Is posthumous semen retrieval ethically permissible?

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It is possible to retrieve viable sperm from a dying man or from a recently dead body. This sperm can be frozen for later use by his wife or partner to produce his genetic offspring. But the technical feasibility alone does not morally justify such an endeavour. Posthumous semen retrieval raises questions about consent, the respectful treatment of the dead body, and the welfare of the child to be.

We present two cases, discuss these three issues, and conclude that such requests should generally not be honoured unless there is convincing evidence that the dead man would want his widow to carry and bear his child. Even with consent, the welfare of the potential child must be considered.
Whether he would want his wife to be a single mother after his death was troublesome, and his views on the wellbeing of a child raised by a single parent were likewise unknown. The wife believed that he would want this, but they had never discussed the possibility. This presumption was supported by his sister who had talked with him about his intense desire to have children in order to continue his family name. But is a wife’s intense desire for her husband’s offspring morally relevant, and if it is, is it sufficient to justify the removal of semen without his explicit consent? His physicians, nurses and ethics consultant believed the available information adequately supported his wife’s expression of his presumed wishes. Within one hour of his death, his epididymides were removed and frozen.

RESPECT FOR THE DECEASED PERSON
Metaphysically, the person disappears from his or her body at death, but the dead body continues to command respect. This nearly universal respect for the dead body can be observed as the evening news brings images of grieving survivors searching for the bodies of their loved ones who have been lost at the scene of natural disasters around the world. In most cultures, there seems to be an innate drive to recover bodies so they may be given proper burial. Though individuals in some cultures may believe that organs and physical structures of the once living are no longer important, this is distinctly uncommon in Western society. At the same time, this almost sacred respect for the dead body is not held to be absolute. Most people in Western society accept that there are some exceptions when the body may be disturbed before being buried—for example, for postmortem examinations, and for organ or tissue retrieval for transplantation. Other uses of the dead body have led to considerable controversy—for example, the practising of techniques for retrieval of organs from “non-heart-beating” patients. Consent has been universally accepted, but the dead body continues to command respect. Metaphysically, the person disappears from his or her body at death, but the dead body continues to command respect. This example of treating dead bodies in less than a respectful way has often been carried out in secret and has clearly not achieved societal acceptance as have autopsy and organ retrieval.

The majority acceptance of some instances of trespassing the integrity of a dead body in order to benefit others indicates that the strong societal mandate to show respect for a dead body is not inviolable. The practice of retrieving sperm from men in coma or recently dead has not, however, been similarly accepted. This practice has been criticised as “perilously close to rape” by law professor Andrews.

CONSENT
The ethical concept of valid consent and the legal doctrine of informed consent have become firmly established as foundational in the practice of modern medicine. Ethically valid consent has three components: (1) the patient must have decision making capacity; (2) he must be given adequate information, and (3) then he must give voluntary consent without coercion.

When a patient does not have decisional capacity, consent may be obtained from a proxy. The proxy’s “substituted judgment” ought to reflect the decision that the patient would make if able, based on a written advance directive, the patient’s previously expressed wishes, or an understanding of his or her values.

In some situations “implied consent” may substitute for a formal consent discussion. Implied consent may sometimes be inferred from the patient’s actions. For example, when a man comes to the emergency room (ER) complaining of chest pain and collapses, it can be assumed he wanted treatment. Different still is “presumed consent” which does not depend on a patient’s words or actions, but is based on a theory of human goods. It may be presumed that a person unconscious from injuries sustained in a motor vehicle accident would want to be treated. Thus, when substituted judgment is not possible—for example, in a child who has not developed decision making capacity or in an adult who has not made his wishes known, the proxy is allowed to use the lower and more ill defined standard of “best interests”.

When an emotionally involved third party requests sperm retrieval after death, it might seem desirable to seek the same level of certainty we attempt when making other medical decisions, such as limitation of treatment for patients near the end of life. We could use the same hierarchy of (a) patient’s current statement; (b) written advance directive; (c) report of previously stated wishes; (d) recognised values, and (e) presumed best interests. When making limitation of treatment decisions, professionals often experience greater discomfort as we move down this scale of increasing uncertainty, but we cannot avoid making the decisions. We must make the
best decision possible in the face of limited information and a particular set of clinical circumstances.

This hierarchy, complex as it is to apply in limitation of treatment decisions, may be even less useful in decisions about sperm collection after death. It is rare for a healthy young man to anticipate life-threatening illness, and even more rare for him to contemplate or discuss whether he would want his sperm to be collected after death so that his widow could bear his child. In addition, such a decision, like many end-of-life decisions, is not just about his life. It has major implications for his wife's future and for the future of his potential progeny.

The legal doctrine of informed consent is based on the ethical principle of autonomy. But this right to self determination should not be misinterpreted to mean that whatever the patient wants should be done. Autonomy is a bounded liberty. Though the patient’s negative right to be left alone is nearly absolute, the positive right to have what one wants is clearly not absolute. While a patient may request any treatment desired or imagined, the physician, also an autonomous moral agent, is free to decline a treatment he or she believes is not medically indicated, or is felt to be not in the patient’s best interests. A patient’s request to forgo or stop dialysis when he finds it disproportionately burdensome should almost always be honoured. On the other hand, a request for narcotics to treat chronic tension headaches should not be honoured if the physician believes an alternative treatment is more appropriate.

WELFARE OF THE CHILD-TO-BE

This recognition that the physician has an obligation to do only beneficial procedures and to decline those which are potentially harmful raises the question “who is the patient in posthumous sperm collection”? Does the physician also have a responsibility to decline procedures which may be harmful to a future individual or future generation?

The Human Embryology and Fertilisation Authority of Great Britain requires physicians who provide assisted reproductive technology services to consider the welfare of the potential child before making a decision to proceed. Most physicians would decline to do artificial insemination for a woman who carries a dominant gene for a lethal condition. Whether voluntarily frozen for that purpose before death or achieve a pregnancy using the semen of her deceased partner, many discussions of infertility, it is also true that the desires of the man’s stated desire to produce offspring or preserve his family name? While the strength of this desire is clearly evident in many discussions of infertility, it is also true that the desires of many infertile couples can be met through adoption. Thus, the use of requested technology is not always needed to satisfy such desires, and some would say the availability of such alternatives make the use of technology unjustified.

In case 1 above, the lack of consent and lack of knowledge of the man’s wishes led appropriately to a refusal to comply with the request. In case 2, there was likewise no consent. His willingness to undergo infertility testing and their plan to pursue in vitro fertilisation suggests that this man had a
strong desire to have a child. While this evidence gave some guidance to his medical professionals, it provided no indication of what his wishes would have been in circumstances that he never discussed and probably never contemplated. His sister's statement lent some support to his wife's contention, but this is still not as definitive as if he had made an explicit statement. The decision to honour her request was thus not clear cut, but was a marginal judgment call.

CONCLUSION
A request for sperm retrieval after death should not be honoured unless there is convincing evidence that the dead man would want his widow to carry and bear his posthumously conceived offspring. Even when consent is available, professionals should also consider the welfare of the potential child. The evidentiary standards for such a decision are difficult to define and far from clear.

References

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