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Parenthood From the Grave: Protocols for Retrieving and Utilizing Gametes from the Dead or Dying

Katheryn D. Katz[†]

INTRODUCTION

There are many circumstances in which posthumous conception or reproduction takes place.¹ This article is limited to a discussion of what has been described as the “quagmire” of postmortem gamete acquisition for purposes of subsequent conception.² I factor out postmortem gamete retrieval from other postmortem reproduction because it is usually non volitional and because the law governing this practice is so underdeveloped. Accordingly, it raises legal and ethical issues not necessarily present with other types of postmortem procreation.

For over thirty years it has been possible to retrieve sperm from males who are deceased, brain dead, comatose or in a persistent vegetative state for use in procreation by the recipient.³ Although harvesting gametes from dead women is not a current practice, I include female gamete retrieval because it may soon be possible to obtain ovarian slices for future ovarian stimulation

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¹ See Anne Reichman Schiff, *Arising from the Dead: Challenges of Posthumous Procreation*, 75 NC L Rev 901 (1997) (discussing philosophical and moral dimensions of posthumous reproduction occurring “when an individual or couple elects to cryopreserve gametes or embryos and subsequently, one or both of the contributors dies, or when gametes are harvested from a dead body”).

² See E.E. Gottenger and H.M. Nagler, *The Quagmire of Postmortem Sperm Acquisition*, 20 J Andrology 458 (1999) (reviewing medical and legal literature regarding postmortem sperm acquisition).

³ See, for example, Cappy Miles Rothman, *A Method for Obtaining Viable Sperm in the Postmortem State*, 34 Fertility and Sterility 512 (1980) (discussing surgical exposure and irrigation of the vas deferens to retrieve sperm in a case involving a family’s request to extract and freeze the sperm of a thirty-year-old male who died following a motorcycle accident). The first pregnancy that resulted from such postmortem sperm retrieval was reported in the lay press in 1998 and the first live birth in 1999. Carson Strong, *Ethical and Legal Aspects of Sperm Retrieval After Death or Persistent Vegetative State*, 27 J L Med & Ethics 347, 347 (1999). The first report of a birth from such a procedure was published in peer-reviewed literature in 2001. Arnold M. Belker, et al, *Live Birth After Sperm Retrieval From a Moribund Man*, 76 Fertility and Sterility 841 (2001).

and fertilization through in vitro fertilization ("IVF").⁴ Further, if a woman is in a persistent vegetative state, it may be possible to stimulate her ovaries and retrieve her eggs for fertilization and storage as frozen pre-embryos.⁵ The day may come, moreover, when the medical technology will exist so that the husband may seek to have his brain-dead wife put on life support, inseminated with his sperm, and continued on life support so that she may bear his child.

When physicians face a request to remove sperm from a dead or dying male or ovarian tissue from a woman who has suffered sudden death or is declared brain-dead, the physician is presented with ethical and legal issues of profound dimensions but scant direction as to the proper course of action. The pleas of a bereaved spouse or parents arise from the tragic circumstances, which evoke compassion and an understandable desire to lessen the survivor's suffering.⁶ Nevertheless, acceding to a request for gamete retrieval raises questions of who, if anyone, may give consent, what informed consent means in these circumstances, and whether the dead or dying have procreative rights that must be respected.

In this Article, I explore the debate on the appropriate framework for evaluating the bio-ethics regarding postmortem gamete retrieval and unitization ("PMGR"). Given the legal void surrounding PMGR, some teaching hospitals have developed protocols to provide guidance to physicians who face requests for PMGR. I examine these guidelines through the lens of reproductive liberty and conclude that the protocols accord too much power over procreative choice to the medical professionals involved in deciding whether to honor a request for PMGR.

⁴ James J. Finnerty, et al, *Gamete Retrieval in Terminal Conditions: Is It Practical? What are the Consequences?*, 2 Current Women's Health Reports 175-78 (2002). See also Michael R. Soules, *Commentary: Posthumous Harvesting of Gametes A Physician's Perspective*, 27 J L Med & Ethics 362, 362-63 (1999) (stating that "ovarian cryopreservation technology has proceeded far enough that it can now be considered reasonable to offer cryopreservation to women shortly after death or during a persistent vegetative state").

⁵ Soules, 27 J L Med & Ethics at 362-63 (cited in note 4). In either case, a surrogate gestator will be necessary to carry the pre-embryos to term.

⁶ See, for example, Cappy Miles Rothman, *Live Sperm, Dead Bodies*, 20 J Andrology 456 (1999) (contending that "to bestow such consolation [by collecting sperm from dead men] at a time of grief and tragedy is clearly part of my role as a healer"). Dr. Rothman, a urologist and andrologist, was one of the first to report postmortem harvesting of viable sperm. Rothman, 34 Fertility & Sterility at 512 (cited in note 3).

I. DIFFERENTIATING TYPES OF POSTMORTEM REPRODUCTION

A. Postmortem Births

Postmortem births have occurred for as long as humankind has existed—certainly as long as men have gone to war.⁷ Conception in these cases was purposeful in the sense that the male was aware that a pregnancy might result from his act of sexual intercourse. The conception, however, was followed by the untimely death of the father from accident, illness, or violence before the child's birth.⁸ These postmortem births do not take place in a legal void. The laws of inheritance have had rules governing postmortem births for centuries.⁹

Females have given birth after death; that is, babies have been delivered from the body of a woman within minutes of her death.¹⁰ As with males who died before the birth of the child, conception in these instances took place before death. Further, medical literature in the English language reports that since 1979 there have been at least eleven cases of irreversibly brain-damaged women whose lives were prolonged for the benefit of the developing fetus.¹¹ These pregnant women would have died too early in their pregnancies to deliver, so they were kept on life support in the hope that the fetus would survive to viability.¹² Even here there is some legal guidance, controversial though it is. In the majority of American states, laws addressing living wills and health care proxies provide that an advance directive clearly stating a pregnant woman's wishes regarding end of life care is to be disregarded.¹³

⁷ The Ethics Committee of the American Society for Reproductive Medicine ("ASRM"), *Posthumous Reproduction*, 82 Fertility and Sterility Supp 1 (Sept 2004).

⁸ *Id.*

⁹ *Id.*

¹⁰ See, for example Daniel Sperling, *Maternal Brain Death*, 30 Am J L & Med 453, 454 n 7 (2004) (noting that the term "Caesareans" traditionally referred to actions "carried out on women who had died before delivering their babies").

¹¹ *Infant Born to Dying Mother Dies as a Result of Infection*, NY Times A18 (Sept 13, 2005).

¹² See, for example, James M. Jordan III, *Incubating for the State: The Precarious Autonomy of Persistently Vegetative and Brain-Dead Pregnant Women*, 22 Ga L Rev 1103 (1988) (discussing cases involving the rights of vegetative or brain-dead pregnant women). See also Richard Paige, *Postmortem Pregnancies: A Legal Analysis*, 9 Dis-patches 2 (King's College London) (2000) (discussing the maintenance of brain-dead pregnant women in Britain).

¹³ See Bretton H. Horner, *A Survey of Living Wills and Advanced Health Care Directives*, 74 N D L Rev 233 (1998) (reporting that thirty-six states prohibit the withdrawal of life support from a pregnant woman).

B. Premortem Gamete Cryopreservation

Medical technology permits postmortem conception where a gamete donor has purposely given his sperm over to cryopreservation or banking, as the practice is sometimes called.¹⁴ There are several reasons that a male might pursue such a course. The sperm may have been cryopreserved before a vasectomy in order to provide the option of fatherhood if the male later changes his mind.¹⁵ Curative chemotherapy and radiotherapy have gonadal toxicity as an important adverse effect.¹⁶ Accordingly, for years men have had their sperm frozen before undergoing radiation and chemotherapy¹⁷ or, in the case of astronauts, going into space, lest the experience render them sterile or cause genetic damage to their sperm.¹⁸ Concerned about exposure to chemical or biological weapons, some American troops deployed to the Middle East have deposited their sperm in sperm banks for their own use later.¹⁹ In each of these instances another motive may also be present: preserving their genetic potential in case the sperm bankers die from the disease, do not return from space, or are killed in war.²⁰

The banking of frozen sperm opens the possibility of procreation by these men long after their deaths, as does the cryopreservation of pre-embryos created for use in IVF.²¹ In the absence of

¹⁴ For a general discussion, see, J. K. Sherman, *Research on Frozen Human Semen: Past, Present and Future*, 15 *Fertility and Sterility* 485 (1964). See also E. Donald Shapiro & Benedene Sonnenblick, *The Widow & the Sperm: The Law of Postmortem Insemination* 1 *J L & Health* 229, 234 (1986-87) (providing a detailed history of artificial insemination).

¹⁵ Gottenger and Nagler, 20 *J Andrology* at 458 (cited in note 2).

¹⁶ A.K Schroder, K. Diedrich, and M. Ludwig, *Strategies for Preventing Chemotherapy and Radiotherapy Induced Gonadal Damage*, 3 *Amer J Cancer* 97 (2004).

¹⁷ Kristine S. Knaplund, *Postmortem Conception and a Father's Last Will*, 46 *Ariz L Rev* 91 (2004).

¹⁸ W. Barton Leach, *Perpetuities in the Atomic Age: The Sperm Bank and the Fertile Decedent*, 48 *A B A J* 942 (1962).

¹⁹ Knaplund, 46 *Ariz L Rev* at 91 (cited in note 17).

²⁰ See, for example, Belinda Bennett, *Posthumous Reproduction and the Meaning of Autonomy*, 23 *Melb U L Rev* 286, 302 n 112 (1999), quoting Robert Jansen, *Sperm and Ova as Property*, 11 *J Med Ethics* 123, 125 (1985), on reasons men bank semen:

[M]en often store semen when they have a life-threatening disease. On the face of it, the motive may seem to be that they are to receive cancer-killing drugs which are likely . . . to destroy the sperm-forming tissue of the testes. But . . . they often have another motive: to protect their genetic potential in the event they die as a result of their disease. Many dying patients take comfort in the fact that they have children, that it is not the end of the road genetically.

Id.

²¹ John A. Robertson, *Posthumous Reproduction*, 69 *Ind L J* 1027 (1994).

specific instructions, postmortem conception, or in the case of the pre-embryos, implantation, under these circumstances raises issues of the progenitors' intention to procreate after death. Consent forms for cryopreservation of gametes or pre-embryos, however, usually have instructions for the disposition of the gametes or pre-embryos if the progenitors die leaving genetic material in storage.²² The very limited decisional law in this area establishes that public policy is not violated when the decedent has expressly stated that a named individual may be impregnated with the sperm.²³ Moreover, issues of a resulting child's inheritance, survivor's benefits, and parentage are gradually being answered by legislatures and the courts.²⁴

C. Gamete Retrieval from the Dead or Comatose

In addition to the above instances of postmortem procreation, it is possible to retrieve gametes from individuals who are deceased, brain dead, comatose, or in a persistent vegetative state ("PVS") for use in procreation by the recipient. There are a variety of techniques that can be used. For males, these include "stimulated ejaculation, micro surgical epididymal sperm aspiration or testicular sperm extraction."²⁵ In some cases insemination will have to be achieved using intra cytoplasmic sperm injection, a technique in which an egg is fertilized using a single sperm even though the practice may increase the risks of birth defects in the child born as a result of the procedure.²⁶

Recently, women undergoing treatment or suffering from a disease that may result in their sterility have the option of creating pre-embryos to be cryopreserved.²⁷ More recently they have

²² Soules, 27 J L Med & Ethics at 363 (cited in note 4) ("In fact, the cryopreservation consent would be considered incomplete if it did not address the posthumous disposition of the sperm or embryos.").

²³ See *Hecht v Superior Court of Los Angeles*, 59 Cal Rptr 2d 222 (Cal Ct App 1996) (order not published) (finding that neither court nor adult children possess reason or right to prevent decedent from procreating with the woman of his choice in the context of will contest); *Hall v Fertility Institute of New Orleans*, 647 S2d 1348 (1994) (stating that "the act of donation by which now deceased donor conveyed ownership of frozen sperm did not violate public policy and donee's proposed artificial insemination was not contra bonos mores").

²⁴ See generally, Michael K. Elliott, *Tales of Parenthood from the Crypt: The Predicament of the Posthumously Conceived Child*, 39 Real Prop Prob & Tr 47 (2004) (discussing case law and recommending legislative solutions to rights of posthumous child).

²⁵ ASRM, 82 Fertility and Sterility Supp 1 (cited in note 7).

²⁶ Gottenger and Nagler, 20 J Andrology at 460 (cited in note 2).

²⁷ See, for example, Kathryn D. Katz, *The Clonal Child: Procreative Liberty and Asexual Reproduction*, 8 Alb L J Sci & Tech 1, 35-39 (1997) (discussing cryopreservation

been offered the option of having their ovaries removed and cryopreserved.²⁸ Women have had their ovarian tissue autografted back in their bodies with successful hormone functioning for a period of time²⁹ and at least one live birth after transplant of ovarian tissue has been achieved.³⁰ Moreover, there are recent advances in egg-freezing techniques that may allow this practice to be a reproductive option for women who have to delay motherhood for social or medical reasons.³¹ It is likely, therefore, that postmortem gamete retrieval from females will become a reality in the near future.³²

II. THE EXTENT OF THE PRACTICE OF POSTMORTEM GAMETE RETRIEVAL

Is PMGR really an issue worthy of our consideration, or is it such a rarity that it is of academic interest only? The fact is that requests for PMGR are numerous, they appear on a worldwide basis, and their number is expected to grow. Moreover, the number of requests increases every time headlines such as “Woman pregnant with sperm from a corpse”³³ make the news.

of embryos and the legal implications arising with the death of the potential parents).

²⁸ See, for example, K. Oktay, et al, *A Technique for Transplantation of Ovarian Cortical Strips to the Forearm*, 80 Fertility & Sterility 193 (2003) (concluding that “heterotrophic transplantation of ovarian tissue to the forearm is simple and promising technique to restore ovarian function in women who have become menopausal due to chemotherapy, surgery, or radiation”); Schmidt K.L. Tryde, et al, *Orthotopic Auto Transplantation of Cryopreserved Ovarian Tissue to a Woman Cured of Cancer—Follicular Growth, Steroid Production and Oocyte Retrieval*, Reprod Biomed Online 448 (2004) (reporting that cryopreserved human ovarian tissue restored ovarian function for several cycles and supported development of mature oocytes in women cured of cancer).

²⁹ Soules, 27 J L Med & Ethics at 363 (cited in note 4).

³⁰ J. Donnez, et al, *Live Birth After Orthotopic Transplantation of Cryopreserved Ovarian Tissue*, Lancet, available at <http://www.saintluc.be/press/commu/tamara_lancet_complet.pdf> (last visited at Jan 26, 2006).

³¹ See, for example, Mark Henderson, *Frozen Eggs Allow Women to put Motherhood on Ice*, The Times Online, available at <<http://www.timesonline.co.uk/article/0,,8122-1670393,00.html>> (last visited Jan 26, 2006) (describing research undertaken in Bologna, Italy by Eleanora Porcu that demonstrates that egg-freezing is as viable an option as embryo freezing). See Sarah Wildman, *Stop Time*, New York Magazine 24 (Oct 17, 2005) (discussing the possibility that young women could freeze their eggs in order to have procreative options when they are older).

³² Finnerty, et al, 2 Current Women's Health Rep at 176 (cited in note 4).

³³ Carson Strong, *Consent to Sperm Retrieval and Insemination After Death or Persistent Vegetative State*, 14 J L & Health 243, 269 n 7 (1999-2000).

A. Sperm Retrieval

In 1980 the first report of a successful PMGR of sperm was published.³⁴ Since then, requests for the procedure have been increasingly frequent and are expected to grow with each media report of a baby's birth following PMGR.³⁵ Wives, fiancées, and girlfriends request sperm retrieval from a dead, near dead, or dying male in order that the male's sperm may be frozen and later used for procreation, that is, to produce his genetic offspring.³⁶ There are instances where the parents of male patients have sought the sperm in hopes of finding a woman who will agree to serve as a surrogate wife; that is, she will agree to be inseminated with the decedent's sperm and bear them a grandchild.³⁷ Others, including social workers, family friends, or intensive care nurses, have also made requests.³⁸ In some cases the request was made for an anonymous donation.³⁹ Occasionally, the male whose sperm is desired is not yet dead but is comatose or in a persistent vegetative state.⁴⁰

Some hospitals have guidelines that dictate that certain medical conditions must be present before a physician who is willing to accede to the request for PMGR may go forward. For instance, New York Presbyterian Hospital requires that if retrieval is postmortem, the death should be sudden and "not due to communicable disease or disease known to adversely affect spermatogenesis."⁴¹ If the patient is dead, the sperm must be harvested within twenty-four hours of death.⁴² There must be a

³⁴ Strong, 27 J L Med & Ethics 347 (cited in note 3) (noting that since 1980 more than ninety requests for postmortem sperm retrieval have been reported).

³⁵ Robert D. Orr and Mark Siegler, *Is Posthumous Semen Retrieval Ethically Permissible?*, 28 J Med Ethics 299 (2002).

³⁶ See, for example, Lori B. Andrews, *The Sperminator*, NY Times Magazine 64 (March 28, 1999) (describing first successful pregnancy using sperm collected after the father's death). I use the term "male" instead of "man" because in some cases the male who is dead or dying has not obtained his majority.

³⁷ See, for example, Laura A. Dwyer, *Dead Daddies: Issues in Postmortem Reproduction*, 52 Rutgers L Rev 881 (2000) (discussing issues raised by parents' request for sperm removal from their dying nineteen-year-old son so that his mother could be a "grandma").

³⁸ Steven E. Kahan, Allen D. Seftel, and Martin I. Resnick, *Postmortem Sperm Procurement: A Legal Perspective*, 161 J Urology 1840, 1842 (1999).

³⁹ Id.

⁴⁰ See, for example, Strong, 14 J L & Health at 250-51 (cited in note 33) (discussing the legal status of consent to postmortem sperm retrieval).

⁴¹ New York Hospital Guidelines for Consideration of Requests for Postmortem Sperm Retrieval ("New York Hospital Guidelines"), available at <<http://www.cornellurology.com/uro/cornell/guidelines.shtml>> (last visited Jan 24, 2006).

⁴² Id.

nearby sperm cryobank to immediately process the retrieved sperm.⁴³ Retrieval of the sperm does not guarantee that the one requesting the retrieval will be allowed to utilize it. In fact, it has been suggested that PMGR without the likelihood of its use might "represent a mutilation of the dead that may represent a lack of respect."⁴⁴

B. Postmortem Egg Retrieval

The harvesting of gametes from dead women does not appear to be a current practice but it is predicted that it soon will become feasible.⁴⁵ Even in the living, retrieving eggs is more medically complex than sperm retrieval.⁴⁶ This is due to the need for advance preparation, such as ovarian stimulation with gonadotropin, which encourages the production of mature eggs, and collection of the eggs transvaginally, which occurs with a needle while the patient is under a local anesthetic.⁴⁷ Thus, if attempted with a dead woman, it would necessitate delay in burying or otherwise disposing of the body.

A more realistic possibility for egg retrieval exists if the woman is in a PVS. It may be possible to stimulate her ovaries and retrieve eggs for fertilization and storage as frozen pre-embryos.⁴⁸ Or, it may be possible to obtain ovarian slices for future ovarian stimulation and fertilization through IVF.⁴⁹

This last point brings up another complicating factor with female gamete retrieval. Unlike postmortem sperm retrieval, there is a need for another woman to gestate the pre-embryo. Finally, it requires no imagination to foresee a development related to keeping a pregnant woman on life support in order to incubate her fetus until viability. The day may come when the medical technology will exist so that a husband may seek to have

⁴³ Id.

⁴⁴ Id.

⁴⁵ Finnerty, et al, 2 Current Women's Health Reports at 176 (cited in note 4) ("We have reviewed the process by which male and female gametes could be retrieved and stored for future reproduction, and determined that it is possible, within certain limitations, for this to be done.").

⁴⁶ Although the first pregnancy from a cryopreserved egg was achieved in 1986, it has taken almost twenty years for cryopreservation of eggs to become a viable procedure, since defrosting the eggs has often destroyed them. Henderson, Times Online Health News, (June 27, 2005) (cited in note 31). Britain did not legalize the defrosting and implantation of frozen eggs until 2000. Id.

⁴⁷ Michele Goodwin, *Altruism's Limits: Law, Capacity, and Organ Commodification*, 56 Rutgers L Rev 305, 391-92 (2004).

⁴⁸ Finnerty, et al, 2 Current Women's Health Rep at 175-76 (cited in note 4).

⁴⁹ Id at 176.

his brain-dead wife inseminated with his sperm and kept on life support so that she may bear his child.⁵⁰

III. THE DEVELOPMENT OF PROTOCOLS

Physicians in the United States who receive requests for PMGR have little to guide them in determining whether to accede to the requests. The mere technical feasibility of PMGR does not warrant the procedure's use. There are ethical, moral, and legal questions that must be answered before a physician may take sperm from a male corpse or gametes from a deceased female so that these deceased may reproduce. There is an abundance of medical and legal literature discussing PMGR, but there is scant legal authority directly on point in the United States.⁵¹ If we look for governing law on the legality of PMGR and subsequent use of the gametes for conception, the most cited authority is the case of Diane Blood, decided by the courts of Great Britain.⁵²

The Human Fertilisation and Embryology Authority ("HFEA") in Great Britain prevented Diane Blood from storing or utilizing sperm taken from her dying husband because Mr. Blood had not given his written permission after having had a proper opportunity to receive counseling.⁵³ Mrs. Blood then sought permission to export the sperm to Belgium, where the law would permit her to use the sperm.⁵⁴ The HFEA ruled that Mrs. Blood was barred from taking the sperm abroad for use on the ground

⁵⁰ See Richard V. Grazi and Joel B. Wolowelsky, *Parenthood from the Grave*, 65 Jewish Spectator 4 (2001) (suggesting the possibility of postmortem insemination and pregnancy).

⁵¹ See, for example, Kahan, Seftel, and Resnick, 161 J Urology at 1840 (cited in note 38) (concluding, after review of state and federal laws, uniform acts and medical and law review articles, that no state or federal statute establishes standard protocol or procedural guidelines). See also J. Dostal, et al, *Postmortem sperm retrieval in new European Union countries: Case report*, 20 Human Reproduction 2359 (2005) (discussing the lack of guidance in laws of countries of the European Union). But see La Rev Stat Ann § 14:101.2D (West 2004) (providing that the deceased spouse must have consented to the use of his sperm by the surviving spouse); Wash Rev Code Ann § 26.26.730 (West Supp 2005) (requiring deceased spouse's consent to postmortem conception). Arguably these provisions are intended for the situation where sperm is frozen prior to the man's death. Margaret Ward Scott, Comment, *A Look at the Rights and Entitlements of Posthumously Conceived Children: No Surefire Way to Tame the Reproductive Wild West*, 52 Emory L J 963, 966 (2003).

⁵² *Regina v Human Fertilisation and Embryology Authority ex parte Blood*, 2 All E R 687 (C A 1997). See Margaret Foster Reilly and Richard Merrill, *Regulating Reproductive Genetics*, 6 Colum Sci & Tech L Rev 1, 56-57 (2005) (discussing *Blood* in detail).

⁵³ Reilly and Merrill, 6 Colum Sci & Tech L Rev at 56 (cited in note 52).

⁵⁴ *Ex Parte Blood*, 2 All E R at 687.

that she should not be able to avoid the specific requirements of the Human Fertilisation and Embryology Act by exporting the sperm to a country to which she had no connection.⁵⁵

Mrs. Blood sought judicial review of the Authority's decision. In the litigation that followed, the Court of Appeal upheld the HFEA on the issue of consent but found that Mrs. Blood had the right to export the sperm under the European Community Treaty, which guarantees freedom of movement for goods and medical services among member states.⁵⁶ As a result of the High Court's finding that HFEA was incompatible with the European Convention on Human Rights, Mrs. Blood eventually was able to have two sons using the frozen sperm.⁵⁷ Yet, after their birth Mrs. Blood could not place her deceased husband's name on her sons' birth certificates because HFEA declared that any baby conceived after his father's death had no biological father for the purposes of succession and inheritance.⁵⁸ Eventually, Mrs. Blood succeeded in getting the Act amended to provide that children conceived postmortem would be recognized as the legal heirs of their deceased father.⁵⁹

The international publicity generated by Mrs. Blood's effort to have children with her late husband demonstrates how compelling the facts may be when a loved one dies suddenly before he or she has had a chance to become a parent.⁶⁰ The legal resolution of the case, however, is of little help in the United States, where the very idea of a central licensing authority for reproductive technology is anathema to our belief in state, as opposed to federal, control of medical practice and parentage issues.⁶¹ Of course, in the case of reproductive technology there is virtually no oversight of any kind.⁶² In any event, it is difficult to imagine

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ *Ex Parte Blood*, 2 All E R at 687.

⁵⁹ *Id.*

⁶⁰ *Id.*

⁶¹ Consider Reilly and Merrill, 6 Colum Sci & Tech L Rev 1 (cited in note 52) (examining the role of government institutions in designing regulations of assisted reproduction and technologies). See also Alicia Ouellette, et al, *Lessons Across the Pond: Assisted Reproductive Technology in the United Kingdom and the United States*, 31 Am J L & Med 419 (2005) (describing the approach used in the United Kingdom to issues of reproductive technology).

⁶² See Robert Jansen, *Evidence-Based Ethics and the Regulation of Reproduction*, 12 Human Reproduction 2068, 2073 (1997) (mentioning the laissez-faire—that is, predominantly commercial—competitive approach in the United States to reproductive technology).

Americans submitting their reproductive decisions to government authority.

The American Society for Reproductive Medicine ("ASRM") has determined that medical personnel do not have to honor a surviving spouse's request for PMGR if the patient has not given prior consent or else made his wishes known.⁶³ The ASRM avoids the issue of whether PMGR is permissible by stating that "such requests pose judgmental questions that should be answered within the context of the individual circumstances and applicable state laws."⁶⁴ Inasmuch as there are few applicable state laws, the ASRM's statement provides little guidance but may be read to permit PMGR. There is some legislative and judicial direction on issues such as inheritance after posthumous conception, the status of cryopreserved pre-embryos, and parentage when donated gametes are used to achieve pregnancy, but nothing specifically addresses PMGR.⁶⁵

Although requests for PMGR occur in a legal void, time is of the essence when a request for PMGR is made. Unlike removing a respirator or discontinuing nutrition or hydration, where the status quo continues while decisions are made, with PMGR there is a very small window of opportunity in which to act.⁶⁶ Moreover, the situation is often tragic, involving the sudden death of someone who is relatively young. Experience documents that in the absence of restrictive protocols, physicians have difficulty resisting the pleas of a wife, parent, or lover who request PMGR.⁶⁷ Many physicians have acceded to requests for PMGR on the assumption that there were no significant legal objections.⁶⁸ Physicians' acquiescence may also be a function of their sympathetic impulses and the gratification of offering help to the bereaved.⁶⁹

⁶³ ASRM, 82 Fertility and Sterility Supp at S261 (cited in note 7).

⁶⁴ Id.

⁶⁵ Consider Kristine S. Knaplund, *Postmortem Conception and a Father's Last Will*, 46 Ariz L Rev 91 (2004) (discussing questions of inheritance and postmortem conception); Sharona Hoffman and Andrew Moriss, *Birth After Death: Perpetuities and the New Reproductive Technologies*, 38 Ga L Rev 575 (2004) (discussing the threat new reproductive technologies impose upon the rule against perpetuities); Kristine S. Knaplund, *Equal Protection, Postmortem Conception, and Intestacy*, 53 U Kan L Rev 627 (2005) (discussing the claim for Social Security survivor benefits of a child conceived postmortem).

⁶⁶ Gottenger and Nagler, 20 J Andrology at 459 (cited in note 2).

⁶⁷ Id.

⁶⁸ See Andrews, *The Sperminator*, NY Times Mag at 65 (cited in note 36) (highlighting anecdotal incidents involving patient requests for gamete harvesting).

⁶⁹ See Rotman, 54 Fertility and Sterility at 512 (cited in note 3).

As a consequence of the lack of guidance on the acceptability of PMGR, some medical institutions have developed their own protocols to assist physicians, who are usually urologists or emergency room physicians, in assessing requests for PMGR.⁷⁰ The institutions have forged ahead despite the uncertainty surrounding the legality of PMGR. At New York Presbyterian Hospital, for example, as soon as the hospital received its first request for PMGR, guidelines were formulated with input from legal experts, psychologists, medical ethicists, institutional representatives, and medical experts.⁷¹

IV. THE ETHICAL DEBATE

Protocols or standards for PMGR have been developed against a background debate on the ethics of retrieval and reflect various positions advanced in that debate. The three main views at play in this debate include a restrictive approach, a permissive approach, and an approach that takes guidance from both the restrictive and permissive extremes. The issue of consent is the starting point for proponents of all views. There is little dispute that some form of premortem consent of the decedent is required.⁷² One could argue that the dead have no rights or interests; that since the dead cannot be harmed, there is no reason that a grieving spouse should not be able to conceive a child with gametes acquired after the progenitor's death. If one adopts this position, it is difficult to see why the decedent's gametes should not be harvested for use in anonymous donation, particularly if he or she is a fine physical specimen or unusually talented. In the debate over standards for PMGR, however, there is no voice advocating the complete dismissal of the wishes of the dead,⁷³ although it is recognized that reproductive autonomy has a very

⁷⁰ See Kahan, Seftel, and Resnick, 161 J Urology at 1840 (cited in note 38) (introducing the lack of protocol for urologists asked to retrieve sperm from recently deceased patients).

⁷¹ New York Hospital Guidelines (cited in note 41). See also Soules, 27 J L Med & Ethics at 364 (cited in note 4) (discussing University of Washington protocol for gamete harvesting after death).

⁷² See, for example, Strong, 14 J L & Health at 267 (cited in note 33) (proposing that statutes should deny authority to retrieve sperm from dead males without explicit prior consent or convincing evidence that he would approve).

⁷³ The exception to this statement is found in the Superior Court of Richmond County decision involving a brain-dead pregnant woman. See Jordan, 22 Ga L Rev at 1108-12 (cited in note 12) (discussing *University Health Services, Inc v Piazza*, No CV86-RCCV-464 (Super Ct of Richmond County, Ga Aug 4, 1986), where the court held that the constitutional rights of a brain-dead pregnant woman were extinguished at death).

different meaning after death.⁷⁴ Nevertheless, the importance of the decision to reproduce is of such moment and has such a deeply personal nature that procreative autonomy survives death.⁷⁵ The disagreement is over which guidelines best respect the decedent's reproductive autonomy.

The difference between the most restrictive and the more permissive positions is whether explicit prior consent of the deceased or incompetent is required or, as in the permissive protocols, reasonably inferred consent fulfills the need for consent. The most permissive position would create a presumption in favor of PMGR in the absence of evidence that the decedent made his or her opposition clear while alive. Even those who adopt the most expansive stance toward PMGR do so in the belief that they espouse what the decedent would have wanted, had he or she thought about the matter. Whichever protocol is adopted, the other guidelines are sufficiently exclusionary that they have "dramatically" reduced the number of postmortem gamete retrievals performed.⁷⁶

A. Restrictive Approach

Proponents of restrictive legislation or standards regarding PMGR and conception frame their arguments in terms of individual autonomy and procreative rights.⁷⁷ Further, they express concerns about respectful treatment of the deceased's body.⁷⁸ Professor Anne Reichman Schiff is one of the most forceful proponents of respect for the decedent's procreative interests. Speaking of the "deep human need . . . to treat the dead with respect and reverence,"⁷⁹ she notes: "Arguably, therefore, if the state allowed family members to utilize the gametes of the dead for procreation without the deceased's consent, the lack of assurance

⁷⁴ See, for example, Robertson, 69 Ind L J at 1031 (cited in note 21) (discussing the value of reproduction for the living because of the "genetic, gestational and rearing experiences involved" and raising question of whether posthumous reproduction is a meaningful experience, that is, "to know in advance that one's genes might (or might not) be used to produce offspring after one's death").

⁷⁵ Bennett, 23 Melb U L Rev at 286 (cited in note 20).

⁷⁶ Jennifer A. Tash, et al, *Postmortem Sperm Retrieval: The Effect of Instituting Guidelines*, 170 J Urology 1922 (2003).

⁷⁷ See, for example, Robertson, 69 Ind L J at 1027-28 (cited in note 21) (discussing the "normative preeminence" of personal autonomy in bioethics).

⁷⁸ See, for example, Orr and Siegler, 28 J Med Ethics 299 (cited in note 35); Anne Reichman Schiff, *Arising from the Dead: Challenges of Posthumous Procreation*, 75 N C L Rev 901 (1997); Anne Reichman Schiff, *Posthumous Conception and the Need for Consent*, 170 Med J Australia 53 (1999).

⁷⁹ Schiff, 75 N C L Rev at 946 (cited in note 76).

that individuals would have about the fate of their own body parts could be a source of apprehension to the living."⁸⁰ We also need assurance that our wishes not to leave partial orphans will survive our death.⁸¹ Apprehension about the welfare of any resulting children who will be born without the opportunity to know their genetic fathers also informs the more restrictive views.⁸²

This restrictive view is one that still permits PMGR in some circumstances: it requires that the decedent must have executed an advance directive "that indicates explicitly his or her willingness to have the procedure performed in these specific circumstances"⁸³ This is the policy adopted by the University of Virginia, a policy that further requires that the advance directive name the individual who can request PMGR, "inherit the stored samples[,] and be a partner in future procreative attempts."⁸⁴ Moreover, the University's policy demands that the advance directive address the issue of parentage so as to avoid challenges involving the estate of the gamete donor and resulting offspring.⁸⁵

B. Permissive Approach

Proponents of permissive legislation or standards regarding PMGR contend that respect for the dead is best served by allowing posthumous conception, thereby satisfying the interest of the deceased in parenthood.⁸⁶ Some of the more expansive philosophical positions come from Australia, a country, ironically, in which postmortem conception has been banned in a number of states.⁸⁷ Dr. Malcolm Parker of Mayne Medical School, Queensland, Australia, questions the restrictive view of posthumous in-

⁸⁰ Id (citing Paul M. Quay, *Utilizing the Bodies of the Dead*, 28 St Louis U L J 889, 920 (1984)).

⁸¹ Katheryn D. Katz, *The Clonal Child: Procreative Liberty and Asexual Reproduction*, 8 Alb L J Sci & Tech 1, 39 (1997).

⁸² See, for example, Gottenger and Nagler, 20 J Andrology 460-61 (cited in note 2).

⁸³ Finnerty, et al, 2 Current Women's Health Reports 175 (cited in note 4).

⁸⁴ Id.

⁸⁵ Id. The University of Virginia's policy was developed by the members of the Ethics Consult Service and Ethics Committee, the director of the Human Gamete and Embryo Laboratory, a urologist and a reproductive endocrinologist. Id.

⁸⁶ Dr. Malcolm Parker, *Response to Orr and Siegler—Collective Intentionality and Procreative Desires: The Permissible View on Consent to Posthumous Conception*, 30 J Med Ethics 389 (2004). Consider Orr and Siegler, 28 J Med Ethics 299 (cited in note 35).

⁸⁷ See, for example, Parker, 30 J Med Ethics at 390 (cited in note 86) ("Laws, guidelines and the courts in the UK and Australia have also generally supported the restrictive view.").

semination and conception currently dominating law and practice, a restrictive view based on "rights conceived exclusively as owned by individuals."⁸⁸ He contends that postmortem sperm retrieval should be allowed unless the decedent had explicitly refused to allow sperm retrieval or where there is "no reasonable evidence that the deceased person desired children."⁸⁹ Dr. Parker defends his presumption in favor of posthumous conception by postulating that people generally desire to become parents. Further, that desire is more than a wish to be an active (and present) parent; the desire to be a parent includes a desire to experience genetic integration with a partner, to advance one's lineage, and to experience having a child with one's partner.⁹⁰

Dr. Rebecca Collins of the University of Western Australia also challenges the requirement, common throughout Australia, that the decedent's prior consent to posthumous reproduction is necessary before sperm may be retrieved.⁹¹ Dr. Collins argues that since the majority of requests for PMGR occur when there is a sudden and unexpected death, "it is essential to consider whether the legal equation of lack of consent with refusal of consent is justified."⁹² Dr. Collins posits that there are many reasons to suppose that people would likely consent to posthumous reproduction, had they contemplated it. A prime reason is concern for survivors, that is, the deceased would want to promote the happiness of his loved ones.⁹³ Moreover, most people want to perpetuate their genes.⁹⁴ And a person might also be willing to consent to posthumous reproduction in order to have a life plan fulfilled.⁹⁵ Finally, there is a lack of evidence that posthumous birth is harmful to children.⁹⁶

One of the justifications for a presumption against consent is that, given that posthumous reproduction is not a norm in our society, "it is unfair and undesirable to place the onus upon individuals to state their opposition to posthumous reproduction."⁹⁷ Dr. Collins replies that this argument is irrelevant in cases of

⁸⁸ Id at 392.

⁸⁹ Id at 389.

⁹⁰ Id at 390-91.

⁹¹ Rebecca Collins, *Posthumous Reproduction and the Presumption Against Consent in Cases of Death Caused by Sudden Trauma*, 30 J Med & Philosophy 431 (2005).

⁹² Id at 433.

⁹³ Id at 435.

⁹⁴ Id at 435-36.

⁹⁵ Collins, 30 J Med & Philosophy at 435-36 (cited in note 91).

⁹⁶ Id at 435.

⁹⁷ Id at 436, quoting Schiff, 170 Med J Australia at 53 (cited in note 78).

sudden death (although she does not make clear why this should be so).⁹⁸ Finally, Dr. Collins dismisses concerns about the reproductive autonomy of the deceased with the statement that “the mere lack of contemplation by the deceased of a particular use of his or her body or is neither a necessary nor a sufficient condition of disrespectful use.”⁹⁹

C. Hybrid Approach

Extremely permissive views such of those of Drs. Parker and Collins, however, do not enjoy widespread support. Instead, the prevailing view is that some affirmative evidence of the decedent’s wish to procreate after death is needed before posthumous gamete retrieval is ethically permissible.¹⁰⁰ In fact, many countries simply prohibit all posthumous reproduction.¹⁰¹ While not prohibiting posthumous storage and use of sperm, Great Britain requires the prior written permission of the decedent.¹⁰²

An intermediate position would permit PMGR based on the reasonably inferred consent of the decedent or person in a PVS.¹⁰³ Relying on the case of organ donation, Dr. Carson Strong is among those who suggest that it is respectful of patient autonomy to “make decisions in accordance with the reasonably inferred wishes of the patient.”¹⁰⁴ In refuting this supposition, Gladys B. White notes that “most men have never considered the possibility that sperm would be sought or put to use after death or after diagnosis of PVS.”¹⁰⁵ Moreover, there is a great deal of guesswork in determining what the decedent would have wanted had he but thought about the subject while living. Absent prior

⁹⁸ Id at 437.

⁹⁹ Collins, 30 J Med & Philosophy at 437-38 (cited in note 91).

¹⁰⁰ See, for example, Strong, 14 J L & Health 243 (cited in note 33) (discussing various rights of the deceased and the legal status of their consent to postmortem sperm retrieval).

¹⁰¹ See, for example, Kahan, Seftel, and Resnick, 161 J Urology at 1840 (cited in note 38). In Germany knowingly fertilizing an egg with the sperm of a man after his death carries potential criminal liability. See also Ian Fisher, *Bill Would Govern Use of Dead Men’s Sperm*, NY Times B5 (Mar 7, 1998) (noting that a state senator’s proposed bill would allow sperm to be taken postmortem only if the man had consented in writing before he died and the sperm could be used only by his wife or partner).

¹⁰² Kahan, Seftel, and Resnick, 161 J Urology at 1842 (cited in note 38).

¹⁰³ See, for example, Strong, 27 J L Med & Ethics at 347 (cited in note 3) (outlining methods of sperm extraction for procreative purposes from males who are deceased or in a persistent vegetative state).

¹⁰⁴ Id at 348. See also New York Hospital Guidelines (cited in note 41).

¹⁰⁵ Gladys B. White, *Commentary: Legal and Ethical Aspects of Sperm Retrieval*, 27 J L Med & Ethics 359 (1999).

explicit consent, any guess "is clearly one that is colored by the interests, motivations and purposes of those who are seeking to use the sperm."¹⁰⁶

Nevertheless, Dr. Strong argues that it is justifiable to retrieve gametes in the absence of explicit prior consent, that there are sound reasons "to act in accordance with a patient's autonomous wishes concerning postmortem sperm retrieval, whether those wishes are explicitly stated . . . or reasonably inferred."¹⁰⁷ Among the reasons to procreate during one's lifetime are: participating in the creation of new life, affirming mutual love, contributing to sexual intimacy, providing a link to future persons, and experiencing child rearing as well as pregnancy and childbirth.¹⁰⁸ Some of these reasons, in particular the creation of a new person, may be applicable to postmortem procreation. Moreover, planning for procreation after the death of one of the progenitors may be an expression of love and acceptance and may contribute to self-identity.¹⁰⁹

Conversely, some individuals may not wish to procreate after death.¹¹⁰ Avoiding procreation after one has died so that a child is not born into undesirable circumstances has some strength as an argument for respecting those decisions.¹¹¹ Moreover, Dr. Strong's position, that the reasonably inferred wishes of the decedent should be respected, is tempered by his requirement that the decedent has previously discussed and approved of postmortem sperm retrieval with his family.¹¹² Moreover, there must be "either explicit prior or reasonably inferred consent not only for sperm retrieval and storage but also the selection of the woman to be the insemination recipient"¹¹³ in order that the decedent's procreative freedom will not be violated.

D. Protocol Specifics: Who Has the Right to Request Retrieval?

Current hospital protocols regarding PMGR ask the question: who has the right to request retrieval? By this question it is meant, who has the right to consent to PMGR?¹¹⁴ Among most of

¹⁰⁶ Id at 359-60.

¹⁰⁷ Strong, 27 J L Med & Ethics at 351 (cited in note 3).

¹⁰⁸ Id at 349-51.

¹⁰⁹ Id.

¹¹⁰ Id at 350.

¹¹¹ Strong, 27 J L Med & Ethics at 350 (cited in note 3).

¹¹² Id.

¹¹³ Id at 352.

¹¹⁴ Kahan, Seftel, and Resnik, 161 J Urology at 1840 (cited in note 38) ("Urologists

those who have considered the issue there is a shared conclusion that laws governing organ donation or autopsies do not apply to PMGR,¹¹⁵ that organ donation and gamete retrieval are not ethically equivalent.¹¹⁶ Arguably the Uniform Anatomical Gift Act ("UAGA"),¹¹⁷ adopted in some form by all fifty states, authorizes the postmortem retrieval of gametes for use in assisted reproduction in the absence of a clear objection by the subject before he or she died.¹¹⁸ Since the Act defines "part" as "an organ, tissue, eye, bone, artery, blood, fluid or other portion of the human body," it has been argued that a wife should have the right to obtain her husband's sperm postmortem.¹¹⁹ Further, it is the case that autopsies and organ harvesting have immediate consequences to the dead body and may be more "invasive, destructive and disfiguring" than sperm retrieval.¹²⁰ Nevertheless, gamete retrieval followed by artificial insemination or IVF has ongoing important effects that affect the deceased's family and his or her own legacy.¹²¹ In the words of Anne Reichman Schiff, posthumous conception "recasts the content and contours of the deceased's life."¹²² She adds that when it occurs without the person's consent, it deprives an individual of "the right to be the conclusive author of a highly significant chapter of his or her life."¹²³

Further, the purpose of organ donation is to preserve life and is for the medical benefit of the recipient of the organ.¹²⁴ The purposes of donation under the UAGA are "transplantation, ther-

must focus on the express intent of the decedent and limit any postmortem sperm retrieval to the specific requests made by the decedent.").

¹¹⁵ See, for example, Goettenger and Nagler, 20 J Andrology at 459 (cited in note 2) (equating organ donation and sperm donation by declaring: "Organ donation preserves a life. Sperm donation creates a life."). Compare New York State Task Force on Life and the Law, *Assisted Reproductive Technologies: Analysis and Recommendations for Public Policy* 266 (April 1998) ("It is arguable that the [Uniform Anatomical Gift Act] would authorize the posthumous retrieval of sperm for use in assisted reproduction in the absence of clear objection by the subject before he died.").

¹¹⁶ White, 27 J L Med & Ethics at 359 (cited in note 105). See Schiff, 75 NC L Rev at 922-32 (cited in note 1) (discussing in detail the law relating to dead bodies and organ donation).

¹¹⁷ UAGA (amended 1987), ULA Anat Gift § 8A (1993).

¹¹⁸ New York State Task Force, *Assisted Reproductive Technologies* at 266 (cited in note 115).

¹¹⁹ See id (noting that the UAGA's provision allowing next of kin to consent to the retrieval of organs and tissues after death could arguably apply to posthumous sperm retrieval).

¹²⁰ Orr and Siegler, 28 J Med Ethics at 299, 301 (cited in note 35).

¹²¹ Id.

¹²² Schiff, 75 NC L Rev at 944 (cited in note 1).

¹²³ Id.

¹²⁴ Goettenger and Nagler, 20 J Andrology at 459 (cited in note 2).

apy, medical or dental research, education, research, or advancement of medical or dental science."¹²⁵ Utilization of a decedent's gametes creates life and is for the benefit of a healthy individual.¹²⁶ With PMGR, the recipient, who is usually the next of kin and would be the one to give consent to procurement of the sperm, stands to benefit personally.¹²⁷ Moreover, it has also been suggested that "there is no strong social argument in favor of bringing additional children into the world."¹²⁸

Because of the legal uncertainty surrounding disposition of gametes, the safest course of action is to require (1) that the one making the request is the decedent, that is, a decedent who has made a specific request when competent and of age and (2) that the intended recipient is a spouse.¹²⁹ While such a practice may ignore the desires of others, such as parents or lovers, to have the decedent's lineage continue, it has the virtue of a bright-line rule and avoids speculation about the deceased's intentions. No right of parents to control the reproductive decisions of their adult progeny is recognized in the law. The parents' desire to have a grandchild with the genes of the deceased—that is, to "prolong" the deceased's life though postmortem conception, or to simply continue their lineage—is not among the recognized legal interests.

On the other hand, the law recognizes that families are often formed outside of marriage¹³⁰; therefore, someone who had explicit permission for PMGR and utilization of the gametes might have a valid claim against the institution that denied a request. There is legal precedent for cases in which sperm was given premortem to a paramour.¹³¹

¹²⁵ UAGA (amended 1987), 8A ULA. 6, 8A, Unif L A 53.

¹²⁶ Goettenger and Nagler, 20 J Andrology at 459 (cited in note 2); Schiff, 170 Med J Australia at 53 (cited in note 78).

¹²⁷ Gottenger and Nagler, 20 J Andrology at 459 (cited in note 2).

¹²⁸ Id, quoting L.B. Andrews, Hearings Before the New York State Standing Committee on Investigations, Taxation and Government Operations, 220 Reg Sess (1997) (written testimony of L.B. Andrews).

¹²⁹ See, for example, Kahan, Seftel, and Resnik, 161 J Urology at 1840 (cited in note 38) (discussing the possibilities for a workable protocol for postmortem sperm procurement).

¹³⁰ See, for example, *Stanley v Illinois*, 405 US 645, 652 (1972) ("Nor has the law refused to recognize those families unlegitimized by a marriage ceremony.").

¹³¹ *Hall v Fertility Institute of New Orleans*, 647 S2d 1348, 1348 (1994). See also *Hecht v Superior Court of Los Angeles*, 59 Cal Rptr 2d 222, 227 (Cal Ct App 1996) (finding that sperm bequeathed to a decedents' paramour should be given to her; the children of the decedent had no cognizable interest).

Since the purpose of the request for PMGR is to achieve a pregnancy, consent to PMGR requires not just consent to the gamete retrieval but evidence of the deceased's desire to achieve procreation. Some protocols demand explicit prior authorization; they specify that the consent must be that of the deceased and must have been given premortem.¹³² At least one medical institution specifies that it must be documented in writing.¹³³

Recognizing that prospective authorization for PMGR is unlikely, other guidelines allow for "reasonably inferred" consent.¹³⁴ The New York Hospital Guidelines provide that "only men undergoing fertility treatment, actively attempting conception or who had specifically expressed their plans to attempt conception in the immediate future would be suitable candidates for retrieval."¹³⁵ The guidelines also state that the deceased's wife is the one from whom evidence of the dead man's intentions should be sought and, as the next of kin, she is most capable of giving "procedural consent."¹³⁶ The difficulty here is allowing evidence of conversations heard only by the wife, an interested party. The New York Hospital Guidelines also state that the parents of the deceased should not provide consent since the purpose of the retrieval is procreation with the wife. A later discussion in the guidelines states that "if there's a discrepancy between the wife and other family members, we [urologists] will not proceed."¹³⁷

The "consent" that is the focus of the medical protocols is not what is usually meant by informed consent to a medical procedure. The purpose of informed consent is to have the patient be an informed participant in his or her health care. Valid and informed voluntary consent for medical services requires that a physician impart information so that the patient may make informed choices about his or her medical care. The physician should discuss the diagnosis and prognosis and disclose the risks and benefits of the proposed treatment as well as those of alternative procedures, including nontreatment. Except for those institutions that require explicit, affirmative premortem permis-

¹³² See Kahan, Seftel, and Resnick, 161 J Urology at 1842 (cited in note 38) ("[W]ithout an express written statement decedent intent cannot be known and, thus, any requests for sperm retrieval must be denied.").

¹³³ Id.

¹³⁴ See, for example, New York Hospital Guidelines (cited in note 41).

¹³⁵ Id.

¹³⁶ Id.

¹³⁷ Peter N. Schlegel, *Is Postmortem Sperm Retrieval Ethical if the Deceased Did Not Leave Explicit Instructions*, OB/GYN News (Aug 1, 2003).

sion for PMGR, the consent requirements are actually substituted judgment requirements.

In a recent request for PMGR, for example, the spouse of a dying man was able to convince the urologist to accede to her request based on a comment her husband had made ten years earlier.¹³⁸ The husband and wife had viewed a telecast about a woman who had requested PMGR from her murdered husband. When the wife asked her then-healthy husband what she should do if ever faced with such a situation, he replied, "If it's really tragic, go for it."¹³⁹ Years later, when the husband was comatose and on a ventilator, the wife got in touch with Dr. Peter Schlegel, the urologist from the telecast. She told the doctor that she and her husband had been trying to have a child and repeated her husband's offhand comment about sperm retrieval.¹⁴⁰ Shortly after the husband's death, Dr. Schlegel removed a specimen from one of the husband's testicles. Six years later the wife tried to become pregnant using the sperm using IVF but the stored sperm was not viable.

Although in this case the request was honored, Dr. Schlegel favors "a prudential, conservative approach . . . including clear evidence that the deceased man had wanted his sperm to be used to father a child."¹⁴¹ Query whether evidence of the husband's intentions from ten years ago is evidence of his current intentions at the time of his death.¹⁴²

Some of the current guidelines are both benevolent and intrusive. A common feature of these protocols is a one-year waiting period and quarantine on the use of gametes. The one-year period is believed to be "the initial period of psychological adjustment and bereavement after the loss of a loved one."¹⁴³ We are told that "this one-year quarantine . . . lets women go through the grieving process."¹⁴⁴ Further, the wife is to undergo medical and psychological consultations which "should include a basic assessment of the psychological status of the wife, family,

¹³⁸ Barron H. Lerner, *In a Wife's Request at her Husband's Deathbed, Ethics are an Issue*, NY Times F1 (Sept 7, 2004).

¹³⁹ Id.

¹⁴⁰ Id.

¹⁴¹ Id.

¹⁴² Schlegel, *Is Postmortem Sperm Retrieval Ethical*, OB/GYN News (cited in note 137). Dr. Schegel, who is the acting Chairman of the Department of Urology at Cornell University, New York, has stated that a doctor following their guidelines would probably turn down most requests. Id.

¹⁴³ New York Hospital Guidelines (cited in note 41).

¹⁴⁴ Id.

social and financial support systems as well as a discussion of the implications of raising the child as a single parent without its genetic father.¹⁴⁵ Moreover, there should be discussion of disclosing to the child the method of conception.¹⁴⁶ What is not mentioned is the fact that the child will have no legal father and will not be recognized as an heir.¹⁴⁷

It is expected that the waiting period and the counseling that the wife is to receive will enable her to make a more "rational" decision when the period of grief has passed.¹⁴⁸ This rationale assumes that everyone grieves in the same way and that there is a point at which grief ends. Both of these assumptions are questionable and reveal a linear approach to a process which is more chaotic than straightforward. Further, no matter how benign the intentions behind the one-year quarantine, it presents a serious barrier to the procreative hopes of a recipient who suffers from premature ovarian failure, is at the outer limit of her reproductive years, or has some other condition that demands immediate rather than later use of the sperm.¹⁴⁹

Since use of the gametes is downstream from the decision to harvest them, it is not clear that the limitations imposed by these protocols will bind the storage facility when the sperm is available for use under the regulations of the storage facility. Nor is it clear that the one-year quarantine will ease the grieving process. In fact, having the gametes preserved and possibly available may well prolong it.¹⁵⁰ There is also the question of whether the requirements as they pertain to wives are not somewhat condescending and paternalistic. Since there is so little, if any, empirical evidence regarding the effect of postmortem conception on anyone, including the spouse, partner, or the child, there is an element of speculation and possible bias in the concerns expressed in the protocols. In this respect, the University of Virginia has the most detailed and thoughtful of the protocols

¹⁴⁵ Id.

¹⁴⁶ Id. These guidelines make plain that physicians are the gatekeepers of parenthood, just as they are in almost all cases where assisted reproductive technologies ("ARTS") are used.

¹⁴⁷ See ASRM, 82 Fertility and Sterility Supp at S260 (cited in note 7) ("[A] child born from conception and pregnancy after a man's death may not always be attributed to him for purposes of inheritance and legitimacy.").

¹⁴⁸ New York Hospital Guidelines (cited in note 41).

¹⁴⁹ See, for example, Ellen Waldman, *The Parent Trap: Uncovering the Myth of "Coerced Parenthood" in Frozen Embryo Disputes*, 53 Am U L Rev 1021, 1054-55 (2004) (discussing data demonstrating that a woman's reproductive capacity is impaired by the passage of time).

¹⁵⁰ Lori B. Andrews, *The Clone Age* 233 (Owl Books 2000).

surveyed for this article. Their protocol requires not only the donor's consent to the sperm retrieval but also the recipient's consent to "the triangular relationship between himself or herself, the gamete donor and the health-care team."¹⁵¹ Along with detailed information concerning the gamete recipient's responsibilities, the limited role and responsibility of the institution, and various housekeeping details, there is a requirement for psychological counseling and approval before the release and use of the stored gametes. There is, however, no waiting period. Despite the care and thought that has gone into the protocol, it shares with the others the effect of making physicians the gatekeepers to parenthood, just as is the case with all assisted reproduction.¹⁵²

A very practical concern, the matter of cost, is not mentioned in the protocols discussed in this article. Dr. Michael Soules has noted: "Based on current charges for medical and reproductive laboratory procedures, [harvesting and cryopreservation] would generate moderate fees (several thousands of dollars)."¹⁵³ Dr. Soules further notes that it is unlikely that insurance would cover the cost; accordingly, the person requesting the procedures would have to pay,¹⁵⁴ questioning the accuracy of Dr. Soules's characterization of the fee as "moderate." When we consider the low success rate of IVF in general, the unknown but undoubtedly low success rate with the use of gametes harvested postmortem, and the fact that most women who have had their husbands' sperm collected after death never use the sperm,¹⁵⁵ we might conclude that there should be a mandated disclosure of the unlikelihood of a child resulting from PMGR.

V. PROCREATIVE LIBERTY AND PMGR

If we look at PMGR through the lens of reproductive rights, we must first determine whose procreative rights are at issue. The dead are not usually thought of as having rights that survive death, but, as noted above, procreative rights are exceptional.¹⁵⁶

¹⁵¹ Finnerty, et al, 2 Current Women's Health Reps at 176 (cited in note 4).

¹⁵² See, for example, Katz, 8 Albany L J Sci & Tech at 33 (1997) (cited in note 81) ("Interference with procreational choice, based on 'unworthy' reasons, comes not from the state but from the medical profession, inasmuch as physicians have been allowed to be the gatekeepers deciding who is eligible to utilize the technologies under their control.").

¹⁵³ Soules, 27 J L Med & Ethics at 363 (cited in note 4).

¹⁵⁴ Id.

¹⁵⁵ Lerner, *In a Wife's Request*, NY Times at F1 (cited in note 138).

¹⁵⁶ But see Jordan, 22 Ga L Rev at 1108-12 (cited in note 12) (detailing a case where the court opined that even if a brain dead pregnant woman had left a will directing the discontinuation of end-of-life treatment, she had no right to discontinue life support when

Moreover, we do honor the wishes of the dead as to the disposition of property even though we could just as easily say that death ends all property rights. We do not speak of our deceased loved ones as corpses even though metaphysically the decedent has left the body. If an individual has expressed clear intention to procreate with a particular individual or not to procreate, then those wishes should be honored in the same way that testamentary provisions receive deference.¹⁵⁷ Of course, if a testamentary provision violates public policy it will not be honored. If utilization of the gametes would result in consanguinity, for example, the provision would be invalid.¹⁵⁸ The difficulty is that in most instances where there is a request for PMGR, the deceased has left no instructions.

The issue then becomes whether the one requesting the PMGR has a right to procreate, including the right to use the gametes of the deceased in absence of explicit evidence of the deceased's intentions. If both parties were alive, there would be no question that one's choice of a willing procreative partner is protected under notions of reproductive privacy.¹⁵⁹ It is because of the difficulty of ascertaining the wishes of a dead or comatose patient that medical institutions, such as the University of Virginia, have required advance directives. Others are willing to consider evidence from other sources such as family members or clergy.¹⁶⁰ Although the right not to procreate has received explicit constitutional recognition,¹⁶¹ whether there is an affirmative right to procreate under any circumstances is arguable.¹⁶²

the life of the fetus was at stake).

¹⁵⁷ See Schiff, 75 NC L Rev at 965 (cited in note 1) ("[T]he interests involved ought to be weighed with reference to the same principles that apply in a conflict over the use or non-use of IVF embryos when both progenitors are alive.").

¹⁵⁸ Gottenger and Nagler, 20 J Andrology at 459 (cited in note 2).

¹⁵⁹ See, for example, *AZ v BZ*, 725 NE2d 1051, 1059 (Mass 2001) (declining to enforce an agreement that would force one party to become a parent against his will in part because "respect for liberty and privacy requires that individuals be accorded the freedom to decide whether to enter into a family relationship"); *JB v MB*, 783 A2d 707 (NJ 2001) (citing several cases upholding the right to privacy in procreation and marital relationships).

¹⁶⁰ Finnerty, et al, 2 Current Women's Health Reports at 175-78 (cited in note 4), citing P.A. Ohl, et al, *Procreation After Death or Medical Incompetence: Medical Advances or Technology Gone Awry?*, 66 Fertility and Sterility 889, 889-895 (1996).

¹⁶¹ See, for example, *Griswold v Connecticut*, 381 US 479 (1965) (holding that the use of contraceptives by a married couple was protected against a government ban); *Eisenstadt v Baird*, 405 US 438 (1972) (finding that whatever right of access to contraceptives is for married couples, equal protection requires that unmarried individuals enjoy same right); *Roe v Wade*, 410 US 113 (1973) (holding that the Fourteenth Amendment Due Process Clause protects woman's decision to terminate pregnancy); *Carey v Population Services International*, 431 US 678 (1977) (striking bans on distribution of contraceptives

If we define the issue very narrowly as a question of whether there exists a right to harvest the gametes of a dead person for use in a spouse or paramour's attempts to bear or beget the deceased's child, then the answer is probably going to be no. The Supreme Court generally looks to history and tradition in determining whether an interest is constitutionally protected.¹⁶³ Neither will help here. If the issue is framed in more inclusive terms—in other words, as whether there is a right to procreate with a partner of one's choice—then history and tradition are on the side of the proponent. However, that right is limited by the requirement that the partner must consent. I conclude that current Supreme Court jurisprudence protects the procreative liberty only of the decedent who left explicit instructions regarding procreation after death.

VI. WHAT ABOUT THE CHILD?

The existing hospital protocols on PMGR are concerned about the child who may be born as a result of PMGR to the extent that they question whether a child should be deliberately conceived without a father (or mother).¹⁶⁴ This is primarily a social and psychological issue. There is no uniform policy against single parenthood. To the extent that such a policy existed in adoption laws or is present in laws that limit the utilization of reproductive aid to married couples, the wave of the future is to abandon such boundaries. Several commentators have noted that there are millions of children being raised in single parent homes.¹⁶⁵ Furthermore, although this is a frequently mentioned issue in protocols and in debates over PMGR, there is no mention

to minors and barring all distribution of contraceptives except by licensed pharmacists).

¹⁶² See, for example, Kathryn D. Katz, *Lawrence v. Texas: A Case for Cautious Optimism Regarding Procreative Liberty*, 25 *Women's Rts L Rep* 249, 249-50, 252-53 (2004).

¹⁶³ See *County of Sacramento v Lewis*, 523 US 833, 857 (1998) (Kennedy concurring) ("That said, it must be added that history and tradition are the starting point, but not in all cases the ending point of the substantive due process inquiry.").

¹⁶⁴ See New York Hospital Guidelines (cited in note 41) ("Consultation should include a . . . discussion of the implications of raising a child as a single parent without its genetic father.").

¹⁶⁵ See Collins, 30 *J Med & Philosophy* at 434 (cited in note 91) ("[A]s a result of the high divorce rate, the increasing acceptance of gay parenting and possibilities such as surrogacy, there are many more single parent families and also more situations where the social parent is different from the genetic parent."); Waldman, 53 *Am U L Rev* at 1040 (cited in note 149) ("Divorce rates remain steady at roughly 50 percent while non-marital childbearing continues to increase. With the two-parent family in retreat on multiple fronts, researchers are examining the effects of single-parent child rearing on the economic and psychological well-being of children.").

of the weight or effect this consideration should be given in deciding whether to harvest gametes from the dead.

The fact that single parenthood is commonplace does not answer the question of the status of a child conceived through the use of gametes harvested postmortem. Is a child the legitimate child of the dead parent? Is the child a presumptive heir? In truth, the answer to these questions is to a large extent unknown. (This uncertainty extends to any child conceived postmortem, such as by artificial insemination with sperm harvested before the father's death.) Accordingly, physicians who want to perform a beneficent act by acceding to a PMGR request should not be sanguine about the legal status of a subsequent child. The law in the jurisdictions that have considered these questions is not supportive of postmortem conception without the decedent's explicit premortem consent.¹⁶⁶

The drafters of the former Uniform Status of Children of Assisted Conception Act ("USCACA") denied legal parentage to any child conceived after the death of the donor. In other words, the donor of the gametes is not considered a parent of the resulting child. That means that the child would be considered a non-marital child even if the parents were married. It also means that the child would not be entitled to Social Security benefits, military service benefits, or other benefits from the deceased parent and would not be able to bring a wrongful death action for the death of that parent. In order to avoid disinheritance of his child, the donor would have to have specific provisions in his or her will recognizing and providing for posthumously conceived children.

The Uniform Parentage Act ("UPA")¹⁶⁷ provides that if assisted reproduction occurred after a provider of ova, sperm, or genetic material for an embryo died, that provider will not be considered a parent unless he has given written consent to be treated as a parent.¹⁶⁸ Four states have adopted the UPA and a

¹⁶⁶ See, for example, *Woodward v Commissioner of Social Security*, 760 NE2d 257 (2002) (holding that before a posthumously conceived child can inherit from his father, the father's consent to conception and support the child and his genetic relationship to the children must be proven); *In re Estate of Kolacy*, 753 A2d 1257 (2000) (holding that posthumously conceived twins born nearly eighteen months after father's death could be legal heirs of dead father; court accepted mother's statement that decedent consented to father a child after his death; suggested that imposing time limits would be fair and constitutional); *Gillett-Netting v Barnhart*, 371 F3d 593 (9th Cir 2004) (holding that posthumously conceived children who were legitimate under Arizona law need not meet additional requirements under the Social Security law).

¹⁶⁷ 9-B ULA 354-385 (2000), amended 2002 (Supp 2005).

¹⁶⁸ *Id.* at § 707.

number of states are considering adopting the Act.¹⁶⁹ A number of other states have already adopted legislative changes that limit the inheritance rights of posthumously conceived children.¹⁷⁰

There are also psychological and social issues to consider. It is difficult, however, to state with any certainty what the effect will be of learning that one was conceived using the gametes of a deceased person. It may be that the psychological impact is the same as in the case of any child raised without a father. Further, it is not necessarily true that the child will be raised without a social father. Is there any way that the urologists who are asked to retrieve gametes postmortem and must make a time-pressured decision can ensure that the child is raised in an appropriately supportive environment, as some protocols have suggested they do? Should that be a concern of the medical personnel involved in the decision whether to honor the request?

What about other children of the deceased? Should their wishes be consulted? Again, although they are silent as to the effect of such a consideration on the decision to harvest gametes postmortem, some of the protocols include this concern. Query whether this is a decision which should be considered beyond the competence of the medical practitioner.

Timothy F. Murphy, a medical ethicist, and Gladys B. White, a bioethicist, have encapsulated the dilemma of PMGR for any resulting children. They suggest that postmortem gamete collection (and other biomedical innovations) raise the questions: "What identities are possible for children born with [the help of these innovations], when connections to deceased parents are simply biological? Are we forging new opportunities for human intimacy and well-being or fracturing the dynamics essential to family life?"¹⁷¹

CONCLUSION

Postmortem gamete retrieval is a practice that cries out for guidelines. The question that will have to be answered, sooner rather than later, is where the locus of decisionmaking authority

¹⁶⁹ Susan N. Gray, *Posthumously Conceived Heirs*, 19 Probate & Property (ABA) (March/April 2005).

¹⁷⁰ *Id.*

¹⁷¹ Timothy F. Murphy and Gladys B. White, *Dead Sperm Donors or World Hunger: Are Bioethicists Studying the Right Stuff?*, 35 Hastings Center Report 48 (March-April 2005).

should be. Is there a need for legislative intervention or should we continue to regard the matter as one of medical ethics? I believe that medical institutions are to be commended for grappling with these difficult issues. Nevertheless, in order to protect the decedent's reproductive rights, requests for PMGR should be honored only when there is explicit prior consent from the decedent. Protocols to this effect would provide clarity and certainty to the urologists and emergency room physicians who are asked to make decisions that call for prescience beyond anyone's abilities. Although it is not evident that the legislation addressing PMGR itself is necessary,¹⁷² it is clear that there must be legislation to clarify the status of children born as the result of PMGR.

¹⁷² See Ronald Chester, *Double Trouble: Legal Solutions to the Medical Problems of Unconsented Sperm Harvesting and Drug-Induced Multiple Pregnancies*, 44 SLU L J 451 (2000) (concluding that the best non-statutory method to address unconsented sperm harvesting is the injunction).