates. South Korea was one of the first Asian countries to effectively face the sex selection problem and used harsh penalties with

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[177] Ramesh Bhat, *Characteristics of Private Medical Practice in India: A Provider Perspective*, 14 HEALTH POL'Y & PLAN. 26, 31–32 (1999), *available at* http://heapol.oxfordjournals.org/content/14/1/26.full.pdf+html.

[178] *Id.* at 34.

[179] *Id.*

[180] *Id.*

[181] *Id.*

[182] Kate Gilles & Charlotte Feldman-Jacobs, *When Technology and Tradition Collide: From Gender Bias to Sex Selection*, POPULATION REFERENCE BUREAU 4 (Sept. 2012), http://www.prb.org/pdf12/gender-bias-sex-selection.pdf.

[183] *Id.*

[184] *Id.*

strict enforcement as a key part of their strategy to fight the practice.[185] In order to more effectively implement the PNDT Act, the medical community must implement their own ethics code with stricter punishments and self-regulation.

V. CONCLUSION

A. How the Medical Community Should Respond

The Indian Medical Association (IMA) and the Medical Council of India (MCI) must take a firm stance against sex determination and sex selective abortion by strictly upholding the PNDT Act to self-regulate within the medical profession. Because of their influence and authority over doctors and their professional licensing, they hold considerable persuasive power to change the current state of the PNDT Act implementation.[186] By enforcing the provisions of the Act through harsher and more public prosecution and conviction, they can actively cut down on the use of prenatal diagnostic techniques for sex determination and selection.[187] As demonstrated previously, this is a lucrative business, but by revoking licenses for offenses, doctors will be more likely to comply with the law. The PNDT Act will only be a deterrent to sex determination if the IMA and the MCI actually enforce the provisions of their ethics code and promptly report any violations to the appropriate authorities.[188] One source comments that this is key so that doctors who do not comply could be denied funding and support, and "could even be ostracized as 'quacks'."[189]

In addition to the self-regulation of the medical profession, the Indian government should place additional pressure on the IMA and MCI to more proactively support the ban in a public manner.[190] An Indian activist and sex ratio expert, Dr. Sabu George, believes that the "widespread decay of medical ethics and continuing leniency by state governments" is responsible for the misuse of sex determination tests and ultrasound technology.[191] With added pressure and the public eye of both India and the world on them, these medical organizations may be persuaded to restore respectability to medical ethics in India. The government and the medical community must pressure medical professionals and change their perceptions of sex determination within their profession so that they comply with ethical standards and the law.

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185 *Id.*

186 Chander, *supra* note 11, at 466.

187 *Id.*

188 *Id.*

189 *Id.*

190 Manhoff, *supra* note 25, at 908.

191 *Id.*

B. Looking Ahead for India

Because of India's history of discrimination against female children and its deeply ingrained societal son preference as a motivation for sex determination, it must fight to stop the increasingly skewed sex ratio at birth. The current laws in place, specifically the PNDT Act, will not be effective unless India and the medical community unite to recognize the seriousness of the problem of a skewed sex ratio and begin to forcefully combat the causes of sex selection. Culture and media campaigns to champion the rights of the girls are necessary to help change societal norms and values, in addition to the immediate solution of enforcing the existing law and medical ethics codes within the medical community. The most important step in combating the skewed sex ratio in India is for the medical community to recognize their role in sex determination and sex selective abortion and to take responsibility for that role by becoming an effective self-regulating profession that abides by the Code of Medical Ethics.