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NOTE: At the time of publication, the author Vardit Ravitsky was affiliated with the Gertner Institute for Health Policy Research, Tel HaShomer, Israel. Currently March 2007, he is a faculty member in the Center for Bioethics at the University of Pennsylvania.

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Abstract
Unlike most Western nations, Israel does not recognize full separation of church and state but seeks instead a gentle fusion of Jewish and democratic values. Inasmuch as important religious norms such as sanctity of life may clash with dignity, privacy, and self-determination, conflicts frequently arise as Israeli lawmakers, ethicists, and healthcare professionals attempt to give substance to the idea of a Jewish-democratic state. Emerging issues in Israeli bioethics—end-of-life treatment, fertility, genetic research, and medical ethics during armed conflict—highlight this conflict vividly.

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Israel: Bioethics in a Jewish-Democratic State

MICHAEL L. GROSS and VARDIT RAVITSKY

Unlike most Western nations, Israel does not recognize full separation of church and state but seeks instead a gentle fusion of Jewish and democratic values. Inasmuch as important religious norms such as sanctity of life may clash with dignity, privacy, and self-determination, conflicts frequently arise as Israeli lawmakers, ethicists, and healthcare professionals attempt to give substance to the idea of a Jewish-democratic state. Emerging issues in Israeli bioethics—end-of-life treatment, fertility, genetic research, and medical ethics during armed conflict—highlight this conflict vividly.

The Right to Die

A patient's right to control life-sustaining treatment is no longer controversial in Western Europe and the United States. Following an intense debate that began with a terminally ill patient's right to refuse extraordinary lifesaving care, patients' rights moved quickly to encompass a competent, incompetent, or never-competent patient's right to withhold or withdraw ordinary, extraordinary, and/or basic care. In most Western nations, chronically ill patients enjoy the same rights as terminally ill patients in this regard.

The situation in Israel is much different. A 1996 patients' rights law[1] pointedly excludes any mention of a patient's right to die with dignity, and criminal law forbids any action that "accelerates" a patient's death. In this atmosphere, the courts have been reluctant to affirm any but the simplest requests of competent, terminally ill patients to refuse ventilator support on the grounds that these are extraordinary, heroic, and probably futile measures. In exceptional cases, district courts have permitted physicians to remove life support from a once-competent patient who was careful to document his intentions well before losing consciousness.[2]

These rulings are rare, however, trying to knit together recent Israeli legislation affirming respect for human dignity with long-standing arguments from American bioethics that refute the distinction between withholding and withdrawing treatment. Apart from these exceptions, patients in Israel do not enjoy the right to withdraw treatment. The effects of this policy are problematic. Permanent vegetative state (PVS) patients linger, end-state cancer patients cannot end their lives with dignity, and failure to allow parents of critically ill neonates to withdraw treatment spurs late-term abortion.

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In light of growing concern and lack of coherent policy, Israel's health minister established a public committee in 2000 to formulate guidelines for end-of-life care—that is, for terminally ill patients with a remaining life span of 6 months or less. Their mandate *excluded* chronically ill patients with minimal hope of recovery (e.g., patients in a permanent vegetative state). In spite of dissenting opinions, this multidisciplinary committee sought consensus rather than confrontation as it wrestled with religious and democratic imperatives. In general, the final recommendations walk a fine line between the demands of autonomy-based secular bioethics and religious norms granting great weight to the sanctity of life.

Apart from establishing guidelines for palliative care and advance directives, the proposed law contends with a patient's right to forego treatment.[3] Although it stipulates that no patient can be treated without informed consent, the law prohibits termination of "continuous" treatment—that is, any form of care that is essentially uninterrupted and admits of no clear distinction between the end of one cycle and the beginning of another. The prime example is mechanical ventilation. Continuous care contrasts with "discrete" care, which does begin and end in well-defined cycles. Thus, the kinds of care a patient may withdraw are limited. Nor is the right to *refuse* care absolute. Although the proposed law allows competent patients to refuse food and fluids, it prevents surrogate decisionmakers from exercising the same right on behalf of incompetent patients. And whereas incompetent patients may refuse basic care by advance directive, physicians may only honor their request when death is imminent and the failure to provide food and fluids will not shorten a patient's expected life span. Recommendations for end-of-life neonatal care are equally contentious. Although the current draft law does not yet address neonatal care, preliminary guidelines stipulate that neonates less than 25 weeks old must be resuscitated and treated with the full complement of available care unless the statistical rate of survival is less than 5%. Infants whose gestational age is greater than 25 weeks must be provided with vigorous care, including resuscitation, even when they show no signs of life.

Key features of the Israeli debate depart from currently well accepted bioethical norms in most Western countries. Disagreement led the committee to defer a decision about including PVS and other chronically ill patients in the draft legislation. In the meantime, this is a significant exclusion. Failure to consider PVS patients, an important class of patients who retain the right to terminate life support, violates principles of equality and autonomy, ignores the cost of continued futile care, and may offend human dignity. In response to the neonatal guidelines, the Israeli Society of Neonatalogists asked why infants over 25 weeks enjoy special status, how doctors can reasonably evaluate statistical survival rates during a difficult delivery, and why physicians are *obligated* to resuscitate and treat certain classes of newborns when it may be against their better judgment and the best interests of the neonate to do so.

Moreover, the underlying logic is, within the context of Western bioethics, no longer compelling. The distinction between continuous and discrete care, for example, calls to mind the animated ruling of *Barber v. Los Angeles County*, whose presiding judge reminded us that "each pulsation of the respirator or each drop of fluid introduced into the patient's body by intravenous feeding devices is comparable to a manually administered injection or item of medica-

tion."[4] The argument was important in 1983, enabling one to see that withdrawing treatment, a contentious idea at the time, is nothing more than refusing treatment, a well-founded moral and legal right. Since then, the distinction between refusing treatment and refusing to continue treatment has largely disappeared and no longer carries ethical and legal weight in the United States and in Europe.

In Israel, however, the distinctions between withholding and withdrawing, ordinary and extraordinary care, continuous and discrete treatment, and terminally ill and PVS patients remain important. Fear of the slippery slope is one reason why this is so. Given wariness of developments in the United States and Europe, it may make sense to draw the line at terminally ill rather than PVS patients to avoid mistreating chronically ill incompetent patients and to arrest the slide toward physician-assisted suicide (PAS) or physician-assisted death (PAD). Thus, the proposed legislation explicitly forbids PAS and PAD and only respects the wishes of competent or once-competent terminally ill patients with advance directives.

Beyond the slippery slope, however, one must also consider the prevailing influence of Orthodox Jewish norms in Israel. PVS patients and neonates merit vigorous treatment because of the overriding duty to offer medical care to any human being. Terminally ill patients represent a special class of carefully defined exclusions in Orthodox Jewish law (Halacha). Within this class, treatment options are limited. One may withhold treatment but must be careful to avoid any hint that one is actually taking a patient's life. Hence the distinction between continuous and discrete care. Whereas a patient may refuse the latter, physicians are prohibited from withdrawing continuous care, so as to avoid an active intervention that hastens a patient's death. This prohibition, therefore, seriously obstructs a patient's right to die. Although the *Barber* Court resolved this dilemma with a clever linguistic argument, Israeli bioethicists looked to a mechanical solution: intricate "timers" to turn off ventilators at certain intervals to transform continuous care into discrete treatment. These devices may successfully bridge secular and religious interests.

If secular bioethicists accommodated religious interests by deferring discussion of PVS patients, agreeing to timers, and accepting limitations on a patient's right to refuse treatment, advocates of traditional Jewish norms made concessions of their own. Not all rabbinic authorities support advance directives, arguing instead that no directive beyond Jewish law can govern decisionmaking. Others strongly believe that there are never grounds for withholding food and fluids—an act tantamount to assisted suicide. In the process of forging a consensus, however, these reservations were put aside as the committee formulated its guidelines.

Patient rights at the end of life offer a challenge to any nation grappling with democratic and religious norms. Unlike Western nations that must sometimes seek compromise with powerful religious interests, the imperative to synthesize secular and traditional values in Israel is as important for national identity as it is for political stability. Many attempts to reconcile, let alone unite, these two disparate sets of values have come up empty, and whereas some feel that the law is a compromise, each side gaining and losing (some more than others), others are convinced that its novelty paves the way for a genuine consensus and successful integration of Jewish and democratic values. Similar efforts infuse the debate over genetics and fertility.

Population Genetics, Stem Cell Research, and Fertility Treatment

Dilemmas of Population Genetics

Efforts by private companies to collect DNA samples from Jews of Eastern European descent (Ashkenazi) for mapping and identifying genes associated with such diseases as diabetes, heart disease, and Alzheimer's generate considerable controversy in Israel. These companies are gradually creating a "private genetic databank," and although patients sign an informed consent form allowing their unidentified DNA to be used in research, there is some concern that data may later be sold to drug companies outside of Israel for further research without patients realizing that the data have been resold.

This raises significant ethical issues. First, the company's intention to "export" the genetic data risks loss of what some consider a "national resource." Second, the research may stigmatize the Ashkenazi Jewish community by revealing predispositions to certain diseases and thereby leading to discrimination by employers and insurance providers. Third, the source of genetic information is unidentifiable. Without any way to track the donor, patients may be denied future medical and pharmacological benefits. Finally, genetic research generates conflicts of interest because private companies pay physicians significant fees ($50 per sample), which may lead patients to question the integrity of physicians who propose participation in research. These questions are prompting preliminary attempts at regulation and legislation, particularly as interest in population genetics is likely to grow in light of the large variety of ethnic groups available for research in Israel today.

Embryonic Stem Cells Research

In 1999, Israeli lawmakers created a 5-year moratorium on cloning and germline gene therapy to study the ethical, legal, social, and scientific ramifications of these technologies.[5] This law bans in utero implantation of blastocysts created by cloning but does not address nonreproductive cloning for research purposes. In 2001, a bioethics advisory committee considered the issues further.[6] In view of the tremendous potential benefits of stem cell research, the committee asked whether it is ethically acceptable to extract embryonic stem (ES) cells from a human embryo prior to its implantation in utero (thereby ending its potential development) to cultivate and study these cells in the laboratory. To answer this question, the committee examined how different religious traditions define and categorize the embryo at its different developmental stages. In contrast to the Catholic view,[7] which treats the embryo as a person from the moment of conception, Jewish and Muslim traditions see an embryo that progressively acquires human status during embryonic development. According to the Orthodox Jewish view, genetic materials outside the uterus have no legal status because they are not considered part of a human being until implantation. Therefore, the status of the preimplantation embryo outside the womb is comparable to that of gametes—namely, it should not be wasted but may be manipulated for therapeutic purposes.

Based on traditional Jewish guidelines, the committee's recommendations allow the donation of excess embryos from IVF (prior to implantation) for therapeutic research, provided parental donors give informed consent and the medical team performing the IVF is distinct from the research team using the

ES cells. However, researchers may not create embryos from gamete donors for any reason other than implantation. These embryos may be used for research only when parents choose not to implant them. Although preembryos are not considered human beings, there is concern that creating embryos from gamete donors for the sole purpose of research may offend donors, lead to the abuse and commercialization of gamete donations, and, more generally, cause the public to fear that IVF technology is being misused. Researchers may, however, clone embryos for research because cloned embryos, like excess embryos, have no potential to become human beings, given that their implantation is prohibited under current Israeli law.

Relative to other countries, guidelines for genetic research in Israel allow researchers considerable freedom. Israelis tend to trust new technology and rapidly embrace the benefits it offers. This tendency is partly attributable to a religious tradition that ascribes overriding value to any attempt to cure and save lives and underlies open-minded attitudes toward research efforts that have therapeutic aims. Moreover, Jewish values do not regard human efforts to intervene in nature as an assault on divine will but rather as an appropriate use of the powers with which God endowed mankind. Contrary to the understanding expressed in the Universal Declaration on the Human Genome and Human Rights,[8] therefore, reproductive cloning is *not* necessarily perceived as an affront to human dignity. For this reason, the United Nations' "International Convention against the Reproductive Cloning of Human Beings" poses an interesting challenge for Israel. Although it wishes to contribute to international efforts to control what is now a medically and ethically unsafe method of reproduction, Israel, as a Jewish state, cannot support limitations on cloning for therapeutic research and will be reluctant to support a ban on *reproductive* cloning if the *sole* objection is built on the belief that cloning offends human dignity.

Fertility and Parenthood

Because of a unique combination of historical, cultural, legal, and economic factors, bioethical issues surrounding fertility are very salient in Israel. Female barrenness is a consistent motif in the Bible, and the desire for biological offspring—"Be fruitful and multiply"—is a profound element of Jewish tradition. The perception of infertility as a "curse" and of fertility as a "blessing" pervades Israeli culture, where community life is centered on children.[9] The historical trauma of the Holocaust and the demographic imbalance between Arabs and Jews in the region fuel concerns that the very future of the Jewish people is threatened. These fears further encourage an official pronatalist population policy and a birth rate that is double the average of most European countries.[10]

Israel's pronatalist policy is evident in every aspect of its legal and regulatory framework. Incremental social security benefits for each child encourage large families. State-funded healthcare covers pregnancy and birth-related expenses but not contraception. National health insurance also covers infertility treatment (including IVF) to enable couples without children from their current marriage to have a first and second child, and to treat childless women who wish to establish a single-parent family. This level of public funding is unparalleled in any other country in the world. Moreover, labor laws compensate

working women for absences resulting from infertility treatment. As a result, Israel has the highest rate of consumption of IVF in the world.[11]

The legal system also demonstrates a strong bias in favor of reproduction. In the precedent-setting *Nakhmani* case,[12] an estranged couple that had previously undergone IVF fought over the disposition of the frozen embryos. The woman wanted to implant the embryos in a surrogate to have a genetic child of her own, but the hospital refused to release the embryos without the genetic father's consent.[13] Construing the case as a conflict between a woman's "right to motherhood" and a man's "right to nonfatherhood," the Supreme Court ruled in favor of motherhood, thus acknowledging a right that imposes a correlative duty on the father.

Israel's surrogacy law is similarly pronatal. In 1996, Israel was the first country in the world to enact a law to regulate and give legal validity to surrogacy agreements.[14] The law requires approval of all surrogacy agreements by a special statutory committee. The child's status is carefully delineated, giving the "intended parents" custody at birth and guaranteeing their status as the "exclusive parents and guardians of the child." The surrogate mother's wish to withdraw from the agreement and/or gain custody requires court approval based on a justifying change in circumstance and a reasonable expectation that the child's best interest will not be harmed. As of March 2002, 104 agreements were approved (of 150 requests), and 44 children were born of 33 deliveries.

With nearly 2000 women awaiting donation in Israel today, another impediment to fertility is a severe shortage of donor eggs. Until recently, only women undergoing fertility treatments could donate their excess eggs. In 2001, the Minister of Health allowed doctors to implant eggs harvested and fertilized outside of Israel, thereby meeting the growing demand by what may be called "egg import." Further proposals include legislation that will expand the possible circle of donors by allowing altruistic (i.e., unpaid) donations from women who are not undergoing treatment themselves.

Whereas the strong pronatalist atmosphere in Israel explains free and unimpeded access to generous fertility treatment, it also raises serious ethical difficulties. Some bioethicists claim that this cultural atmosphere imbued with pronatalism encourages individuals to overconsume reproductive technologies, creates a "national obsession" with biological parenthood, and raises questions about the indoctrination of women toward motherhood at all costs.[15] In most cases, the healthcare system does not provide support systems for failed treatment or for discussion of alternatives such as adoption or voluntary childlessness, an option that is virtually unheard of in Israel. Moreover, public funding of fertility treatment prompts serious questions about equity and access in healthcare as economic constraints now force Israelis to consider the urgency of rationing basic and life-saving services. Lifesaving services also emerge in an entirely different context as we consider medical ethics and armed conflict.

Medical Ethics in Armed Conflict

Following the outbreak of violence between Israelis and Palestinians in October 2000, Israeli military planners found themselves struggling to contain terror while, at the same time, ensuring, among other things, unimpeded access to

medical care in the occupied territories. But this proved difficult to achieve. Blockading Palestinian cities to prevent terrorism caused severe hardship among the local civilian population and disrupted access to medical care. During combat, Palestinians claimed that Israeli soldiers attacked clearly marked ambulances, killed medical personnel, and obstructed the evacuation of wounded militiamen and civilians.

Prior to March 2002, Israel made no attempt to reoccupy Palestinian cities and largely refrained from entering Palestinian-controlled territory. Israel did, however, blockade Palestinian cities from time to time to disrupt communication between terrorist cells. Regardless of its efficacy, the policy wreaks havoc on the civilian population. Troops stationed around major population centers slow traffic as they check ID cards and search residents. Many are turned back at roadblocks, and entire villages are cut off from one another. Physical obstructions, concrete blocks, trenches, and pits make internal movement difficult, as do frequent curfews and closures.

These disruptions hinder access to medical care. B'Tselem, the Israeli Information Center for Human Rights in the Occupied Territories, cites an appeal by the Palestinian Red Cross to Israel's High Court of Justice in February 2001 on behalf of 121 sick or wounded patients whose transportation to medical facilities was delayed. Their report reiterates concern voiced by the International Committee of the Red Cross (ICRC) that the failure to provide timely treatment aggravates individual medical conditions and describes how closures adversely affect the functioning of Palestinian hospitals.[16]

Sustained military actions exacerbate these hardships. Following a vicious wave of terror attacks against Israelis in March 2002 the Israeli Defense Forces (IDF) systematically entered Palestinian cities to destroy terrorist infrastructures. The fighting in some areas was fierce, and it was soon apparent that troops fired on ambulances and killed medical personnel. In the most serious incidents, the director of the Red Crescent in Jenin, a medic, an ambulance driver, and an UNRWA employee were killed by gunfire when their ambulances were attacked. The director of a Bethlehem hospital also died after he was fired on by troops unaware that he had been authorized to collect medical supplies. Intense fighting also impeded the timely evacuation of the wounded and made access to medical care precarious. B'Tselem, The Public Committee against Torture in Israel (PCATI), and Physicians for Human Rights (PHR) document cases of hospitals blockaded and closed, of wounded who died unable to reach medical facilities, and of dialysis patients and pregnant women unable to receive treatment after being turned back at roadblocks and checkpoints.[17]

Human rights organizations such as B'Tselem, PHR, and the ICRC call on Israel to fulfill its obligations under international law which requires Israel, as an occupying power, to safeguard access to medical facilities. As a party to an armed conflict, Israel, like the Palestinians, must also respect the protected status of medical personnel and medical facilities (Fourth Geneva Convention, Articles 18, 20) and provide care for the wounded, the sick, the infirm, and expectant mothers (Articles 16, 17).

In response to the charges leveled by Palestinians and by human rights organizations, Israel invokes exceptions provided by international law together with the more generalized defense of military necessity. International law allows exceptions to the timely evacuation of the wounded if "military consid-

erations do not enable medical teams to enter the area and evacuate the wounded."[18] Hospitals and ambulances lose their protected status if used for hostile purposes (Article 19), and indeed Israeli officials documented several cases of Palestinians using ambulances to transport terrorist personnel and material. Although critics agree that this may necessitate careful searches of ambulances, it cannot, in their opinion, justify indiscriminate attacks on medical personnel.

The argument from military necessity is less specific and more complicated. To justify the blockades and subsequent distress caused to the Palestinian civilian population, one must take the uneasy view that Israelis and Palestinians are engaged in a perpetual conflict without any well-defined goal or criterion of successful conclusion. Although Israel is fighting both to end terror and to bring the Palestinians back to the negotiating table, it is terror—indiscriminate and brutal attacks on innocent civilians—that is the chief concern. Suppressing terror is Israel's sole military goal, but it is not one that is easily quantified or measured. Because this goal is indeterminate and interminable, Israel finds that it is necessary to curtail the movement of most civilians and sometimes obstruct access to medical care to contain terror.

But one must be careful about pushing these arguments too far. Although sieges, blockades, and attacks on ambulances are sometimes necessary to fight terror, exceptions to international law and claims of military necessity cannot underwrite a sweeping norm of unacceptable behavior. Instead, they can only offer grounds for infrequent exceptions to internationally accepted rules and practices. This point is often overlooked. As the current conflict drags into its third year, medical care remains impeded and medical personnel are vulnerable to the dangers of armed conflict. Although terrorism and the fight against terrorism take a heavy toll on both sides, Israelis, particularly those in the medical profession, must be vigilant and vocal about maintaining the protections due civilians, noncombatant medical personnel, and the wounded.

Conclusion

A conflict of local and universal norms underscores many of the bioethical dilemmas facing Israel today. Traditional values, a strong sense of community, and national interests square off against universal humanitarian norms ranging from respect for dignity to noncombatant immunity. Israel is not a liberal state forged entirely in the Western mold, and its attempts to fuse disparate values will serve emerging nations struggling to embrace democratic norms as well as those more established nations coming to grips with parochial interests and traditional values.

Notes

1. Israel Patients Rights Act, SH 5756, 327 (1996).
2. Bibas v. The Attorney General of Israel, HP 528/96 (1997); Idit Meir v. The Attorney General of Israel, HP 401/98 (1998).
3. The Public Committee for Issues Related to Patients at the End of Life. *Proposed Law: The Patient at the End of Life*. Jerusalem: The Public Committee for Issues Related to Patients at the End of Life; 2002:paragraphs 12, 13.
4. Barber v. The Superior Court of Los Angeles County, 147 Cal. App. 3d 1006 (1983).

5. *Prohibition of Genetic Intervention (Human Cloning and Genetic Manipulation of Reproductive Cells) Law*, SH 1697 (1999), p. 47.
6. Bioethics Advisory Committee of the Israel Academy of Sciences and Humanities. *Report on the Use of Embryonic Stem Cells for Therapeutic Research*. 2001. Available at: http://stwww.weizmann.ac.il/bioethics/index-e.html.
7. The committee could find no definitive Protestant position inasmuch as "it is part of the Protestant ethos that moral questions are determined by the individual conscience and, as such, Protestant theology is pluralistic and admits of no single source of authority on questions of stem cell technology and fetal development." See note 6, Bioethics Advisory Committee of the Israel Academy of Sciences and Humanities 2001.
8. UNESCO. *Universal Declaration on the Human Genome and Human Rights*. 1997. Article 11: "Practices which are contrary to human dignity, such as reproductive cloning of human beings, shall not be permitted."
9. Fogiel-Bijaoui S. Families in Israel. In: Izraeli DN, Friedman A, Dahan-Kalev H, Fogiel-Bijaoui S, Herzog H, Hasan M, Naveh H, eds. *Sex Gender Politics: Women in Israel*. Tel Aviv: Hakibbutz Hameuchad; 1999:107–66. (In Hebrew.)
10. There are 2.98 children born per woman, according to: Central Bureau of Statistics. *Statistical Abstract of Israel* 2000, No. 51.
11. According to data from the Israeli Ministry of Health, there are 1,800 cycles per million population, compared to 240 in the United States and 416 in the United Kingdom.
12. Nakhmani v. Nakhmani, FH 2401/95 50(4) P.D.661 (1995). (In Hebrew.)
13. In accordance with U.S. cases such as: Davis v. Davis, 842 S.W. 2d 588 (1992); Kass v. Kass, 91 N.Y. 2d 554 (1998). Here the courts ruled that any use of frozen embryos requires the consent of both parties.
14. *Surrogate Mother Agreements (Approval of the Agreement and Status of the Child) Law*, SH 1577 (1996), p. 176.
15. Shalev C, Remenick L. Where is the child? *Ha'aretz, Independence Day Supplement* 2000 May 9.
16. B'Tselem, the Israeli Information Center for Human Rights in the Occupied Territories. *No Way Out: Medical Implications of Israel's Siege Policy*. Jerusalem: B'Tselem; 2001:5.
17. Physicians for Human Rights. *Medicine Under Attack: Critical Damage Inflicted on Medical Services in the Occupied Territories: An Interim Report*. Jerusalem: Physicians for Human Rights; 2002 Apr 4. (Information about Physicians for Human Rights, Jerusalem, is available at: http://www.phr.org.il); B'Tselem, the Israeli Information Center for Human Rights in the Occupied Territories. *Impeding Medical Treatment and Firing at Ambulances by IDF Soldiers in the Occupied Territories*. Jerusalem: B'Tselem; 2002. (Information about B'Tselem is available at: http://www.btselem.org.)
18. See note 17, B'Tselem 2002:18.