Normative Regulation of Reproductive Technologies in Israel

Amos Shapira*
Normative Regulation of Reproductive Technologies in Israel

Amos Shapira

Abstract

The novel reproductive technologies raise problems - ranging from the pragmatic to the Olympian - which cut across national frontiers and transcend cultural boundaries.

KEYWORDS: Israel, technologies, reproduction
to free associate the thought that we have survived 1984, but the year 2001 is fast approaching.

Normative Regulation of Reproductive Technologies in Israel

Amos Shapira

I. Introduction

The novel reproductive technologies raise problems — ranging from the pragmatic to the olympian — which cut across national frontiers and transcend cultural boundaries. Communities in the modern world promoting such technologies are bound to face common dilemmas of ethical, socio-political and normative-regulatory dimensions. Yet these underlying similarities are qualified, sometimes substantially, by the inherent differences — in cultural heritage, religious tradition, social organization and form of government — marking the various nations of the world community. It might, therefore, be instructive — and occasionally puzzling — for an informed American observer to cast a comparative glance at a regulatory scheme devised elsewhere for the exercise of societal control over the novel reproductive technologies.

Despite profound disparities between the United States and Israel — in history, size, population make-up, socio-economic ethos and system of government — there is a striking resemblance in the essentially secularist, liberal and permissive individual life-style led by many (if not most) Americans and Israelis. But Israel, unlike the United States, has never subscribed to the principle of separation of religion and state. Cultural-religious values, institutions, practices, and injunctions are formally woven into the Israeli communal fabric. The ongoing debate on the proper role of religious tradition in the life of the nation generates heightened cultural tensions and heated political divisions, sometimes throwing society into turmoil. Also, unlike the United States, Israel has not yet adopted a formal written constitution complete with a super-law model of a bill of rights. Consequently, in the Israeli normative reality, the precepts of privacy, autonomy and self-determination are not anchored to any entrenched constitutional text backed by

* This essay was written when the author was Julius Silver Scholar at Columbia University School of Law, New York, in 1988.
** The Kalman Lubowski Chair in Law and Biomedical Ethics, Faculty of Law, Tel Aviv University, Tel Aviv, Israel.
an elaborate apparatus of judicial review of legislation. Thus, the ethical underpinnings and repercussions of the current artificial means of reproduction have had to be argued in Israel in a socio-cultural context displaying a unique mix of orthodoxy and secularism, paternalism and individualism, prescription and permissiveness. By the same token, normative arrangements in this field have often had to be grounded in compromise and expediency.

II. Artificial Insemination

Artificial insemination was the first reproductive technology to become regulated by law in Israel. For many years, artificial insemination by donors [hereinafter AID] had been practiced in hospitals and clinics without any formal and explicit legislative, administrative or judicial direction. In June 1979, the Minister of Health promulgated the Declaration on Control of Commodities and Services (Sperm Bank and Artificial Insemination), 1979, and the Public Health (Sperm Bank) Regulations, 1979. According to the Declaration, the "operation of a sperm bank", the "service of a sperm bank", and the "performance of artificial insemination upon a woman" are a "controlled service". The Regulations prescribe that "no person shall operate... a sperm bank except where the Director General of the Ministry of Health has recognized that sperm bank and except under the terms of the recognition. The Director General will not recognize a sperm bank unless it operates within a hospital as a department thereof."

Following the promulgation of the above Declaration and Regulations, the Director General of the Ministry of Health issued a circular to all hospitals in Israel, in which "Rules Concerning the Operation of a Sperm Bank and Directives for the Performance of Artificial Insemination" were laid down. This document stipulates, inter alia, that sperm banks must be administered by a qualified physician with suitable expertise and training. Two separate records are to be kept—a donor record and a sperm record. In the donor record the personal identity of each donor and the month and year of the donation are to be recorded, while the sperm record specifies such particulars as the blood-type, skin-color, color of hair and RH factor (but not the personal identity) of the donor. Numerous donations of sperm are not to be accepted from the same donor. Access to records and documents in a sperm bank is strictly limited. Procedures for the recognition, inspection and withdrawal of recognition of a sperm bank are spelled out in detail.

The directives for the performance of artificial insemination provide that AID be administered only by a qualified physician after determining the reason for the woman's failure to conceive by natural means and concluding that she cannot become pregnant from the sperm of her husband alone. The sperm to be used for AID will be chosen solely by the physician. The physician must not use the sperm of a particular donor if sexual relations between the woman and the donor, were they to exist, would be incestuous. The donor's blood-type should be identical to that of the woman's husband. The sperm of the husband, combined with that of the donor, ought to be used insofar as possible. The identities of the donor and of the husband and wife may be revealed to no one, including either party. AID may not be performed if prior to the donation the donor failed to undergo a general medical examination. A married man is not eligible as donor.

AID is also conditioned on the written consent of the parties concerned. The circular prescribes that "the consent of both the woman and her husband must be obtained, and the husband must declare that the child that is born will be considered as his own child for all purposes, including maintenance and inheritance, and that it will bear the husband's family name, as if it were his natural child." The donor, too, is required to give his written consent to the use of his sperm for the purpose of artificial insemination. In the form outlined for this purpose, the donor undertakes, inter alia, to scrupulously abide by the principle of anonymity of all parties concerned.

It must be noted that the legal foundation of the above Declaration and Regulations promulgated by the Minister of Health is rather shaky, as the enabling law relied upon by the Minister (the Commodities and Services Control Law, 1957) is explicitly designed to control "vital activities" only when "it is necessary so to do for the maintenance of an essential activity or the prevention of profiteering and speculation"—terms which are scarcely applicable to the performance of artificial insemination. Be that as it may, the rules and directives specified in the circular issued by the Minister of Health were never published in the Official Gazette and therefore they can hardly have any binding legal force. Furthermore, even if one assumes the formal validity of these measures of secondary legislation, it is hardly conceivable that matters of personal status, such as the determination of paternity of a child born of artificial insemination, can be decreed normatively except by primary legislation, that is, a statute passed by the Knesset (the Israeli Parliament).

Thus far, only one instance of AID has come before the Israeli
II. Artificial Insemination

Artificial insemination was the first reproductive technology to become regulated by law in Israel. For many years, artificial insemination by donors [hereinafter AID] had been practiced in hospitals and clinics without any formal and explicit legislative, administrative or judicial direction. In June 1979, the Minister of Health promulgated the Declaration on Control of Commodities and Services (Sperm Bank and Artificial Insemination), 1979, and the Public Health (Sperm Bank) Regulations, 1979. According to the Declaration, the “operation of a sperm bank”, the “service of a sperm bank”, and the “performance of artificial insemination upon a woman” are “controlled services”. The Regulations prescribe that “no person shall operate...a sperm bank except where the Director General of the Ministry of Health has recognized that sperm bank and except under the terms of the recognition. The Director General will not recognize a sperm bank unless it operates within a hospital as a department thereof”.

Following the promulgation of the above Declaration and Regulations, the Director General of the Ministry of Health issued a circular to all hospitals in Israel, in which “Rules Concerning the Operation of a Sperm Bank and Directives for the Performance of Artificial Insemination” were laid down. This document stipulates, inter alia, that sperm banks must be administered by a qualified physician with suitable expertise and training. Two separate records are to be kept—a donor record and a sperm record. In the donor record the personal identity of each donor and the month and year of the donation are to be recorded, while the sperm record specifies such particulars as the blood-type, skin-color, color of hair and RH factor (but not the personal identity) of the donor. Numerous donations of sperm are not to be accepted from the same donor. Access to records and documents in a sperm bank is strictly limited. Procedures for the recognition, inspection and withdrawal of recognition of a sperm bank are spelled out in detail.

The directives for the performance of artificial insemination provide that AID be administered only by a qualified physician after determining the reason for the woman’s failure to conceive by natural means and concluding that she cannot become pregnant from the sperm of her husband alone. The sperm to be used for AID will be chosen solely by the physician. The physician must not use the sperm of a particular donor if sexual relations between the woman and the donor, were they to exist, would be incestuous. The donor’s blood-type should be identical to that of the woman’s husband. The sperm of the husband, combined with that of the donor, ought to be used insofar as possible. The identities of the donor and of the husband and wife may be revealed to no one, including each other. AID may not be performed if prior to the donation the donor failed to undergo a general medical examination. A married man is not eligible as donor.

AID is also conditioned on the written consent of the parties concerned. The circular prescribes that “the consent of both the woman and her husband must be obtained, and the husband must declare that the child that is born will be considered as his own child for all purposes, including maintenance and inheritance, and that it will bear the husband’s family name, as if it were his natural child.” The donor, too, is required to give his written consent to the use of his sperm for the purpose of artificial insemination. In the form outlined for this purpose, the donor undertakes, inter alia, to scrupulously abide by the principle of anonymity of all parties concerned.

It must be noted that the legal foundation of the above Declaration and Regulations promulgated by the Minister of Health is rather shaky, as the enabling law relied upon by the Minister (the Commodities and Services Control Law, 1957) is explicitly designed to control “vital activities” only when “it is necessary so to do for the maintenance of an essential activity or the prevention of profiteering and speculation” — terms which are scarcely applicable to the performance of artificial insemination. Be that as it may, the rules and directives specified in the circular issued by the Minister of Health were never published in the Official Gazette and therefore they can hardly have any binding legal force. Furthermore, even if one assumes the formal validity of these measures of secondary legislation, it is hardly conceivable that matters of personal status, such as the determination of paternity of a child born of artificial insemination, can be decreed normatively except by primary legislation, that is, a statute passed by the Knesset (the Israeli Parliament).

Thus far, only one instance of AID has come before the Israeli
Supreme Court. In that case, the husband refused to support a child born to his wife as a result of AID alleging that the artificial insemination was performed without his consent. The Supreme Court dismissed the husband’s allegation and required him to pay maintenance. In fact, even if prior consent by the husband to AID could not have been established, he would have lost the case since under Israeli law a person is bound to pay maintenance not only for his own minor children but also for the minor children of his spouse. It is only when the marriage is dissolved that this statutory duty expires and the obligation to pay support may then become dependent upon explicit or implicit consent to AID. "[t]he agreement between the husband and wife concerning the performance of artificial insemination implies the husband's undertaking to maintain the child to be born in the same way as a father is bound to support his own child." The Court’s preparedness to accept in principle the agreement as a sufficient basis for the husband’s implied maintenance obligation may be regarded as a tacit but unambiguous endorsement of the position that AID ought not to be viewed as violative of public policy, at least when administered to a married woman with her husband’s consent.

On the other hand, this decision of the Israeli Supreme Court by no means provides an authority for the proposition that a husband consenting to AID of his wife thereby assumes the juridical status of a father for all intents and purposes. Indeed, the Court correctly observes in passing that "[t]he whole subject lacks legislative regulation". Yet the Knesset (Israeli Parliament) is hardly likely to embark upon a legislative endeavor on this matter in the foreseeable future, in view of the negative attitude to AID displayed by the politically influential religious circles. This attitude stems from an age-old Jewish religious law injunction which attaches the stigma of bastardy to a child born to a married woman and not fathered by her Jewish husband. Any premature legislative initiative may indeed do more harm than good to the widespread practice of AID in Israel, and it is likely to provoke the presently dormant religious opposition into open political campaigns against the performance of artificial insemination by donor.

Supreme Court. In that case, the husband refused to support a child born to his wife as a result of AID alleging that the artificial insemination was performed without his consent. The Supreme Court dismissed the husband’s allegation and required him to pay maintenance. In fact, even if prior consent by the husband to AID could not have been established, he would have lost the case since under Israeli law a person is bound to pay maintenance not only for his own minor children but also for the minor children of his spouse. It is only when the marriage is dissolved that this statutory duty expires and the obligation to pay support may then become dependent upon explicit or implicit consent to AID. “...the agreement between the husband and wife concerning the performance of artificial insemination implies the husband’s undertaking to maintain the child to be born in the same way as a father is bound to support his own child.” The Court’s preparedness to accept in principle the agreement as a sufficient basis for the husband’s implied maintenance obligation may be regarded as a tacit but unambiguous endorsement of the position that AID ought not to be viewed as violative of public policy, at least when administered to a married woman with her husband’s consent.

On the other hand, this decision of the Israeli Supreme Court by no means provides an authority for the proposition that a husband consenting to AID of his wife thereby assumes the juridical status of a father for all intents and purposes. Indeed, the Court correctly observes in passing that “...the whole subject lacks legislative regulation.” Yet the Knesset (Israeli Parliament) is hardly likely to embark upon a legislative endeavor on this matter in the foreseeable future, in view of the negative attitude to AID displayed by the politically influential religious circles. This attitude stems from an age-old Jewish religious law injunction which attaches the stigma of bastardy to a child born to a married woman and not fathered by her Jewish husband. Any premature legislative initiative may indeed do more harm than good to the widespread practice of AID in Israel, and it is likely to provoke the presently dormant religious opposition into open political campaign against the performance of artificial insemination by donors.

III. In Vitro Fertilization

In December 1980, the Director General of the Ministry of Health promulgated the Public Health Regulations (Human Experimentation). This is a secondary-legislative measure presenting the first endeavor in Israel to devise a normative supervisory mechanism in the field of biomedical research involving human subjects. The term “medical experiment on humans” embraces “the performance of any process, procedure and investigation on a person which is not common.” The Regulations prohibit the conduct of medical experiments in a hospital unless authorized by the Director General in writing and subject to the conditions set forth by him. They further provide that no medical experiment on humans may be conducted in a hospital contrary to the provisions of the Regulations and of the Helsinki Declaration (as adopted by the 18th World Medical Assembly, Helsinki, Finland, 1964, and as revised by the 29th World Medical Assembly, Tokyo, Japan, 1975). Before the Director General may authorize a medical experiment involving human beings, it must be approved by a Helsinki committee, namely, an institutional review board at the hospital where the experiment is to be carried out. In addition, prior to deciding on the matter, the Director General must obtain an opinion from the Drugs and Food Administration of the Ministry of Health or from the Supreme Helsinki Committee for Medical Experiments on Humans appointed by the Director General on a general or ad hoc basis. The opinion of the Supreme Helsinki Committee must be sought in the following instances: 1) an experiment concerning the human genetic code; 2) an experiment concerning the artificial fertilization of a woman; 3) any other matter as to which the Director General wishes to be advised concerning the experiment’s compliance with the provisions of the Regulations and of the Helsinki Declaration. The Committee’s ten member panel includes a jurist, a clergymen, six University professors (of which at least three are physicians), the Director General of the Ministry of Health or his representative (provided that they are licensed physicians), and the head of the Medical Association in Israel.

Given the relative scarcity of pre-formulated human experimentation standards, the Supreme Helsinki Committee has had to break new paths on virgin soil. It functions, in fact, as a semi-legislator, fashioning directives of a general purview in the course of scrutinizing specific research proposals. The principal field of concern assigned to the Committee...
committee so far has been in-vitro fertilization (hereinafter IVF) and embryo replacement. A qualified authorization to engage in this reproductive technique was granted by the Director General, upon the advice of the Supreme Helsinki Committee, in mid-1981 to two leading medical centers. Later, a few additional major hospitals were accorded a similar permit. Initially, the Committee was mainly concerned with the professional validity of the IVF and embryo replacement programs brought to its attention, and it scrutinized the expertise of available personnel and the suitability of attainable equipment and facilities.

Ova could be removed solely with a view to subsequent replacement and not for any other purpose. Consequently, the eligibility of women who were not realistic candidates for ovum replacement (for reasons of, for example, age or physical ailment) was a priori ruled out. Also, considering the risks inherent in laparoscopy (the then prevalent procedure for harvesting eggs), participation was restricted to women for whom the performance of laparoscopy was indicated in any event and irrespective of the proposed IVF treatment. The Committee outlined an informed consent process, including the provision of written explanatory material, counseling, and ultimately the signing of a detailed informed consent document specifying, inter alia, the reasons for and purposes of the experimental treatment, the procedures involved (including laparoscopy and implantation) and the risks they import, and the actual prospects for a successful pregnancy and birth of a healthy child. A system of monitoring and reporting was established.

Mindful of public sensitivities and possible political repercussions, the Committee at first limited participation in the IVF and embryo replacement program to married couples only. Subsequently, it allowed also single women — as a rule those with a stable family environment — to be eligible for IVF treatment.

The issue of ovum donation was considered next and its overall handling by the Supreme Helsinki Committee has been clouded with some ambiguity. Initially, the Committee advised permitting human egg donation from single women donors only. The reason for that restriction lay in the above-mentioned Jewish religious law injunction which attaches the stigma of bastardy to a child born to a Jewish married woman and not fathered by her husband. According to certain Jewish religious law authorities, this injunction could be interpreted as extending to the situation of an egg donation by a married Jewish woman with a view to its fertilization by the sperm of the recipient woman’s husband. Inevitably, the exclusion of ovum donation by married women’s husbands had a limiting effect on the natural reservoir for such

Donations, namely surplus eggs retrieved from married women themselves undergoing IVF treatment. In addition, singling out non-married women as the only eligible egg donors could possibly expose young single volunteering donors (not themselves undergoing IVF treatment) to unnecessary risks involved in ovum recovery procedures. It could also possibly encourage the practice of offering payment for such donations to single women volunteers.

In reality, however, the situation was somewhat mitigated by the circumstance, mentioned above, that single women too became eligible for IVF treatment. It appears that quite a few single women undergoing IVF treatment agreed to donate spare ova retrieved through such treatment. Also, certain medical centers (although apparently not all of them) have voluntarily adopted a policy to reject offers of egg donation (with or without pecuniary reward) made by young non-married volunteers not themselves receiving IVF treatment. Furthermore, the Director General of the Ministry of Health and the Committee have expressly indicated a preference for accepting egg donations from single women who have already borne children of their own. They have also instructed that the Informed Consent document signed by the ovum donor should specify that the donation was made without any remuneration. And finally, at a later stage, the Supreme Helsinki Committee authorized the acceptance of an ovum donation from a married woman in exceptional instances.

After the practice of IVF and embryo replacement had become established and egg donation received a qualified endorsement, the Supreme Helsinki Committee was asked to approve the performance of IVF and embryo transfer to a “host” or “carrier”, that is, a gestational mother. The Committee summarily dismissed such applications without thoroughly considering the problems entailed in the different variations of the so-called “surrogacy” situation.

The matter of freezing and storage of pre-implantation embryos was brought to the attention of the Supreme Helsinki Committee in 1984. The Committee resolved to authorize, during a trial period of two years, the freezing of fertilized ova for up to six months and only for the use of the couple involved. A sub-committee was appointed to explore in detail the scientific, ethical and legal implications of frozen embryo storage, implantation, donation and thawing. The sub-committee submitted its report which was discussed but not fully endorsed by the Supreme Helsinki Committee.
Shapira: Normative Regulation of Reproductive Technologies in Israel

The committee so far has been in vitro fertilization (hereinafter IVF) and embryo replacement. A qualified authorization to engage in this reproductive technique was granted by the Director General, upon the advice of the Supreme Helsinki Committee, in mid-1981 to two leading medical centers. Later, a few additional major hospitals were accorded a similar permit. Initially, the Committee was mainly concerned with the professional validity of the IVF and embryo replacement programs brought to its attention, and it scrutinized the expertise of available personnel and the suitability of attainable equipment and facilities.

Ova could be removed solely with a view to subsequent replacement and not for any other purpose. Consequently, the eligibility of women who were not realistic candidates for ovum replacement (for reasons of, for example, age or physical ailment) was a priori ruled out. Also, considering the risks inherent in laparoscopy (the then prevalent procedure for harvesting eggs), participation was restricted to women for whom the performance of laparoscopy was indicated in any event and irrespective of the proposed IVF treatment. The Committee outlined an informed consent process, including the provision of written explanatory material, counseling, and ultimately the signing of a detailed informed consent document specifying, inter alia, the reasons for and purposes of the experimental treatment, the procedures involved (including laparoscopy and implantation) and the risks they impart and the actual prospects for a successful pregnancy and birth of a healthy child. A system of monitoring and reporting was established. Mindful of public sensitivities and possible political repercussions, the Committee at first limited participation in the IVF and embryo replacement program to married couples only. Subsequently, it also allowed single women — as a rule those with a stable family environment — to be eligible for IVF treatment.

The issue of ovum donation was considered next and its overall handling by the Supreme Helsinki Committee has been clouded with some ambiguity. Initially, the Committee advised permitting human egg donation from single women donors only. The reason for that restriction lay in the above-mentioned Jewish religious law injunction which attaches the stigma of bastardy to a child born to a Jewish married woman and not fathered by her husband. According to certain Jewish religious law authorities, this injunction could be interpreted as extending to the situation of an egg donation by a married Jewish woman with a view to its fertilization by the sperm of the recipient woman’s husband. Inevitably, the exclusion of ovum donation by married women has put a severe limitation on the natural reservoir for such donations, namely surplus eggs retrieved from married women themselves undergoing IVF treatment. In addition, singling out non-married women as the only eligible egg donors could possibly expose young single volunteering donors (not themselves undergoing IVF treatment) to unnecessary risks involved in ovum recovery procedures. It could also possibly encourage the practice of offering payment for such donations to single women volunteers.

In reality, however, the situation was somewhat mitigated by the circumstance, mentioned above, that single women too became eligible for IVF treatment. It appears that quite a few single women undergoing IVF treatment agreed to donate spare ova retrieved through such treatment. Also, certain medical centers (although apparently not all of them) have voluntarily adopted a policy to reject offers of egg donation (with or without pecuniary reward) made by young non-married volunteers not themselves receiving IVF treatment. Furthermore, the Director General of the Ministry of Health and the Committee have expressly indicated a preference for accepting egg donations from single women who have already borne children of their own. They have also instructed that the Informed Consent document signed by the ovum donor should specify that the donation was made without any remuneration. And finally, at a later stage, the Supreme Helsinki Committee authorized the acceptance of an ovum donation from a married woman in exceptional instances.

After the practice of IVF and embryo replacement had become established and egg donation received a qualified endorsement, the Supreme Helsinki Committee was asked to approve the performance of IVF and embryo transfer to a “host” or “carrier”, that is, a gestational mother. The Committee summarily dismissed such applications without thoroughly considering the problems entailed in the different variations of the so-called “surrogacy” situation.

The matter of freezing and storage of pre-implantation embryos was brought to the attention of the Supreme Helsinki Committee in 1984. The Committee resolved to authorize, during a trial period of two years, the freezing of fertilized ova for up to six months and only for the use of the couple involved. A sub-committee was appointed to explore in detail the scientific, ethical and legal implications of frozen embryo storage, implantation, donation and thawing. The sub-committee submitted its report which was discussed but not fully endorsed by the Supreme Helsinki Committee.

Published by NSUWorks, 1999
IV. The Extra-Corporeal Fertilization Regulations

In 1987, the Minister of Health promulgated regulations dealing with various aspects of extra-corporeal fertilization. The regulations are entitled "Public Health (Extra-corporeal Fertilization) Regulations" 1987. The regulations prohibit the retrieval, fertilization, freezing, and implantation of a fertilized egg except in a medical facility authorized for these purposes by the Director General of the Health Ministry and under the terms of the regulations. An authorized medical facility performing extra-corporeal fertilization shall not disclose information concerning the identity of sperm or egg donors. The authorization of a medical facility is revocable by the Director General of the Ministry of Health. Ova may be recovered only for purposes of extra-corporeal fertilization and subsequent implantation in a woman's womb following such fertilization. An egg may be recovered only from a woman undergoing medical treatment due to infertility problems and following an authorized physician's determination that the egg's retrieval is likely to advance such treatment. A retrieved egg may be fertilized only by sperm initially intended for fertilization which was obtained from the husband of the woman whose egg it is or from a donor or from a recognized sperm bank. An egg retrieved from a married woman for her own implantation may be fertilized by a donor's sperm or by sperm obtained from a sperm bank only with the written prior consent of the woman in question and her husband. Fertilization of a donated egg with the sperm of the husband of the woman in whom the fertilized egg is to be implanted requires the written prior consent of both woman and husband. It is prohibited to implant a donated egg unless it is fertilized by the sperm of the implanted woman's husband.

Single women are explicitly recognized in the regulations as eligible for fertilized egg implantation, provided that the eggs are their own and that the procedure is supported by a report submitted by a social worker. Implantation of a fertilized egg in a widow may not be performed except when at least a year has elapsed since the retrieval of the egg and its fertilization and with the supporting opinion of a social worker. An egg fertilized by the sperm of the husband prior to the spouses' divorce will be implanted in the divorced woman only with the consent of her former husband. No use shall be made of an egg retrieved from a married woman who subsequently died. An egg retrieved from a married woman whose husband subsequently died may be donated with her consent. If the husband dies following the fertilization of his wife's egg with his own sperm, the fertilized egg shall not be implanted in the widow before at least a year has elapsed since the retrieval of the egg and its fertilization and upon obtaining a supportive report by a social worker. If the wife dies following fertilization of her egg by her husband's sperm, no use shall be made of the fertilized egg. An egg or a fertilized egg retrieved from a single woman who subsequently died may not be implanted in another woman except with the prior consent of the deceased. Freezing of eggs and fertilized eggs is limited to a period not exceeding five years. An extension of the freezing period by five more years may be granted upon the written request of the spouses and the approval of the physician in charge.

A fertilized egg may be implanted only in a woman "designed to be the child's mother." It is forbidden to implant a fertilized egg in a woman related to the egg donor. Relatives, for this purpose, include parents, their parents and grand-parents, children, brothers and sisters, uncles and aunts and their offspring. An egg donor is limited in her donation to only one woman recipient (in order to preclude the possibility of numerous half siblings being born into different families and thus minimizing the risk of future incestuous marriages).

The regulations stipulate that no extra-corporeal fertilization may be performed unless each and every concerned party has received an explanation from the physician in charge regarding its meaning and likely consequences and unless each and every one of them has separately given informed consent. A married couple will sign a single consent form. Extra-corporeal fertilization of a married woman requires the prior consent of her husband. Consent must be given in writing and in the presence of a physician.

V. Critique of the Extra-Corporeal Fertilization Regulations

The initiative to subject the novel reproductive technologies to systematic normative regulation is definitely welcome. In this respect, the regulations concerning extra-corporeal fertilization are a step in the right direction. This is not to say, however, that the specific standards enunciated by the Ministry of Health are impeccable.

The following are a few critical comments on the 1987 regulations:

1. It is not entirely clear whether or not the regulations are designed to guarantee that the identities of the child, the custodial-social parents, and the gamete donors must forever be kept secret from
IV. The Extra-Corporeal Fertilization Regulations

In 1987, the Minister of Health promulgated regulations dealing with various aspects of extra-corporeal fertilization. The regulations are entitled “Public Health (Extra-corporeal Fertilization) Regulations” 1987. The regulations prohibit the retrieval, fertilization, freezing, and implantation of a fertilized egg except in a medical facility authorized for these purposes by the Director General of the Health Ministry and under the terms of the regulations. An authorized medical facility performing extra-corporeal fertilization shall not disclose information concerning the identity of sperm or egg donors. The authorization of a medical facility is revocable by the Director General of the Ministry of Health. Ova may be recovered only for purposes of extra-corporeal fertilization and subsequent implantation in a woman’s womb following such fertilization. An egg may be recovered only from a woman undergoing medical treatment due to infertility problems and following an authorized physician’s determination that the egg’s retrieval is likely to advance such treatment. A retrieved egg may be fertilized only by sperm initially intended for fertilization which was obtained from the husband of the woman whose egg it is or from a donor or from a recognized sperm bank. An egg retrieved from a married woman for her own implantation may be fertilized by a donor’s sperm or by sperm obtained from a sperm bank only with the written prior consent of the woman in question and her husband. Fertilization of a donated egg with the sperm of the husband of the woman in whom the fertilized egg is to be implanted requires the written prior consent of both woman and husband. It is prohibited to implant a donated egg unless it is fertilized by the sperm of the implanted woman’s husband.

Single women are explicitly recognized in the regulations as eligible for fertilized egg implantation, provided that the eggs are their own and that the procedure is supported by a report submitted by a social worker. Implantation of a fertilized egg in a widow may not be performed except when at least a year has elapsed since the retrieval of the egg and its fertilization and with the supporting opinion of a social worker. An egg fertilized by the sperm of the husband prior to the spouses’ divorce will be implanted in the divorced woman only with the consent of her former husband. No use shall be made of an egg retrieved from a married woman who subsequently died. An egg retrieved from a married woman whose husband subsequently died may be donated with her consent. If the husband dies following the fertilization of his wife’s egg with his own sperm, the fertilized egg shall not be implanted in the widow before at least a year has elapsed since the retrieval of the egg and its fertilization and upon obtaining a supportive report by a social worker. If the wife dies following fertilization of her egg by her husband’s sperm, no use shall be made of the fertilized egg. An egg or a fertilized egg retrieved from a single woman who subsequently died may not be implanted in another woman except with the prior consent of the deceased. Freezing of eggs and fertilized eggs is limited to a period not exceeding five years. An extension of the freezing period by five more years may be granted upon the written request of the spouses and the approval of the physician in charge.

A fertilized egg may be implanted only in a woman “designated to be the child’s mother.” It is forbidden to implant a fertilized egg in a woman related to the egg donor. Relatives, for this purpose, include parents, their parents and grand-parents, children, brothers and sisters, uncles and aunts and their offspring. An egg donor is limited in her donation to only one woman recipient (in order to preclude the possibility of numerous half siblings being born into different families and thus minimizing the risk of future incestuous marriages).

The regulations stipulate that no extra-corporeal fertilization may be performed unless each and every concerned party has received an explanation from the physician in charge regarding its meaning and likely consequences and unless each and every one of them has separately given informed consent. A married couple will sign a single consent form. Extra-corporeal fertilization of a married woman requires the prior consent of her husband. Consent must be given in writing and in the presence of a physician.

V. Critique of the Extra-Corporeal Fertilization Regulations

The initiative to subject the novel reproductive technologies to systematic normative regulation is definitely welcome. In this respect, the regulations concerning extra-corporeal fertilization are a step in the right direction. This is not to say, however, that the specific standards enunciated by the Ministry of Health are impeccable.

The following are a few critical comments on the 1987 regulations:

1. It is not entirely clear whether or not the regulations are designed to guarantee that the identities of the child, the custodial-social parents, and the gamete donors must forever be kept secret from...
each other. The opposite position to absolute anonymity in gamete donation would be to allow free access to the stored records, including personal identifying information, in the interests of the child's self-determination when reaching maturity and in line with contemporary trends in the practice and law of adoption. Another alternative is to chart a middle course, scrupulously preserving the personal anonymity of all parties concerned while allowing limited access to non-identifying data — for example, the genetic background of gamete donors — which might be valuable for the child's future physical and mental health-care needs. In any event, the orderly storage of extra-corporal fertilization records will serve to keep all three options open for a later-day policy decision.

2. The regulations allow ovum donation only to women donors themselves undergoing infertility treatment and in the course of advancing such treatment. This is commendable in view of the health risks surrounding ovum-removal procedures, for it is strictly justified to expose women volunteers, particularly young and still childless, to such risks just for the sake of donation. Yet egg-retrieval technologies are likely to be improved and may possibly entail only minimal risk. When this happens, the practice of egg donation by female volunteers should become acceptable, similar to volunteer sperm donation by males. In this context, it should be noted that the regulations' prohibition of ovum retrieval from a woman not herself receiving infertility treatment rule out the practice of laveage, that is, in vitro fertilization by artificial insemination of an ovum donor from whose body the resultant embryo is flushed and then implanted in a recipient woman.

3. The regulations' treatment of the problem of freezing, storage and disposition of fertilized eggs is partial and thin. The regulations fail to address fully such significant issues as the scope of permissible donation of frozen embryos prior to the successful completion of the infertility treatment of the couple whose gametes produced the embryos in question; the possibility, in exceptional circumstances, of prolonging the permissible duration of freezing; the possibility of shortening the agreed-upon period of freezing in special instances (for example, an illness afflicting the woman and preventing her from bearing a child without posing a serious threat to her own health, or a total loss of the woman's capacity to give birth); the fate of frozen embryos in particular situations like the disappearance or disability of any or both of the spouses, the dissolution of their marriage, and the emergence of a dispute between the spouses as to the proper disposition of the frozen fertilized eggs; the questions which the spouses must specifically address in the informed consent form they sign (for example, the agreed duration of freezing within the limits of the permissible maximum period, the terms of disposition of frozen fertilized ova in case of one or more successful pregnancies or the death of either or both spouses or their separation or divorce, and the spouses' position regarding donation of frozen embryos to others); the procedures applicable to the elimination of frozen fertilized eggs; and procedures for reporting on freezing, thawing, implantation, donation, elimination, accidents and deviations. The regulations do not take a comprehensive stand on the crucial issue of what choices are available regarding the frozen embryos' disposition and whether the woman or couple whose gametes are at stake or the storage agency involved (for example, a hospital or an embryo bank) ought to be the principal decision-maker on these matters.

4. One should welcome the formalization of the already existing practice of allowing single women to be eligible for IVF treatment. The condition attached — a supportive report by a social worker — may be viewed as unduly paternalistic and possibly discriminatory. After all, no qualifications of personal aptness are required of a married woman candidate for a fertilized egg implantation. Yet this alleged measure of discriminatory paternalism seems a price worthwhile paying for making the novel reproductive technologies available also to single women. Far more restrictive and less justifiable is the prescribed ineligibility of single women for a donated fertilized egg implantation.

5. The regulations endorse, in general terms, the practice of donation of excess ova retrieved in the course and for the sake of infertility treatment undergone by the donor. They neither expressly single out non-married women as the only eligible egg donors nor do they explicitly sanction ovum donation by married women. This cautious posture may signal a more liberal attitude which, if indeed substantiated, would tend to expand the reservoir of surplus eggs available for donation. It would have been advisable to specifically direct in the regulations that ovum donation must be preceded by a credible process of consultation and counseling, possibly involving a psychologist or a social worker, culminating in a properly formulated informed consent document. The regulations do not at all address the issue of gamete selling and buying. Is commerce in gamete and embryo donation to be tolerated? The answer, it is submitted, should be negative and the pro-
each other. The opposite position to absolute anonymity in gamete donation would be to allow free access to the stored records, including personal identifying information, in the interests of the child's self-determination when reaching maturity and in line with contemporary trends in the practice and law of adoption. Another alternative is to chart a middle course, scrupulously preserving the personal anonymity of all parties concerned while allowing limited access to non-identifying data — for example, the genetic background of gamete donors — which might be valuable for the child's future physical and mental health-care needs. In any event, the orderly storage of extra-corporeal fertilization records will serve to keep all three options open for a later-day policy decision.

2. The regulations allow ovm donation only to women donors themselves undergoing infertility treatment and in the course of advancing such treatment. This is commendable in view of the health risks surrounding ovum-removal procedures. It is hardly justified to expose women volunteers, particularly young and still childless, to such risks just for the sake of donation. Yet egg-retrieval technologies are likely to be improved and may possibly entail only minimal risk. When this happens, the practice of egg donation by female volunteers should become acceptable, similar to volunteer sperm donation by males. In this context, it should be noted that the regulations’ prohibition of ovum retrieval from a woman not herself receiving infertility treatment runs out the practice of lavage, that is, in vivo fertilization by artificial insemination of an ovm donor from whose body the resultant embryo is flushed and then implanted in a recipient woman.

3. The regulations’ treatment of the problem of freezing, storage and disposition of fertilized eggs is partial and thin. The regulations fail to address fully such significant issues as the scope of permissible donation of frozen embryos prior to the successful completion of the infertility treatment of the couple whose gametes produced the embryo in question; the possibility, in exceptional circumstances, of prolonging the permissible duration of freezing; the possibility of shortening the agreed-upon period of freezing in special instances (for example, as illness afflicting the woman and preventing her from bearing a child without posing a serious threat to her own health, or a total loss of the woman’s capacity to give birth); the fate of frozen embryos in particular situations like the disappearance or disability of any or both of the spouses, the dissolution of their marriage, and the emergence of a dispute between the spouses as to the proper disposition of the frozen fertilized eggs; the questions which the spouses must specifically address in the informed consent form they sign (for example, the agreed duration of freezing within the limits of the permissible maximum period, the terms of disposition of frozen fertilized ova in case of one or more successful pregnancies or the death of either or both spouses or their separation or divorce, and the spouses’ position regarding donation of frozen embryos to others); the proceedings applicable to the elimination of frozen fertilized eggs; and procedures for reporting on freezing, thawing, implantation, donation, elimination, accidents and deviations. The regulations do not take a comprehensive stand on the crucial issue of what choices are available regarding the frozen embryos’ disposition and whether the woman or couple whose gametes are at stake or the storage agency involved (for example, a hospital or an embryo bank) ought to be the principal decision-maker on these matters.

4. One should welcome the formalization of the already existing practice of allowing single women to be eligible for IVF treatment. The condition attached — a supportive report by a social worker — may be viewed as unduly paternalistic and possibly discriminatory. After all, no qualifications of personal aptness are required of a married woman candidate for a fertilized egg implantation. Yet the alleged measure of discriminatory paternalism seems a price worthwhile paying for making the novel reproductive technologies available also to single women. Far more restrictive and less justifiable is the prescribed ineligibility of single women for a donated fertilized egg implantation.

5. The regulations endorse, in general terms, the practice of donation of excess ova retrieved in the course and for the sake of infertility treatment undergone by the donor. They neither expressly single out non-married women as the only eligible egg donors nor do they explicitly sanction ovum donation by married women. This cautious posture may signal a more liberal attitude which, if indeed substantiated, would tend to expand the reservoir of surplus eggs available for donation. It would have been advisable to specifically direct in the regulations that ovum donation must be preceded by a credible process of consultation and counseling, possibly involving a psychologist or a social worker, culminating in a properly formulated informed consent document. The regulations do not at all address the issue of gamete selling and buying. Is commerce in gamete and embryo donation to be tolerated? The answer, it is submitted, should be negative and the pro-

Published by NSUWorks, 1999
hibition of pecuniary reward (other than out-of-pocket expenses, including the cost of necessary medical treatment) ought to be inscribed in the informed consent document.

6. In an early draft of the regulations it was proposed to expressly direct that implantation of a fertilized ovum might be performed in a woman only if the ovum was retrieved from "a woman of the same People [i.e., national origin]." That proposed directive was patently problematic and disturbing. In addition to raising intriguing questions of interpretation (what is the precise meaning of "people" or "national origin" in this context?), such an injunction could have provoked accusations, whether justified or not, of segregationist or even racist attitudes. The asserted underlying rationale for that directive, formulated in terms of "the welfare [i.e., best interests] of the child" to be born, was not likely to produce a substantially soothing, ameliorative effect. To be sure, the parties involved in an egg donation arrangement may voluntarily wish to stipulate terms and conditions, including the ethnic origin or religious affiliation of the egg donor. But formally enshrining such a restriction in a legislative (albeit secondary) measure is something else.

The actual reason for the proposed restriction lay in the traditional Jewish religious law principle that a Jew is only he or she who was born to a Jewish mother (or duly converted to Judaism). It was apprehended that a child born as a result of the implantation of a fertilized ovum recovered from a non-Jewish woman donor would not be considered Jewish, much to the child's inconvenience and disadvantage given Israeli realities (concerning, for instance, eligibility for marriage and divorce). One has to admit that this is a real problem. Yet the solution offered by the draft regulations can be likened to an overdose of a strong medicine which cures the disease while killing the patient in the process. A way out of the dilemma should and can be found elsewhere. The above mentioned Jewish religious law principle decrees that only the offspring of a Jewish mother is regarded as a Jew. But who is the mother in a situation where woman A is implanted with an ovum retrieved from woman B and then carries the pregnancy to term and gives birth to a child? If one adopts the position that, for purposes of lineage, the gestational-carrier woman is the mother rather than the ovum donor (although the latter is certainly the genetic parent) — a position not without foundation in the teaching of Jewish sages — then the solution becomes obvious.

The Minister of Health did well to erase that troubling proposal.
620 Nova Law Review [Vol. 13

hibition of pecuniary reward (other than out-of-pocket expenses, including the cost of necessary medical treatment) ought to be inscribed in the informed consent document.

6. In an early draft of the regulations it was proposed to expressly direct that implantation of a fertilized ovum might be performed in a woman only if the ovum was retrieved from "a woman of the same People [i.e., national origin]". That proposed directive was patently problematic and disturbing. In addition to raising intriguing questions of interpretation (what is the precise meaning of "people" or "national origin" in this context?), such an injunction could have provoked accusations, whether justified or not, of segregationist or even racist attitudes. The asserted underlying rationale for that directive, formulated in terms of "the welfare [i.e., best interests] of the child" to be born, was not likely to produce a substantially soothing, ameliorative effect. To be sure, the parties involved in an egg donation arrangement may voluntarily wish to stipulate terms and conditions, including the ethnic origin or religious affiliation of the egg donor. But formally enshrining such a restriction in a legislative (albeit secondary) measure is something else.

The actual reason for the proposed restriction lay in the traditional Jewish religious law principle that a Jew is only he or she who was born to a Jewish mother (or duly converted to Judaism). It was apprehended that a child born as a result of the implantation of a fertilized ovum recovered from a non-Jewish woman donor would not be considered Jewish, much to the child's inconvenience and disadvantage given Israeli realities (concerning, for instance, eligibility for marriage and divorce). One has to admit that this is a real problem. Yet the solution offered by the draft regulations can be likened to an overdose of a strong medicine which cures the disease while killing the patient in the process. A way out of the dilemma should and can be found elsewhere.

The above mentioned Jewish religious law principle decrees that only the offspring of a Jewish mother is regarded as a Jew. But who is the mother in a situation where woman A is implanted with an ovum retrieved from woman B and then carries the pregnancy to term and gives birth to a child? If one adopts the position that, for purposes of lineage, the gestational-carrier woman is the mother rather than the ovum donor (although the latter is certainly the genetic parent) — a position not without foundation in the teaching of Jewish sages — then the solution becomes obvious.

The Minister of Health did well to erase that troubling proposed norm from the official text of the regulations as ultimately promulgated.

7. The Informed Consent standards set forth in the regulations are general in purview and meager in substance. A far more structured and detailed Informed Consent process is needed, with an emphasis on credible procedures of consultation and counseling. The signature of the parties concerned on the dotted line of the consent form should merely be the final formal step in this process rather than a substitute for it. Special attention ought to be given to responsible disclosure of all pertinent information and to reliable ascertainment of the actual voluntariness of consent in egg and embryo donation cases.

8. The proscription of ovum retrieval save for purposes of fertilization and subsequent implantation in a woman's womb implies a ban on the conduct of embryo research, at least in the sense of forbidding the deliberate formation of embryos solely for purposes of experimentation. Research on fertilized ova presents a baffling dilemma. There can be no denying of the significant scientific value and substantial clinical usefulness of embryo research (for example, for purposes of exploring spontaneous abortion, investigating transmitted genetic diseases, and improving extra-corporeal fertilization techniques). But, admittedly, serious ethical and legal problems arise where human embryos — which are living biological entities — are used as experimental subjects. One must also realize that embryo research is readily associated with the explosive issue of abortion. Against this controversial background, there seems to be no alternative but to balance all contending values and concerns with a view to hammering out an acceptable solution somewhere between a complete authorization and a total prohibition of embryo research.

Thus, for instance, due concern for the human life potentiality embodied in or symbolized by an embryo can be shown by forbidding the deliberate formation of embryos solely for purposes of experimentation, namely, using them exclusively as a means for a research end. Yet such a concern loses much or all of its weight when research may only be conducted on embryos initially formed in the course and for the sake of infertility treatment and not replaced or donated for implantation for some bona fide reason. Also, understandable humane sensitivities recognizing the living-organism quality of a fertilized egg could sufficiently be protected by proscribing the continuation of research beyond a certain stage of embryo development, thus ruling out any possibility

Published by NSUWorks, 1999
of causing pain or discomfort or otherwise adversely affecting the cognitive or sensory perception of embryos. And finally, whatever qualified authorization of embryo research is deemed acceptable, it must always be subject to the informed consent of the man and woman whose gametes are involved.

9. The regulations prescribe that a fertilized egg may be implanted only in a woman "designated to be the child's mother." Thus they explicitly rule out one variant of surrogacy in which the womb donor carries to term a laboratory embryo genetically unrelated to her with a view to relinquishing the baby after birth and delivering it to its father and genetic mother, that is, the woman from whose ovum the embryo was formed and who could not or would not bear the child. There is, however, no reference to the far more common surrogacy variation where the surrogate undertakes to conceive through artificial insemination (or ordinary sexual intercourse), carry to term and give birth to a child who is then transferred to the custody of its genetic father and his infertile wife. In the latter variation, the surrogate is both the gestational and genetic mother who, nonetheless, is not intended to be the custodial parent of the child.

Both variants of surrogacy are pregnant with biomedical, social, ethical, and legal dilemmas regarding, *inter alia*, the screening of carriers, informed consent of all parties concerned, information-storing and confidentiality, limitations on the surrogate's behavior and control over her medical decisions (*viz-a-viz*, for example, abortion) during pregnancy, financial rewards for womb leasing, custody and adoption procedures, specific performance of surrogate contracts, "welfare or best interests of the child" considerations, commercialization through brokerage agencies and advertising, the rights and obligations of the surrogate (as a mere carrier or as both a gestational and genetic mother) to the child and vice versa, and the rights and obligations of the custodial parents to the child and vice versa.

The case for surrogacy arrangements can be predicated on an expanded version of the fundamental principle of procreative liberty — the right to have children even, if necessary, with the use of novel reproductive technologies and within a normative framework representing a major departure from the traditional paradigm of parenthood as the union of one man and one woman. A surrogacy arrangement guarantees that at least one custodial parent (the male) is genetically affiliated to the child and this is, arguably, preferable to the common adoption situation. Also, the principles of freedom of contracts and gift transactions may be summoned in support of a mature woman's right to voluntarily agree to bear a child for somebody else, whether she does so altruistically or for a pecuniary gain. Opponents of surrogacy were against unacceptable exploitation of women (particularly those of a low socioeconomic background), dehumanizing trading in babies treated as commodities, adverse impact on the future welfare of surrogacy children, perplexing complications of surrogates refusing to surrender babies or intended custodial parents repudiating them, undermining the traditional institution of marriage by infecting it with a measure of polygamous relationship (especially where the surrogate conceives through ordinary sexual intercourse or artificial insemination by the husband of the infertile intended custodial woman), and the unsuitability of the existing system of law to cope with various legal ramifications of surrogacy.

The options for normatively dealing with surrogacy range from a controlled sanctioning of such arrangements (by, for example, the establishment of a regulatory administrative and/or judicial machinery for the prior approval and continuous monitoring of surrogacy transactions), through a qualified endorsement thereof (for instance, prohibiting the commercialization of surrogacy — including the operation of brokerage agencies, advertising and payment — but allowing private, voluntary, and altruistic arrangements), to totally banning surrogacy arrangements and declaring womb leasing agreements null and void. As already observed, the regulations take an express prescriptive position on surrogacy by IVF, yet fail to address the situation of surrogacy through artificial insemination or ordinary sexual intercourse. They also refrain from explicitly stating that surrogacy contracts are legally void. It seems, however, likely that Israeli courts would in any event tend to view such transactions — particularly if commercialized — as contrary to public policy and consequently invalid.

10. When the process of procreation is no longer limited to one man and one woman, intriguing legal questions as to the personal status of parents and children are bound to arise. What are the respective jurisdictional identities, rights and obligations of sperm donors (and their wives), ovum donors (and their husbands), embryo donors, husbands of women inseminated with donor sperm, women implanted with donated fertilized eggs (and their husbands), and surrogates (and their husbands) in both artificial insemination or ordinary sexual intercourse and fertilized egg implantation situations *viz-a-viz* the child born and among themselves? What relative weight ought to be accorded in ei-
of causing pain or discomfort or otherwise adversely affecting the cognitive or sensory perception of embryos. And finally, whatever qualified authorization of embryo research is deemed acceptable, it must always be subject to the informed consent of the man and woman whose gametes are involved.

9. The regulations prescribe that a fertilized egg may be implanted only in a woman “designated to be the child’s mother.” Thus they explicitly rule out one variant of surrogacy in which the womb donor carries to term a laboratory embryo genetically unrelated to her with a view to relinquishing the baby after birth and delivering it to its father and genetic mother, that is, the woman from whose ovum the embryo was formed and who could not or would not bear the child. There is, however, no reference to the far more common surrogacy variation where the surrogate undertakes to conceive through artificial insemination (or ordinary sexual intercourse), carry to term and give birth to a child who is then transferred to the custody of its genetic father and his infertile wife. In the latter variation, the surrogate is both the gestational and genetic mother who, nonetheless, is not intended to be the custodial parent of the child.

Both variants of surrogacy are pregnant with biomedical, social, ethical, and legal dilemmas regarding. inter alia, the screening of carriers, informed consent of all parties concerned, information-storing and confidentiality, limitations on the surrogate’s behavior and control over her medical decisions (vis-à-vis, for example, abortion) during pregnancy, financial rewards for womb leasing, custody and adoption procedures, specific performance of surrogacy contracts, “welfare - or best interests - of the child” considerations, commercialization through brokerage agencies and advertising, the rights and obligations of the surrogate (as a mere carrier or as both a gestational and genetic mother) to the child and vice versa, and the rights and obligations of the custodial parents to the child and vice versa.

The case for surrogacy arrangements can be predicated on an expanded version of the fundamental principle of procreative liberty - the right to have children even, if necessary, with the use of novel reproductive technologies and within a normative framework representing a major departure from the traditional paradigm of parenthood as the union of one man and one woman. A surrogacy arrangement guarantees that at least one custodial parent (the male) is genetically affiliated to the child and this is, arguably, preferable to the common adoption situation. Also, the principles of freedom of contracts and gift transactions may be summoned in support of a mature woman’s right to voluntarily agree to bear a child for somebody else, whether she does so altruistically or for a pecuniary gain. Opponents of surrogacy warn against unacceptable exploitation of women (particularly those of a low socio-economic background), dehumanizing trading in babies treated as commodities, adverse impact on the future welfare of surrogacy children, perplexing complications of surrogates refusing to surrender babies or intended custodial parents repudiating them, undermining the traditional institution of marriage by infecting it with a measure of polygamous relationship (especially where the surrogate conceives through ordinary sexual intercourse or artificial insemination by the husband of the infertile intended custodial woman), and the unsuitability of the existing system of law to cope with various legal ramifications of surrogacy.

The options for normatively dealing with surrogacy range from a controlled sanctioning of such arrangements (by, for example, the establishment of a regulatory administrative and/or judicial machinery for the prior approval and continuous monitoring of surrogacy transactions), through a qualified endorsement thereof (for instance, prohibiting the commercialization of surrogacy — including the operation of brokerage agencies, advertising and payment — but allowing private, voluntary, and altruistic arrangements), to totally banning surrogacy arrangements and declaring womb leasing agreements null and void. As already observed, the regulations take an express proscriptive position on surrogacy by IVF, yet fail to address the situation of surrogacy through artificial insemination or ordinary sexual intercourse. They also refrain from explicitly stating that surrogacy contracts are legally void. It seems, however, likely that Israeli courts would in any event tend to view such transactions — particularly if commercialized — as contrary to public policy and consequently invalid.

10. When the process of procreation is no longer limited to one man and one woman, intriguing legal questions as to the personal status of parents and children are bound to arise. What are the respective juridical identities, rights and obligations of sperm donors (and their wives), ovum donors (and their husbands), embryo donors, husbands of women inseminated with donor sperm, women implanted with donated fertilized eggs (and their husbands), and surrogates (and their husbands) in both artificial insemination or ordinary sexual intercourse and fertilized egg implantation situations vis-à-vis the child born and among themselves? What relative weight ought to be accorded in es-
Establishing personal status relationships of parents and children to genetic, gestational, contractual and social factors? Many of these questions cannot be answered except by primary legislation. Yet conceiving and delivering legislative measures on such issues is no small feat considering the often contentious religious, ethical and socio-economic ramifications of the novel reproductive technologies.

The 1987 regulations do not purport to decree whether, in an ovum donation situation, the ovum donor or the woman bearing and giving birth is to be regarded as the child’s mother for all intents and purposes. Indeed, as noted above in regard to AID, such matters should not and probably could not be determined by secondary legislation. Knesset (Israeli Parliament) legislative action is urgently needed but, in all likelihood, is hardly expectable in the foreseeable future. If and when it becomes feasible, such legislation should expressly divest gamete donors of parental rights and obligations and endow custodial parents with the status of mother and father.