fied in terms of maternal risk, and should not be permitted save under specific medical warrant. Reduction should be of the most severely compromised or most easily reduced (practitioners report that position may be a significant factor) in order to reduce risk of complications. Sex selection may not be a criterion.

Of in-vitro fertilizations, the larger question is the disposal of the excess frozen embryos that commonly result (ova cannot currently be preserved).

Not all agree on this point, but Rabbi Aaron Mackler, of the Conservative Movement's Committee on Jewish Law and Standards, and Rabbi David Halevy and former Sefardic Chief Rabbi Mordecai Eliyahu (Assia 47-48, Tehumin 11) agree that embryos, which are frozen at a very early state of development, well before the 40 day gestation at which they attain any halakhic status, may be destroyed. Elegantly, Rabbi David Feldman and Dr. Fred Rosner argue that, "A fertilized egg not in the womb, but in the environment—the Petri dish—in which it can never attain viability, does not yet have humanhood. It may be discarded" (Compendium on Medical Ethics, NY Federation). We must forbid the use of fertilized embryos except by the consent of both parents. Any disagreement between them should lead to their destruction.

Case 3:

There is no ethical case to be made that would make life insurance a right, so actuaries seemingly stand on strong grounds rejecting anyone they like. Still, genetic information is only potential, and legislation must provide that insurance may not be refused upon such potential indications but only upon some level of symptom that indicates that the disease process has begun. The reason we carry life insurance is as protection of our charges against our untimely demise. It seems to me that a case can be made that there should be universal access to term insurance up to some retirement age and some limit tied to demonstrable obligations, but excess term insurance and whole-life insurance would remain optional for the insurance carrier. Whether such a utopian system could ever be worked out financially, I leave to others to determine.

Case 4:

What would I say? That generally in a recessive genetic illness such as cystic fibrosis both mother and father must be carriers of the defective gene for it to be expressed in any of their children. That the chance of that occurring is one in four. Additionally, that an infinitesimally small amount of cases may arise in which only one parent is a carrier, with the defect occurring spontaneously in the

child. That in any future pregnancies she should have CVS (cervical villus sampling) done early in the pregnancy or amniocentesis, somewhat later, in order to determine if the fetus is affected.

This is in the grandest tradition of large white lies. It is not the brief of the genetic counselor to open up the matter of infidelity. Having thus offered the father a figleaf, the counselor should speak confidentially to the mother and strongly suggest a full accounting by the wife to her husband. The wife should be made to understand that the genetic record is unequivocal, and the husband's gaze may have been drawn away at this moment, but that there is no guarantee that it will continue to be.

On its face, this suggestion seems to be counter-indicated by a halakhic stricture that once a woman has been unfaithful she is forbidden to both her husband and her lover. Can one knowingly disregard the facts? I believe so. The individual addressed is a genetic counselor not a rabbi and he or she is not functioning in the role of the rabbinic court which is enjoined not to allow infidelity. Moreover, even the husband is able, if he can overcome his jealousy, to overlook leading indications and refuse to accept any indication of his wife's infidelity save confirmation by witnesses. Nothing in the law prevented the husband's reliance on such fig-leaves to obviate the necessity of divorcing his wife.

Zahara Davidowitz-Farkas Joseph J. Fins

New medical technologies do not come with the wisdom of how to use them responsibly. Judaism, however, is rich in resources which help us understand the human dilemmas which stem from the nature of disease and the nature of our human strivings to conquer it.

Central to Judaism's humanity is the notion of specificity. Talmudic teachings are always rich in detail, nuance and personal narrative. True to this heritage, we approach bioethical dilemmas by cultivating the narrative and contextual details which often create consensus out of conflict and foster humanity in the face of an overwhelming technological imperative. With this in mind, we

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DR. JOSEPH J. FINS is Director of Medical Ethics at The New York Hospital and Physician-Ethicist-in-Residence at The Chaplaincy, and Associate for Medicine at the Hastings Center. comment on these hypothetical and anonymous case dilemmas with some trepidation.

Case 1:

The first case reminds us that individuals are affected by public policy. Consider the pregnant woman who is mandated to consent to HIV testing. She is deprived of the fundamental and constitutionally protected right to refuse testing or treatment enjoyed by others who are neither female nor pregnant. *Halakhically*, placing the interests of the fetus over that of the mother is generally contrary to Judaism's understanding of the fetus' status which is not considered a life. For this reason, as well as to promote the integrity of the family unit, medical decisions are made for the sake of the mother and not the fetus.

A more productive strategy would be to help the mother understand the risks and benefits of HIV testing and AZT administration for herself and her fetus. Treatment refusal during pregnancy would be problematic because of the emerging benefits associated with prenatal interventions. Judaism asserts that doctors must heal and ill persons must seek medical care. That would imply that any woman who is HIV positive should be obligated to seek treatment. But, compelling care over the objections of a competent and informed woman could disenfranchise the mother from the healthcare system.

Finally, we question the premise of telling mothers the HIV status of their newborns from data for blind demographic surveys. Once that information is linked to a specific individual, consent is necessary for testing.

Case 2:

The second case evokes p'ru u'rvu, the positive commandment to be fruitful and multiply. Many couples find it impossible to bear children without assistance. While infertile couples should be encouraged to seek this help, any intervention should be proceeded by counseling which explores the couple's readiness to have children, the benefits and risks of IVF and specifically the likelihood of a multiple gestational pregnancy requiring selective abortion. A couple who finds abortion contrary to their belief system would need to consider their decision carefully. It would be a profound disservice to inform them of the need for a "therapeutic" abortion after conception.

Abortion with just cause is permissible in Judaism if the physical and psychological welfare of the mother is jeopardized. Since maternal morbidity increases with multiple pregnancy, fetal reduction can be offered for the mother's safety. Recent *poskim* also consider the gestational well-being of the fetuses as an additional justification to ensure that the remaining fetuses have the opportunity to thrive. Fetal reduction for sex selection is the ultimate in medical hubris, bespeaks arrogance, and trivializes life's sanctity. We condemn these actions in the strictest terms.

Finally, what should be done with the "excess" embryos? With existing technology, embryos may be frozen for future use by the couple, implanted into another woman, used for research, or discarded. It is critical that these options are discussed prospectively.

Case 3:

Turning to the third case, Judaism sanctions medical research directed toward the saving of lives and the betterment of humanity. Although access to life insurance is not a guaranteed right, using genetic technology to deprive one of this entitlement seems a departure from the more beneficent motivations that generally sanction biomedical research and an economic co-optation of medical technology. Furthermore, it may be discriminatory under the Americans with Disabilities Act.

The insurance company's response is based more upon market strategies than sound science. They draw the incorrect inference of equating a genetic marker with a "pre-existing" condition. This reductionism turns the individual into his genes and fails to recognize that genetic influences on future health are contingent and multifactorial. Furthermore, all of us carry recessive alleles associated with the risk of either a lethal or highly morbid disease. This genetic diversity protects our species from environmental pressures. Indeed, teleologically, this collective genetic inheritance might be metaphorically understood as divine life insurance.

Case 4:

The final case urges us to use genetic information deliberately. Although the husband is not likely the father of the child with CF, it is possible that the illness was the product of a spontaneous mutation not requiring that the father carry the recessive allele. Once it is confirmed that the first child was the product of another union, our focus must move beyond genetics. We must listen to their life narrative individually and collectively before prudential counsel is offered. Here, genetic testing is the preamble to a more nuanced inquiry that will require rachmanut (generosity of spirit) to foster shalom bayit (marital peace).

In the clinic, we are often unsure about God's expectations. Given this uncertainty, we know that we are commanded to respect and care for one another. When

we listen carefully to individuals as they struggle with illness and uncertainty, we affirm our shared humanity and in doing so find ourselves on sacred ground.

Yitzchok A. Breitowitz

Case 1:

Although Judaism believes that all healing comes from God, our tradition requires that human beings pursue reasonable avenues of diagnosis and therapy. Maimonides, who himself was a prominent physician, writes that he who refrains from medical intervention because God is the healer is as foolish as the person who refuses to eat because God sustains life. Faith in the divine and indeed the miraculous is not at all inconsistent with the obligation to work within the laws of nature.

While it is indeed the case, as Rabbi Elliot Dorff states (Sh'ma 5/24/95), that just because we can do something doesn't mean that we should, it is hard to see the moral justification for not requiring AZT therapy if such therapy radically reduces the risk of passing on the HIV virus to the fetus. Whatever autonomy rights persons may possess to decline medical treatment for themselves should not extend to denying such treatment for their children--born or unborn. I want to emphasize that this conclusion follows regardless of one's position on the abortion debate. One owes a duty not to the fetus as such but to the person that will eventually be born.

The issue of compulsory testing of all pregnant women is a bit more complicated. Such compulsory testing may involve stigma, discrimination and breaches of confidentiality, particularly when we consider the chances of false positives. It appears, however, that the Jewish imperative of *pikuach nefesh*--the preservation of life--overrides all of these concerns.

Case 2:

In light of the religious imperative to "be fruitful and multiply" and in view of Judaism's belief that reliance in God must be coupled with human intervention, it is entirely appropriate to utilize reproductive technologies in attempts to conceive. (It is important to note, however, that Jewish law does not *obligate* the parties to engage in

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painful, protracted and expensive treatments; it merely permits them to do so. The obligation is limited to conception through natural means.)

Jewish law does permit the killing of one fetus to save another. The rationale for this dispensation is the law of pursuit which states that if a person is endangering the life of another, one may kill the pursuer. Although none of the fetuses has malevolent intent, the law of pursuit applies even to the innocent aggressor.

The problem in Multifetal Pregnancy Reduction is: which one is the pursuer? If only two fetuses can be brought safely to term, the most legitimate basis of decision is to selectively intervene on the side of the fetus or fetuses that have the strongest medical probability to survive. Gender or family planning considerations would not be a relevant concern. In the event that each fetus has the same probability of survival, if there is selective termination, the parents should be free to choose any combination of fetuses that they wish and at that point-and only at that point--could gender be a permissible criterion. The maximization of medical viability should always be the dominant criterion.

What should be done with the excess embryos from in-vitro fertilization that the couple does not desire to use? Under the laws of most states, a range of options exist: destruction, letting the embryos thaw, experimentation, donation to other infertile couples. Although intuitively one might conclude that donation to another infertile couple (typically on an anonymous basis) is the most humane alternative, it raises some difficult problems among them: First, neither the child nor the recipient couple has knowledge of the child's true paternity. Second, there is a halakhic uncertainty as to who is the mother--the genetic egg donor or the gestation/birth mother. If maternity is based on the genetic donor, the donation of an embryo generated by Jewish parents to a non-Jewish couple results in a Jewish child being raised as a non-Jew. Third, the impregnation of a married woman by an embryo fertilized by the sperm of a man other than her husband might be regarded as an act of adultery. Some of these concerns are strictly halakhic and apply only to a Jewish couple; others are of a more general import.

The alternative of thawing or experimentation brings us close to the issue of nontherapeutic abortion. A number of sources indicate, however, that the abortion rules prohibit only procedures within the womb where the embryo or fetus is in the environment where its potential for life may be actualized. Prior to uterine transfer, the embryo is not regarded as a "life" that we are bound to protect. Disposal may, thus, be the lesser or two evils.