Introduction

Rabbi Cohen is an authoritative decision-maker (posek) on Jewish legal (Halacha) issues related to reproductive medicine. In 2008, he addressed a group of medical doctors at a session of the Israeli Fertility Association (recorded by Ivry):

As a personal friend of many doctors, and of the world of medicine, I want to give you a piece of advice. Relations with rabbis are highly important; never say to the patient, ‘What nonsense the rabbi talks,’ because for a religious person the rabbi is the authority. . . . The era of rabbis who understand nothing [of medicine] is past; in every area of science there are rabbis who have learned the area and they are experts. We at the FLOH [Fertility in Light of Halacha] Institute have studied the field of gynecology.

The rabbi’s portrayal of absolute rabbinic authority over patients echoes what Saba Mahmood (2005) has designated as a liberal secular notion of religious authority. However, for the doctors at the medical conference session in which the rabbi made this statement, it was clear that when quoting doctors saying, ‘what nonsense the rabbi talks,’ the rabbi was protesting care providers’ refusal to issue medical treatments prescribed by rabbis to religious patients. Rather than uncontested religious authority, the rabbi’s advice echoes the tension-ridden relations with medical doctors and religious patients that we have observed in our ethnographic research on rabbinically mediated reproductive medicine in Israel. Our findings suggest that rabbinic authority on medical issues is an ongoing project rather than a derivative of a legitimation structure that rabbis enjoy as religious scholars. In this chapter, we examine the social skills and strategies that rabbis use to cultivate their authority on reproductive medical issues.

Since the beginning of Ivry’s research on FLOH, a Jerusalem-based, religious, rabbinic non-profit organization, in 2006, FLOH’s name has appeared in public media in connection with several scandals pertaining to rabbinic involvement in reproductive medicine: they were accused of pressuring doctors to give women unnecessary hormonal treatments and later for excluding women doctors from their annual conferences (Ivry 2010, 2013). Nevertheless,
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FLOH’s popularity within a wide range of observant communities in Israel and abroad seems to be on the rise.

This chapter illuminates the social skills and strategies that FLOH rabbis use to cultivate their authority in two arenas of reproductive medicine. The first arena is Assisted Reproduction Technologies (ARTs), whose ‘koshering’ is positioned at the forefront of FLOH’s formal mission statement. The second is prenatal diagnosis (PND), which stands uneasily at the margins of FLOH’s pro-natalist agenda due to the pre-eminence of its potential for post-diagnostic terminations (i.e. abortions).

Our larger project examines rabbinically mediated reproductive medicine from the perspectives of all parties: rabbis, experts in reproductive medicine, and religiously observant Jews. However, in this chapter we chiefly focus on the rabbis, with some attention to the perspective of Haredi Jewish women—Haredi, in Hebrew, meaning those who tremble before the Lord. We look at how rabbis capitalize on the paradigmatic differentiation, in modern societies, between ‘religion’ and ‘medicine’ (Lüddeckens and Schrimpf 2018). We trace rabbis’ skilful navigation of the rabbinic and medical systems of knowledge and practice at the intersection of religion and reproductive biomedicine in Israeli society.

Ethnographic research

This chapter draws on two larger studies, one conducted by Ivry and one by Ivry and Teman together. The first study looked at FLOH, led by Rabbi Cohen. FLOH’s mission statement for the past thirty years has been to help religious couples affiliated with the full range of Orthodox and Haredi Jewish communities in Israel and abroad who have problems conceiving; the scope of their activities, as we show later, reaches beyond assisted reproduction to encompass the full range of reproductive medical issues. FLOH’s rabbis have cultivated specialized hybrid knowledge in reproductive medicine and Halacha in order to help couples navigate the dual labyrinth of biomedical institutions and rabbinic law during fertility treatments. Ivry’s fieldwork on FLOH from 2006 to 2009 included observations at FLOH’s large annual conferences, smaller seminars and workshops, and formal ethnographic interviews with fifteen religious consultees, thirty-two medical practitioners who work with FLOH (heads of in-vitro fertilization (IVF) units in hospitals, fertility experts, and heads and staff of IVF laboratories), four FLOH staff members, and nine FLOH rabbis. Ivry (2010) also conducted repeated formal interviews and long informal conversations with two of the rabbis over the past ten years.

Her initial focus was on the hands-on negotiations between rabbis and doctors in their everyday interactions over Halachically acceptable (kosher) protocols of treatments FLOH created for their religious consultees. She wanted to understand FLOH’s sources of power and authority over religious consultees and their doctors, and the effects of their involvement on both consultees’ experiences of infertility treatments and doctors’ clinical practice. Full details of this study have been published elsewhere (Ivry 2010, 2013, 2015). Since 2009, Ivry has conducted nine more interviews with seven Orthodox and two Haredi women who consulted FLOH after indication and subsequent diagnosis of a foetal anomaly. In three cases, the women’s husbands participated in the interview.

The second study focused on interviews conducted in Israel from 2007 to 2009 with twenty Jewish Haredi women aged twenty-one to forty-five, all mothers of between two and sixteen children, on experiences of pregnancy and PND. Four additional interviews were done in 2013. Full details of this study have been published elsewhere (Ivry et al. 2011; Teman et al. 2016). In the following, we outline the Israeli reproductive medical contexts for both of these studies.
Israeli reproductive biomedical technologies and observant Judaism

In Israel, where religious courts are sanctioned to rule on matters of personal status and family law, and where Haredi representatives play an important role in policy-making, reproductive technologies have been enthusiastically embraced by secular and religious lawmakers. Significantly, in many European countries the opposite is true, where resistance to legalizing ARTs such as surrogacy, gamete donation, and prenatal testing has been strongly influenced by theological considerations. Moreover, Jewish religious patients have not only emerged as consumers of assisted conception technologies but also as consumers of technologies for diagnosing foetal anomalies. Nevertheless, few social scientists have considered this matter. Most sociologists studying ARTs explain Israeli reproductive policies—and the Israeli state’s generous funding of fertility treatments (until the couple has two children with the current partner)—as a convergence of two trajectories of pro-natalism: the religious imperative ‘to be fruitful and multiply’ and the national imperative of collective survival in the face of existential threat (for example, see Portugese 1998; Birenbaum-Carmeli 2004). As a Jewish state surrounded by Arab countries and engaged in almost continuous armed conflict, public discourse in Israel has been preoccupied with a ‘demographic threat’ (Sered 2000) and has tended to translate Israel’s birthrate into its chances of surviving a military conflict. However, the liberal criteria of eligibility for and routinized use of PND and of post-diagnostic termination of pregnancy do not fit neatly into either paradigm of pro-natalism (Ivry 2009).

Rabbinic concerns regarding assisted reproduction

Moreover, even the seeming affinity between ARTs and observant Judaism becomes puzzling when one considers the high degree of rabbinic concern with issues related to assisted reproduction. Of the three monotheistic religions, Judaism, through rabbinic law, presents the longest list of concerns over technologically assisted reproduction. Unlike the Catholic Church that condemned ARTs outright for their potential to destroy reproductive cells (Roberts 2006), rabbinic Judaism, like Sunni Islam, is concerned with the legitimacy of the children who result from ARTs (Kahn 2000; Inhorn 2006; Clarke 2009). Like Sunni Muslim scholars, rabbis consider the kinship ties between the ART users and their resultant children, as well as lineage and national-religious affiliation. These concerns apply to donor technologies but also to any manipulation of patients’ reproductive cells outside their bodies; rabbis are particularly apprehensive about unintentional mismatches of sperm, eggs, and embryos because these may inadvertently result in the baby being defined by rabbinic law as a mamzer, meaning a child born either as the result of incest or as the result of adulterous relations between a married woman and a man who is not her husband. Mamzers are subject to severe restrictions under rabbinic law; for instance, they are forbidden to marry another Jew. Rabbis are also concerned with the medical procedures commonly used to assist conception such as procedures to widen a woman’s cervix. This may cause cervical bleeding and render her ritually impure, thus prohibiting her from sexual relations with her husband until she has immersed in a ritual bath (mikveh) and interfering with conception. Finally, rabbis are concerned with issues regarding men’s involvement with ARTs as well. Specifically, because masturbation is the common method for obtaining sperm for diagnostic or fertility treatments (e.g. IVF), some decision-makers consider it a violation of the prohibition against ‘spilling sperm in vain’ (Ivry 2010). There are many more examples.
The Jewish structure of authority

Importantly, in contemporary Judaism the authority structure is fragmented (Ivry 2010, 2015). Each community ‘vests authority in the hands of recognized teachers’ (Brody 1990: 33). Hence, no uniform rabbinic position can be stated (Ivry 2015: 4). Instead Halachic references to ARTs are formulated as debates between different rabbinic positions; ‘rabbis who are publicly identified with different religious sects and factions have voiced different opinions on the above and other issues’ (Ivry 2010: 664–665; see also Kahn 2000).

At times these opinions converge, at other times deep divergences emerge. Furthermore, a Halachic opinion does not constitute a ruling (psikah): rulings are given on a case-by-case basis.

Observant Jews tend to direct specific questions to the person recognized as their community’s rabbinic authority, and they receive guidance specific to their individual circumstances. Moreover, a rabbi’s ruling on a specific case may prove quite different from the general opinion that he has voiced. In the complex intellectual exercise of formulating their opinions and rulings, rabbis draw on a broad array of authoritative Jewish texts (which nevertheless maintain complex hierarchies of authority) ranging across biblical sources, the old mishnaic literature, the Talmud, the Midrash, as well as early and later rabbinic rulings and responsa (shut). So in a process that closely resembles reaching a decision in jurisprudence, rabbis make an informed selection of sources on which to rely and from which to derive relevant definitions, juxtapose the case in hand to precedents, analogies, and contrasts, and make a practical decision: a ruling.

(Ivry 2015: 4)

The important result is that while virtually all factions and sects of observant Jews can be adequately described as observing Halacha, ‘rabbinic law’—as it is often called in English, rather monolithically—is an extremely wide array of opinions and practical attitudes that draw on the same pool of literary sources to reach considerably different conclusions. With such diversity, one realizes how courageous and ambitious FLOH’s mission statement really is: to make assisted conception ‘usable for religious patients belonging to any of the full range of sects and factions of contemporary observant Judaism’ (Ivry 2015: 5). Yet FLOH does not advocate unification of rabbinic authority under its auspices as a means to advance its mission. Rather FLOH, through this diversity, and due to it, offers an organized way of navigating religious as well as medical diversity. Most importantly, FLOH puts enormous efforts into enlisting the endorsement of prominent rabbinic ‘decision-makers’ (gdolei haposkim), ‘mainly the leaders of Haredi communities,’ for their activities. ‘As a religious-Zionist organization, combining strict religious observance with commitment to Zionism and the Israeli state, [FLOH’s] rabbis are situated in a unique and not always comfortable position in the broader arena of rabbinic authorities’ (Ivry 2015: 6). The expertise they claim in reproductive biomedicine is crucial to understanding their special and often privileged position in rabbinic politics. So FLOH invests continuous efforts in cultivating elaborate social networks of working relations with experts in reproductive medicine with whom they negotiate ‘kosher’ routes of treatment for their consultees.
Tsipy Ivry and Elly Teman

Negotiating kosher routes of fertility medicine

FLOH’s idea is to:

constitute an information center offering religious couples the full range of rabbinic opinions juxtaposed to the full range of medical options. If the couples are affiliated with the religious Zionist stream, they can ask FLOH to give them a ruling. If they belong to another faction, FLOH can provide their rabbi with the full range of precedent rulings and medical information to help him rule for his consultees.

(Ivry 2010: 665)

Rabbinic and medical opinions are presented with information on actual treatment possibilities based on FLOH’s constant mapping of medical services. The efforts to map fertility-related health services in public hospitals as well as private clinics are central to FLOH’s project of mediating fertility services for their consultees. FLOH’s rabbis regularly inform couples (in private, face-to-face interactions, round-the-clock telephone consultations, or both) about doctors who are highly acclaimed in their fields and also accustomed to working with religious clients, hence well-aware of the couples’ special Halachic restrictions. Through their ‘navigations’ of the existing arenas of rabbinic and biomedical knowledge and services, FLOH constantly works to forge rabbinically appropriate routes of using ARTs.

Three main strategies identifiable in rabbinic koshering endeavours are selective appropriation, witnessing, and innovation. Selective appropriation is applied when several technologies or medical procedures exist to achieve the same stage or goal in a fertility treatment. A rabbi may differentiate between them, proclaiming one Halachically inappropriate and another kosher. He may insist, for example, on testicular fine needle aspiration instead of testicular sperm aspiration (involving a testicular incision, considered a form of castration from some rabbinic perspectives) to extract germ sperm cells from the testicle of azoospermic men, despite doctors’ warnings that the former causes greater damage to the testicular tissues. A rabbi may demand a sperm check through a post-coital test (PCT), where the sperm is collected into a special condom or extracted from the woman’s cervical canal with a spatula after sexual intercourse, instead of by masturbation at the clinic.

When no rabbinically endorsed alternative exists for an essential but Halachically problematic procedure, hands-on supervision (hashgacha)—conceptualized in rabbinic literature as a necessary ‘witnessing’ or ‘testimony’ (edut)—takes place. In the case of ARTs, Halachic supervision is designed to allay rabbinic concern about possible manipulations in reproductive cells producing mamzer children (who, as noted earlier, are forbidden to marry). Halachic supervision is provided by ultra-Orthodox women whom FLOH itself trains, to trace the couple’s semen and ovum from extraction from their bodies through fertilization in the IVF lab to re-transplantation as an embryo in the woman’s womb. Sealed containers reserved for FLOH’s couples serve this purpose.

Technological innovation is practised together with appropriation and supervision. By ‘innovation’ we mean the myriad spatial and mechanical ‘solutions’ that accommodate separate containers to freeze FLOH couples’ reproductive cells and separate incubators for their embryos (as well as a range of devices to keep them sealed) in tiny laboratory spaces. The kosher condom used in PCT—perforated and with no spermicide—is a Halachic-technological invention that enables a man to give a sperm sample without violating the prohibition of ‘spilling sperm in vain.’ With the kosher condom, the possibility that the woman will be impregnated
is kept open, and the sperm can be collected, as mentioned previously, after sexual intercourse and then brought to the clinic to be tested.

All three strategies are combined in a long-term rabbinic consultation given to an observant couple undergoing fertility treatments. When an observant couple asks for FLOH’s Halachic consultation on their treatment, FLOH’s involvement will often include negotiating with their doctors. FLOH’s rabbis regularly engage in phone conversations with medical practitioners over the treatment of observant patients to negotiate kosher treatment routes that accord with the Halachic commitments of consultees’ specific religious sect or faction as mediated further vis-à-vis the couple’s own rabbinic authority figures. FLOH speaks about the kosher courses its rabbis plot to utilize ARTs as full-fledged ‘treatment protocols’ of their own, albeit with a rabbinic rationale. These do not necessarily harmonize with clinical treatment protocols prescribed by doctors in keeping with a medical rationale and standards of clinical practice.

**Rabbis as mediators of potential religious clientele**

Realizing that rabbinic authority figures are the gatekeepers of the religious clientele, the great majority of Israeli doctors (regardless of their position on rabbinic interventions) have admitted that they could not afford to lose this clientele, which accounts for a significant portion of potential patients in reproductive medicine. The prospect of losing the religious clientele was often the explanation given by doctors who were critical of rabbinic interventions and yet cooperate despite their extreme discomfort with rabbinic demands. Professor Oren, head of a major fertility unit, reflected as follows when he described the process through which FLOH’s Halachic supervision became inculcated into his department:

> They [FLOH] wanted to be present during different lab procedures to put their patients’ minds at rest when undergoing them. At first the people here complained—it’s a lab after all: How come...?—but by now we have reached a status quo where they don’t interfere in our business too much because when you reach the bottom line, [they are necessary] in order to receive and give service to this particular population [religious patients]... If we were to be ostracized the economic cost would be enormous... It was a practical decision, for sure... As I see it, we have no other choice. We want this population [religious patients] and there’s a lot of competition out there. We’ve learned to live with it.

Professor Oren offers an example of how doctors may collaborate with rabbinic demands while disdaining and trivializing their contribution. His words echo a lucrative arena of state-subsidized fertility medicine at its intersection with communities in which fertility is never a closed issue, even when the couple already has several children.

Yet while virtually all doctors speak of the power of rabbis over the religious clientele, they differ in their grasp of the nature of rabbinical authority. Doctors who tended toward active collaboration were prone to emphasizing the total power of rabbinic authorities over religious patients. They would readily utter comments like, ‘At the end of the day, the patient will adhere to the opinion of his/her rabbi’; or ‘We’re only the consultants on this (fertility) project.’ Such statements reveal a perception of religious patients (particularly religious women) as totally lacking agency. Generalizing his observations of ultra-Orthodox women to include all religious women, Professor Shaul explained: ‘They don’t have a say, the patients—they come as a result of the rabbis sending them.’
In contrast, doctors who feel antagonistic, but still collaborate with rabbinic authorities, albeit unwillingly, tend to attribute more importance to the patients’ agency and emphasize the flexibility of Halacha and its continual evolvement over time. From this point of view, these practitioners find it hard to accept rabbinic decisions as inevitable, and level criticism against rabbinic decisions that they consider especially stringent and as harbouring harmful consequences for the patients. Often, and particularly when relating to stringent attitudes of spiritual leaders of Haredi sects of kabbala-oriented congregations, doctors explain that these leaders lack medical knowledge and thus no communication can be established. In contrast, most doctors acknowledged FLOH’s rabbis’ familiarity with medical knowledge and language. Interestingly, some doctors referred patients to FLOH as a preventive measure: if, at later stages of treatment, the couple decide to consult a rabbi of their own choice, communication with that rabbi cannot be guaranteed. These doctors connected their religious patients to FLOH because they preferred to negotiate treatment protocols with FLOH rather than with medically uninformed rabbis.

The power of common language

Thus, fluency in medical language and knowledge was for many doctors an aspect that positively differentiated FLOH from other, less-informed rabbis, yet practitioners were equivocal about its depth and consequences. Doctors who were inclined toward active collaboration with FLOH tended to speak highly of FLOH rabbis’ command of medical knowledge and their commitment to updating and furthering their understanding of medical matters. Often their appraisals proceeded with a statement about the ease and efficiency of communicating with FLOH’s rabbis. Such doctors would often say, ‘FLOH—they really speak our language,’ and call them ‘colleagues.’

The rabbis, most of whom are native Hebrew speakers, read abstracts of articles published in international professional journals translated into Hebrew for them by a FLOH rabbi who is a native English speaker. FLOH also holds routine Sunday staff meetings for the rabbis to share new information or problems they have encountered, and invite a doctor or a rabbi to update them on new developments in their field of expertise. As members of the Israeli Fertility Association, they also regularly attend medical conferences and study days on a broad range of topics in obstetrics and gynaecology.

Nevertheless, FLOH rabbis are formally educated in rabbinic law, not biomedicine. To compensate for their lack of a basic medical education FLOH rabbis occasionally consult a select number of doctors ‘with whom we are on very good terms’ as a FLOH rabbi explained. As noted, relations with medical practitioners vary. Relations with practitioners who ‘understand the importance of working with us,’ as the rabbi explained to Ivry, are intense: ‘We drive them crazy so to speak. That is, [we ask them] questions that are basic from their perspective and they are willing to answer regarding any area: pregnancy, birth, breastfeeding, childhood, fertility.’ He assured Ivry that these doctors ‘are not doing us a favor. It is important to them too, because if [the doctor] thinks that a couple should terminate the pregnancy it will be difficult for him to persuade them, so he had better do it through us.’

Termination decisions following a diagnosis of a foetal anomaly were the examples often given when Ivry discussed with doctors their pursuit of rabbinic endorsement. It took several years of fieldwork to realize that facilitating post-diagnostic decisions for observant couples constitutes an important arena where FLOH cultivate their authority. It is here that we shift perspective from the arena where rabbis mediate assisted conception, to an arena of selective reproduction that may seem far on the margins of FLOH’s mission statement.
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Rabbinic consultation on prenatal diagnostic decisions

An ‘array of technologies to diagnose fetal anomalies, identified as a new form of eugenics in European and American public debates, were introduced into routine prenatal care in Israel without significant public discussion’ (Ivry 2015: 3). Routine ‘prenatal care in Israel currently involves attending a minimum of six prenatal care visits and emphasizes the absolute necessity of basic prenatal testing, including a second trimester anatomy scan and maternal serum screening, which are covered by the national health insurance’ (Ivry 2015: 3). As Ivry (2015: 3) explains: ‘If these tests indicate a higher risk for fetal anomaly, state-funded amniocentesis is offered. Non-compliance with this norm is rare among women who do not define themselves’ as Haredi (see also Remennick 2006).

Most non-Haredi Jewish women (including a broad range of religiously observant women) with ‘low-risk’ pregnancies follow a similar route of prenatal testing. Many will have scans at each prenatal check-up if their physician has a sonogram in the office, and some will have to decide about amniocentesis, especially if their pregnancies are ‘high-risk’ (maternal age over thirty-five or indication of a problem evident from maternal serum screening or ultrasound).

Prenatal testing is ‘backed up’ by the Israeli abortion law, which seems relatively liberal for a ‘pro-natal’ state (Ivry 2015: 3). The Israeli abortion law ‘accommodates selective reproduction using an elaborate formulation of vague definitions. The law permits the abortion of a foetus with a ‘defect’ [mum], without specifying the particular kind of anomaly or setting a maximum gestational age threshold beyond which abortion is forbidden’ (Ivry 2009: 39).

While virtually no criticism has been voiced by disability movements in Israel against the social meaning of prenatal diagnosis, it is in Orthodox and Haredi communities that one finds explicit critique and selective use of the otherwise widely used series of prenatal tests offered and covered by the state.

In our joint study of Haredi women’s negotiations with prenatal diagnosis, we found that these women were ambivalent toward PND. They used prenatal check-ups selectively, and when their community rabbi voiced explicit opposition to a diagnostic test, they tried to avoid doing it. But even in the absence of rabbinic opposition, they refrained from tests they saw as causing ‘unnecessary anxiety’ (especially screening tests with probability-based results) or explicitly diagnostic tests that can endanger the pregnancy (such as amniocentesis). Nevertheless, many of our interviewees felt obliged to undergo routine check-ups (blood and urine tests) when they could see their practical implications for maximizing foetal and maternal wellbeing (Teman et al. 2016). We also found that, when not prohibited by their rabbis, Haredi women engaged in ‘softer’ forms of PND: nearly all accepted ultrasound scans, though their number and timing varied greatly among women and from one pregnancy to another. Women could, therefore, find themselves in the midst of a routine ultrasound scan facing an indication of a foetal anomaly. It was when their doctors offered amniocentesis following these indications, suggesting that the pregnancy could be terminated if a positive diagnosis resulted, that women turned to rabbis for consultation. Their rabbi would sometimes consult with FLOH rabbis, and occasionally, would advise the couple to consult with FLOH directly. Indeed, one important segment of FLOH’s consultees come from a variety of Haredi communities. However, as Ivry found in her study of FLOH, it handles reproductive dilemmas for consultees from the full range of observant Judaism.
Halachic debates about pregnancy termination

Although the project of diagnosing foetal anomalies in utero is formally allocated to the margins of FLOH’s activities, its rabbis publicly acknowledge at their annual conferences and seminars that they have mastered specific procedures for post-diagnostic counselling of pregnant women facing moral indecision. When speaking to doctors, FLOH’s rabbis ask them not to give up when women resist further testing; they plead with the doctors to ‘refer the women to us rabbis’ and invite doctors to hand over the ethical judgements to them (Ivry and Teman 2019).

Moreover, FLOH’s rabbis use every opportunity—when speaking to audiences of observant women—to publicly challenge the assumption that Halacha necessarily forbids invasive tests after an indication of foetal anomaly and termination following a confirmed diagnosis (Ivry 2015). They urge women to use prenatal diagnosis and offer them their support. ‘You should know,’ Rabbi Cohen informed an all-woman audience in 2007, ‘that if a couple cannot tolerate the idea and thinks that such a baby [with an anomaly] will ruin the family, they must tell . . . the rabbi. Sometimes the rabbi will permit an abortion.’ The message is that there is a Halachically appropriate way out of an unbearable post-diagnostic decision because the diversity of rabbinic opinions can be activated in the careful consideration of each individual case. Rabbi Cohen often illustrates this case-by-case principle with a detailed story about two religious women living in the same community whose foetuses were both diagnosed with Down syndrome within two weeks. In one case, after consulting with the couple’s community rabbi and doctor, the FLOH rabbi permitted termination; in the other, permission was not granted, and the woman gave birth to the child. In both cases, the women received a rabbinic ruling that matched their expressed desires (Ivry 2015). Moving closer to examine how rabbis handle a couple’s post-diagnostic consultations in practice reveals a complex process we have elsewhere discussed as the ‘outsourcing and aggregation’ of medical and rabbinic opinions though the network of medical and rabbinic experts that FLOH cultivates (Ivry and Teman 2019).

How rabbis handle post-diagnostic decisions

Across the board, there is a consensus among contemporary rabbis about the permissibility of termination when the pregnancy endangers the woman. The specific stage of gestation is also an important parameter in rabbinic considerations. The fortieth day after conception is regarded as a meaningful threshold of ‘ensoulment,’ after which endangering the foetus becomes more problematic; the earlier the stage of gestation, the easier it is to receive Halachic permission to terminate.

When it comes to the health of the foetus, rabbinical positions differ considerably. FLOH’s rabbis emphasize the utmost importance and obligation of considering the writings of two rabbinic figures when opting to rule on a question of abortion: Rabbi Moshe Feinstein and Rabbi Eliezer Waldenberg. These two decision-makers were active in the 1970s and FLOH rabbis insist on their relevance to this day.

Rabbi Moshe Feinstein (1895–1986)—an American-Jewish scholar considered in religious and ultra-religious communities as one of the greatest decision-makers of the twentieth century—prohibited the termination of pregnancy even in cases of foetuses with a severe anomaly who are expected to die soon or immediately following birth. Conversely, Rabbi Eliezer Waldenberg (1915–2006)—an equally esteemed Israeli Jewish scholar who wrote extensively on
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Biomedical technologies—permitted such terminations. Writing about Tay-Sachs disease, Rabbi Waldenberg explained that, ‘because of the great necessity and the pain and suffering, it seems as the classic case that should be permitted. And it does not matter which form of suffering and pain: emotional suffering and pain are in many ways greater than physical suffering’ (Waldenberg 1985: part 9 [51:3]).

Rabbi Waldenberg’s positioning of medical predictions of neonatal viability as well as the suffering of both parents and child as important parameters for Halachic considerations inspired many subsequent rabbinic interpretations. Significantly, biomedicine—itself a multivocal knowledge system—plays a crucial role in all of these rabbinic interpretations, because the prognosis for how long neonates and people with different disabilities and their families can be expected to live and what kind of life they can expect is intimately linked with the question of what kind of biomedical interventions are available. Similar to the case of ART treatment options, the map rabbis navigate is an interconnected dynamic entity that combines rabbinic law, biomedical knowledge, and healthcare services. Thus, rabbis consider the kind of foetal disabilities for which it might be permissible to terminate the pregnancy (as well as parental attitudes toward them) while continuously reaching out to doctors for indications, diagnoses, and prognoses.

The following quote from a lecture to an audience of obstetricians and gynaecologists by a FLOH rabbi we call Yosef demonstrates how biomedical opinions and interpretations impact rabbinic post-diagnostic considerations:

A couple called me. They received a diagnosis from an ultrasound scan of foetal heart disease. In the past foetuses with this condition didn’t survive delivery, but nowadays heart surgery can help them and their prognosis is considerably better. This makes a difference Halachically, because the foetus is no longer in the category of treifa [a non-viable foetus]. When a couple calls and describes such a situation, we usually tell them to have an amniocentesis to confirm that the heart problem does not come with some genetic anomaly. Because if this disability is the only thing, and the prognosis is good, we guide them to continue with the pregnancy.

While couples often hesitate about undergoing invasive tests that might endanger the pregnancy (Ivry et al. 2011), FLOH rabbis often refer women to amniocentesis regardless of whether the probability of miscarriage due to the test (which has in fact decreased over the years) is lower or higher than the probability of severe foetal anomaly. They base their recommendation on Rabbi Waldenberg’s unequivocal permission and cite other prominent rabbis who see such permissions as part of an overall mission to support women and their families in raising extra-large families (of eight or more children). Rabbis follow such Halachic trajectories when they evaluate that parenting a special child might take a heavy toll on the parents who will consequently limit the size of the family.

Rabbi Yosef continued, relaying that this couple decided to keep the foetus diagnosed with a heart problem after undergoing amniocentesis as he had advised. In the thirty-first week, the woman called to tell him that in a routine ultrasound scan the doctor had seen cysts on the foetus’ brain and referred her for an MRI. The rabbi encouraged her to have the MRI, which confirmed the ultrasound findings. Rabbi Yosef quoted the woman saying to him, ‘If it is only a heart problem, that is something I can bear, but if the child also has severe mental retardation, that is too much.’ He explained that her statement in combination with the two prospective
disabilities held great Halachic significance. The rabbi called the doctor who told him, ‘I see a ninety per cent chance of mental retardation.’ Rabbi Yosef went on:

We have a rule: in such circumstances, particularly at such an advanced gestational stage, we never do anything without a second medical opinion. So I asked the couple to seek a second medical opinion of the MRI scan. In the meantime, I did some more work. My shoulders are too narrow to make a decision of such size, so I called great decision-makers, and their opinion was that each disability by itself [either the heart problem or the mental retardation] could not legitimize termination, but the combination of both weighs heavy, and there is room to permit termination even at such an advanced gestational age.

The rabbi did not, significantly, reject the possibility of termination due to the advanced gestational age. Rabbi Yosef described a hectic consultation process with clear rules. The process was initiated by the patient who called FLOH with a new medical finding. The rabbi reached out to medical experts to first clarify their medical interpretation and then sought an additional medical opinion. He explained that while checking the medical findings, ‘I do much legwork: I call the decision-makers, tell them about the medical findings, and ask for their opinions.’ The rabbi is active and in control as long as he can solicit more and more rabbinic and medical expert opinions. He is able to ‘shoulder the moral responsibility’ confidently as long as he can continue ‘dividing the moral labor’ (Ivry and Teman 2019), despite the dramatic prospect of an extremely late-term termination.

When the rabbi remains alone with a decision

But what happens when this process comes to a standstill? A second story Rabbi Yosef told the doctors about a thirty-eight-year-old mother of seven children whose foetus was diagnosed with a rare duplication in chromosomes fifteen and sixteen illustrates such a case. There was little medical information about this anomaly, but the rabbi found four medical articles and immediately called the Israeli geneticist who had authored one to enquire about the health prospects of a child carrying this duplication. The geneticist gave a prognosis of mental retardation and autism.

Rabbi Yosef said, ‘At the end of the day, I needed to make a decision on the termination of a pregnancy in the fifteenth week based on data that I didn’t have. On the other hand, if a child like that is born, it will be a catastrophe for the family. There is a limitation here; a rabbi can sometimes say, “I don’t really know what to do.”’ In this case the lack of medical information stopped the rabbinic-medical chain reaction—what we have called ‘the outsourcing of expert opinions’ (Ivry and Teman 2019)—upon which the division of moral labour depends. The rabbi’s inability to continue juggling productively left him alone and perplexed, struggling with a loaded ethical decision. His training in rabbinic law and reprogenetics did not seem to rid him of the burden; his success as a decision-maker depends on his ability to divide the labour and not simply on his competency in the relevant knowledge system.

On one occasion, Ivry asked Rabbi Cohen, introduced earlier, ‘How do you sleep at night?’ He replied, ‘I have God, and I have rabbis who back me up; I am a dwarf standing on the shoulders of giants.’ She asked him whether he didn’t sometimes regret a ruling. He answered:

I can never regret it, because I have never ruled on a difficult Halachic question (like egg donation or abortion) without consulting with a large team of rabbis. Never. So,
in cases that are especially difficult for me, I say to myself, OK, but this rabbi allowed it and that rabbi allowed it, and I divide the burden... The ruling is a result of much study and consultation... I never rule before I make a thorough investigation of the matter. I have many safety backup advisors... No Halachic decision is made alone. No decision is taken after consultation with just one doctor but always a number of doctors. Never with one rabbi... Anything that is beyond my field of expertise, I take another expert doctor [to consult with]. On fertility issues, I know the [medical] material myself, but if, for example, there is a foetal heart problem, I take a heart specialist, as it is not my field of expertise.

The rabbi’s statement that he has various ‘safety backup advisors’ suggests not only that making post-diagnostic decisions is burdensome for him too but also that openly ruling on termination decisions may endanger his position among other rabbinic authorities. Rabbis—professional decision-makers—are revealed as promoters of multiple specialist opinions, both rabbinic and medical.

Discussion

Our findings suggest that FLOH’s rabbinic authority on reproductive medical issues should be understood as an achievement of carefully coordinated skills of collaboration across social networks of expertise rather than a form of doctrinal power. This achievement can only be accomplished at an intersection between two socially distinct networks of experts: rabbis and medical doctors. FLOH’s authority is contingent upon positioning themselves as specialized mediators between the rabbinic and medical authoritative systems of knowledge and practice. The hybrid rabbinic-medical authority is a modern social and political form that flourishes upon the modern differentiation between ‘religion’ and ‘medicine’: two domains that were interconnected historically (Klassen 2016).

Navigating between and within the rabbinic and medical systems—both internally hierarchical and both holding privileged status within the Israeli political economy of reproduction—involves constant mapping of knowledge and services, and acknowledging diversity rather than aspiring for unification (as the liberal notion of religious authority would imagine). Rabbinic-medical authority is constituted in the name of religious and medical diversity, it works through mediation of layers and orders of differentiation and diversity: between ‘religion’ and ‘medicine’ and then among religious sects and styles of observance as well as among medical attitudes and styles of practice.

Back in 1997, Bridget Jordan theorized the concept of ‘authoritative knowledge,’ acknowledging the diversity of knowledge systems. ‘For any particular domain,’ she wrote, ‘several knowledge systems exist, some of which, by consensus, come to carry more weight than others’ (Jordan 1997: 56). Jordan argued that in any given place or situation, hierarchies will have been created between different sets of authoritative knowledge and only one knowledge system will be rendered authoritative in a given set of circumstances. She defined authoritative knowledge as the ‘knowledge that participants agree counts in a particular situation, that they see as consequential, on the basis of which they make decisions and provide justifications for courses of action’ (Jordan 1997: 58). FLOH, as an institution that employs not one but two systems of authoritative knowledge simultaneously, serves as a challenging case for contemplating the creation of authoritative knowledge and practice across systems of expertise.

In rabbinically mediated fertility biomedicine, no single system of knowledge can remain constantly dominant. Rather than stable hierarchies, one is better off thinking about authorities
in this arena as interdependent and in constant flux. FLOH’s cultivation of Halachically appropriate routes to utilize fertility medicine relies not only on their Halachic deliberations (which depend on medical indications, diagnoses and prognosis, and technological options), but also on their ongoing social interactions with medical practitioners over the treatment protocols of their religiously observant consultees. FLOH’s authority, then, is crucially contingent on collaboration with medical doctors whose attitudes might range from ambivalence and antagonism to enthusiastic willingness to collaborate. Regardless of doctors’ attitudes toward rabbinic involvement, FLOH rabbis are perceived by many doctors as the gatekeepers to religiously observant clientele, which medical institutions as well as private clinics cannot afford to lose. FLOH’s push for kosher medical care generates a dynamics of uneasy doctor-rabbi relations that Ivry (2010) has called ‘kosher medicine.’ Rabbis’ hands-on involvement in their consultees’ fertility treatments introduce not only belief systems and Halachic restrictions but also a network of power relations into clinical practice. They transform the basically dyadic doctor-patient relations into a triadic relation of doctor-rabbi-patient with various possible consequences to the patients’ experiences of treatment, sometimes empowering and other times disempowering the patients.

Shifting from fertility treatments to look at prenatal diagnosis puts an emphasis on the ethical dimensions of rabbinic authority. FLOH’s rabbis invite both the patients and the medical doctors to transfer the excruciating ethical burdens of post-diagnostic dilemmas to them. Thus rabbis seem to offer patients and doctors something that doctors—under the formal commitment to non-directive medical counselling—cannot afford to offer their consultees: ethical judgements.

A closer look at how rabbis rule on post-diagnostic dilemmas reveals that a decision never rests on a single rabbi’s shoulders, neither on the shoulders of the group of rabbis that constitute FLOH. Rather, the rabbis enact a procedure to divide the ethical burden of post-diagnostic decisions using the network of rabbis and doctors they cultivate to negotiate kosher fertility treatments. When asked to consult on a post-diagnostic decision, a rabbi passes the decision onwards onto the shoulders of many different rabbinic and medical experts in a chain reaction of consultations. Rabbis might portray doctors as dependent on them in order to persuade couples to terminate a pregnancy, but clearly, rabbis, in their enterprise of dividing the moral labour, are equally as dependent on doctors as they are on other rabbinic decision-makers.

In soliciting more medical and rabbinic opinions, it is not that the rabbis are simply seeking more information; specializing, as they do, in reproductive medicine and Halacha, they are rarely surprised by the findings. Rather, the purpose of their repeated solicitation of medical and rabbinic second and third opinions in each and every case is to divide the moral burden. It is the ability to solicit expert opinions through ‘outsourcing and aggregation’ time and again with each individual case that is at the heart of the enterprise of easing moral burdens for their consultees. The wide range of specialist opinions, enabled by the network of social relations among rabbis and doctors that FLOH works hard to maintain, is what enables this to continue. The power of FLOH’s authority is revealed from the arena of prenatal diagnosis, as a mastery of the technique of ‘outsourcing moral responsibility’ and the division of labour it entails (Ivry and Teman 2019).

Note

1 All of the names used in this chapter, including the name of the FLOH organization, are pseudonyms.
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Bibliography


