ARTIFICIAL REPRODUCTIVE TECHNOLOGIES: THE ISRAELI SCENE

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Israel is an interesting case for the study of the ways societies deal with the various tensions and clashes between modern advances in medical science and traditional values. On the one hand, Israel – despite its small size and limited resources – is eager to play a role in the frontline of contemporary medical research, and is indeed doing so with a great deal of success. On the other hand, Israeli society is committed to basic principles and values of the Jewish, mainly religious, heritage, which has been partly constitutive of its identity since the foundation of the State in 1948. Abortion, euthanasia, organ transplantation, and artificial reproductive technologies are obvious examples for the particular manner in which Israel has been trying to solve those tensions. However, portraying the ethical debate on these topics in polarized terms of medicine vs. religion, or science vs. faith, would be over-simplistic and misleading. The picture is much more complex, both because Israeli public morality consists of strong liberal strands and because the Jewish religion itself is often very flexible in accommodating modern technologies, especially when it comes to matters of life and death of human beings.

Thus, on the one hand, in the abortion issue there is a head-on confrontation between religious principles and liberal views, and the struggle on the conditions for legal abortion has always been raging with much political fervour between the religious and the liberal parties in the legislature. (Israel used to have a fairly liberal abortion law till 1977, when the religious parties succeeded in introducing some significant restrictions. It is remarkable, however, how little effect the new law has had on the actual practice of abortion, and on the rate of both the overall number of abortions and the ratio of legal vs. illegal abortions. It should also be noted that even the stricter orthodox views are generally more flexible than the Catholic doctrine in allowing for abortion in a wide range of cases in which the
continuation of pregnancy is risky to the health of either mother or fetus.) On the other hand, in the case of organ donation and transplantation Jewish rabbinic authorities have gradually come to recognize the benefit and value of some medical practices and options, and allied themselves with the more liberal tendencies prevalent in secular circles which form the majority of Israeli society.

But reproductive technology raises moral problems which are equally difficult to religious and non-religious views. Consequently, the religious-secular divide does not coincide with the conservative-liberal one on such issues as IVF, AID, and even surrogate motherhood. On the one hand, one finds secular doctors, health administrators, and psychologists who oppose much of the use of modern reproductive technology because of medical; economic, or social reasons. On the other hand, there are rabbis who favour the controlled exercise of such technology as a means of enhancing the chances of couples to have children. Their sometimes courageous attempts to solve the problem of a married woman wishing to be fertilized by a “strange” donor are motivated almost exclusively by the particularly high value attached by the Jewish tradition both to existing life and to the creation of new life. Recall that “be fertile and multiply” is literally the first commandment of God to humanity in the first chapter of the Bible, an injunction which is metaphysically no less significant than the one to sustain life and avoid killing. However, derived from this high value put on life is the value of marriage and family life, which are fully realized only in procreation. But the artificial means of reproduction may sometimes put that value of the family in danger.

So we should realize that although in some issues of reproductive technology religious views coincide with secular ones, the motives are totally different. From the religious perspective, artificial interference in the process of reproduction is in some cases welcome because it promotes life, which is a typically metaphysical and impersonal value. But from the secular-liberal point of view, the justification for the use of reproductive technology primarily lies in the interests of the parents, their choice, their autonomy to decide how they wish to lead their lives, their prospects of self-realization through parenthood. This is a most important point which we should keep in mind when we describe the uneasy balance between the various forces involved in the decision making procedure regarding the legal regulation of artificial reproductive technologies. Religiously based values and personal rights may happen to overlap in some issues, but are not natural allies.

On the background of the high value of having children in the Jewish tradition (as well as in the Moslem ethos of Israeli Arabs)
and the inseparable connection between marriage and reproduction, it would be hardly surprising that the number of IVF clinics per capita in Israel today is the highest in the world (one to every 250,000 inhabitants, which is four times as many as in the U.S.!). Doctors in Israel find it more and more difficult to resist the pressure of childless couples, desperately seeking medical treatment, regardless of its low chances, risks, and costs, and the pain involved in it. Childlessness is still considered a tragedy, and children for adoption are in great demand (though in very limited supply).

After years of total absence of guidelines, the Minister of Health issued in 1987 regulations concerning IVF, but their legal validity was considered dubious, since they allegedly went beyond the sphere of ministerial authority by trying to regulate behaviour in matters, which, being of constitutional nature, could only be decided by primary legislation. "Secondary legislation" by ministerial regulations is politically easier, since it does not require Parliamentary debate and decision, which always contains the potential of fierce ideological confrontation and deadlock. But then this legally vague arrangement was challenged in court in 1991 by a couple who wanted to get IVF treatment and later send the fertilized ovum abroad to be implanted in a surrogate mother. (The woman, whose uterus had been previously removed, could not carry the pregnancy). As the regulations explicitly prohibited surrogacy, the doctors declined to perform the IVF procedure for fear of being prosecuted. Following the appeal of the couple, the court directed the hospital to carry out the IVF procedure, and the State to set up a Commission which would make recommendations as to the full legal arrangement of the whole range of issues involving artificial reproduction.

And indeed, in 1991 the Minister of Health and the Minister of Justice jointly nominated a Commission to consider the subject of IVF in all its aspects. It consists of a judge, a lawyer, two doctors (gynecologists), a psychologist, a sociologist, a social worker (specializing in adoption), a rabbi, and a philosopher – a balanced group of five men and four women. After about a year of intensive discussions it has come up so far only with an interim report, and is hoping now to hear systematic reactions to it from members of the public (professional as well as non-professional individuals and organizations). The general trend in the Commission's discussions can be described as "liberal". The more cautious and in a way conservative views were advanced by the two doctors, the rabbi, and sometimes by the social worker, that is to say by those who either have had direct experience with the actual cases of childless couples, or are committed to religious principles. But it should be noted too that many of the permissive opinions, which some members were holding in the
beginning of the Commission's work, gradually gave way to more cautious and restrictive views, following a growing awareness of the risks and dangers – political, financial, medical, and social – involved in a completely free access to IVF treatment and surrogacy. Nevertheless, although the Commission studied seriously the work of other committees (such as the Warnock Report in Britain and similar recommendations made in Australia and Sweden), the general tendency was to leave more free room for the legal use of IVF and surrogacy than is allowed at least by the Australian and Swedish legal systems. (Note that the Swedish law is absurdly, and often inconsistently strict in prohibiting all forms of IVF except for the fertilization of a woman's ovum by her husband's (or permanent partner's) sperm for its implantation in the same woman. It is a strange law, since much of it is based on the assumption that "artificial" amounts to "contrary to nature", which in turn means "dehumanizing". It is inconsistent, since it allows for IVF and AID separately, but not for the combination of the two.)

The work of commissions established with the purpose of forming proposals for legislation is fraught with the threat of being out of touch with the political reality in which actual legislation is made. The view of the Israeli Commission has been that although the general ideological constraints (both of social morality and religious sensibility) should be taken into account and respected, the Commission should not shun the leading and innovative role in these new grounds in which very little precedent exists. This policy stands in direct opposition to the Swedish one, which consciously tried to avoid any moral or social risks. It obviously remains to be seen whether the legislature will be able to agree on a set of guidelines for the practice of artificial reproduction. It is equally a typical dilemma of such commissions whether to come up with detailed recommendations as to the specific arrangements – administrative, medical, financial, etc. – or be content with advising on the more general principles. The Israeli Commission opted for the first alternative.

The rationale behind this decision is that there is a natural tendency in this tricky area of bioethical dilemmas to pass the buck from one authority to the other. Thus, medical practitioners are reluctant to assume responsibility and prefer to either wait for the legal system to supply full guidelines or appeal to the court for instruction. The courts, in their turn, appeal to the legislature to fill the lacuna, and hesitate to exercise their power of judicial legislation (which in other areas of social life they have no qualms in exercising). The legislature is often tied in a deadlock of a political balance of opposite powers. All parties claim that these problems are deep moral and religious issues better left to philosophers and theologians, but are highly
sceptical when philosophers and theologians try to make practical suggestions! Theoreticians often argue that actual decisions must be left to doctors, since they are the only parties who can assess the concrete risks, needs, costs, and chances of certain treatments. But leaving decisions on reproduction in the hands of medical practitioners is often resented by patients, especially by women, who consider the power of doctors a threat to their rights and autonomy. So we are entangled in an endless cycle of evasion of responsibility. New reproductive technologies call for bold choices for which most of our social institutions are too conservative by their very nature.

Now, here are some of the substantive issues which the Commission has been addressing:

**Access:** It was agreed that being a matter of privacy, family planning in general and the use of reproductive technology should remain free from state intervention. The right to get fertility treatments should be universal, and independent of one's marital status and sexual preferences. Only in extreme cases can such treatment be refused. These include obvious medical risks to the mother or child, as well as particularly harsh socio-economic circumstances (extreme poverty or drug addiction) which would prevent the future child from having a minimally decent quality of life. A multi-disciplinary Commission will be formed in order to decide these cases, with the general presumption that the “artificial” creation of children should not be subject to more state interference than its natural counterpart (which is recognized as a totally private matter).

But since in Israel all matters of personal status, marriage and divorce, are decided by religious law and the rabbinical courts, the Commission had to take into account further restrictions on the access to fertility treatment. According to Jewish law, children born as the result of either adulterous or incestuous relations are defined as mamzerim (“bastards”), and cannot — among other things — marry. Thus, the question arises whether a married woman who is fertilized artificially by a donor is considered adulterous. A growing number of rabbis are now adopting a more liberal reading of the law, claiming that adultery applies only to sexual relations and not to the mixing of genetic material in vitro. It seems that this obstacle is therefore surmountable. But the risk of children created by the donation of either male or female genetic material, as well as by means of surrogate pregnancy, leading to incestuous marriages with half-brothers or half-sisters remains a stumbling block. And doctors claim that in a small society like Israel, this risk is not to be taken lightly also from the medical point of view. It was thus agreed that despite the invasion of privacy involved, there should be a system of registration which will be fully confidential, and would only be used to avoid incestuous
marriages. As for the child himself or herself: like in the law of adoption, the child at the age of 18 would have the right to inquire about the identity of his natural parents. If they agree, their identity will be disclosed. If they don’t, the child will be given only general information about his or her parents.

**Financing:** This consists of a wide range of questions, such as the limits of social responsibility to help individuals to procreate, the number of treatments that should be publicly financed, the age limit, the number of existing children of the couple, their level of income, the chances of success, etc. The Commission decided not to come out with any recommendations on these issues, and to leave them to the health insurance companies to work out. The general feeling of the Commission however has been that the right to parenthood is so basic, and the wish to procreate so deep, that society should assume some minimal responsibility to enable those who cannot have children in the natural way to be assisted by medical technology.

**Counselling:** The high social value accorded to children creates both a general stigma on childless couples and a pressure exerted by husbands on their wives to undergo painful and costly treatment in order to have children. These are two dangers which have to be faced by professional counselling, which would discuss also the options of childlessness or adoption. Counselling would of course raise the question of the risks of over-ovulation, multi-embryonic pregnancies, the thawing of frozen embryos, and so forth.

**The definition of parenthood:** Jewish law defines parenthood in exclusively biological terms. Therefore, although adoption is recognized as a way to create certain legal relations, the biological parents of the child remain its parents for purposes of personal status and marriage, and hence a registry is kept of all adoptions. However, when there is no reliable way to ascertain the identity of the father, there is a presumption that the husband of the mother is its legal father. This presumption is standardly appealed to in cases of AID, in which the husband, after giving his consent to the insemination by a donor, becomes the legal father of the child as if he were also the natural father. With egg donation things are more complicated, as there are two competing parameters for the definition of “biological” mother. It seems that most rabbis treat the woman giving birth, rather than the contributor of the genetic material, as the natural mother. It was accordingly the opinion of the Commission, that in cases of both partial and full surrogacy, the surrogate mother should be considered the mother, which would require a process of adoption (though a shortened one) by the other woman wishing to raise the child. The proposed compromise between the natural and the legal definitions of parenthood takes seriously the exclusivity of the legal relation on the
one hand but also the need to avoid incestuous marriages on the other hand.

*Donation of genetic material:* According to the existing regulations, unmarried women can donate ova, but cannot receive such donations. The Commission found this restriction unfair, and saw no reason to impose it, especially once there is full registration of the identity of the sperm donor so as to avoid the risks of "mamzerut" and incest. Registration would also solve the problems connected with the embryo donation (as in the case when both partners are infertile). And as the very mixing of genetic material is not necessarily defined as adulterous, there is no reason to prohibit egg donation by relatives (e.g. a sister), who are usually the best candidates for making such donations.

*Freezing of embryos:* Up to five years, with the option of another five-year period. The decision what to do with the frozen embryo should be left to the parents undergoing the treatment. But the question whether it should be agreed by both partners might create difficulties as happened just this summer in Israel, when the woman wanted to have the embryo thawed and implanted, while her husband, being in the middle of a divorce procedure from her, opposed the idea. The Commission has not decided whether the original consent of the husband to the fertility treatment is reversible (in the time of the actual implantation of the fertilized egg) or not. Equally difficult is the question whether a frozen embryo can be thawed and implanted after the mother’s death or only in the case of the father’s death.

*Surrogacy:* The general tendency of the Commission was not to totally ban surrogacy contracts, but not to allow them without restriction either. It was suggested that a statutory body headed by a judge would make the decisions regarding IVF involving surrogacy, and will endorse in advance contracts on this matter. Women wishing to carry pregnancies for other women would have to be of minimum age and having already given birth, and most of the members of the Commission thought that she can be either married or unmarried. It was agreed that no payment (except for expenses) should be allowed for surrogacy services. This would imply that only relatives or friends would have the motivation to offer this service, making it practically impossible to maintain anonymity. This lack of anonymity was regarded as a disadvantage – from the point of view of both the surrogate mother and the child (who will have to face the fact that he has "two mothers"). But the dangers involved in commercialization, mainly the exploitation of poor women, seemed to the Commission to be overriding.

It was also agreed that the surrogate mother will have the right to go back on her consent and keep the child after birth. This should
be considered as an inevitable risk that must be taken by the couple “ordering” the child. On the other hand, the couple would not be able to refuse to take the child in case it is born with defects, or for any other reason.

Experimentation: So far the Commission has not formed an opinion on experimentation with embryos. It seems that the 14-day limit proposed by the British Commission is reasonable. However, it is not clear whether there is a logical or ethical justification to the restriction of using only embryos created in the process of IVF treatment, and whether it justified to limit those experiments only to those dealing with fertility problems in particular.

To conclude with a personal note, which might bear on interdisciplinary discussions in bioethics in general: As a philosopher, I usually find myself advocating in the abstract principles which are more permissive and liberal than would seem to myself reasonable when confronted with concrete cases. On the other hand, I am struck by the opposite syndrome among many of the professional practitioners, especially doctors: namely in general discussions on abstract principles and policies they defend views which are more conservative and cautious than those that guide them in their actual decisions in their everyday practice. Maybe this dual tension within the two approaches (the theoretician’s versus the practitioner’s) is potentially fruitful in the attempt to create policies and guidelines in the bioethical sphere.

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