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.

There have been sporadic reports of babies born after posthumous conception since the technology became available 50 years ago. Most commonly, a young man has an illness which threatens his fertility or his life—for example, testicular carcinoma. He has some of his semen frozen in order to impregnate his wife in case he should become sterile or to impregnate his widow if he should not survive. In these relatively uncommon cases of posthumous conception, legal questions have been raised about inheritance and eligibility for survivor benefits. Few questions have been raised, however, about the ethics of the procedure because the semen was donated voluntarily, before death, with the expressed intent of use after death.

Retrieval of viable sperm after death, first described by Rothman in 1980, raises significantly different issues. It has been reported in the popular press that a baby has been born using posthumous sperm collection after a young man died unexpectedly from an allergic reaction. At his wife’s request, sperm was collected 30 hours after death. Fifteen months later he was pronounced dead in the intensive care unit. He is the only child of his parents. Just before he died, they asked the intensivist to impregnate his widow.

Such requests are infrequent; 82 were reported in the US in a 1997 study, of which about one-third were honoured. Reported successes will likely encourage more requests. In addition, the advent of intracytoplasmic sperm injection (ICSI) makes it possible to fertilise an egg in the laboratory using a single sperm rather than the several cubic centimetres of semen required for artificial insemination. After describing the technical feasibility of sperm retrieval after death, however, a standard textbook of urology concludes: “[t]he ethical appropriateness of such retrieval is the most important issue surrounding its use”.

An identical endpoint—the dramatic birth of a dead man’s baby—makes voluntary sperm donation before death and involuntary sperm retrieval after death seem only a small step apart. The difference between these two procedures is not, however, a small step.

In Western society, there is no universal prohibition of posthumous gamete retrieval or posthumous in vitro fertilisation. However, recently reported successes have prompted discussion in the popular press. These practices raise at least three significant ethical questions. First, the method of sperm collection raises issues about respectful treatment of a dead body. Second, there is the issue of consent, important in all invasive procedures. Third is the issue of the welfare of the child to be. We will present two cases which highlight these issues.

CASE 1
A 28 year old man had been married for six years and he and his wife were childless. He became depressed after a marital separation three months ago. Two weeks ago he started antidepressant medication, but today he was brought to the hospital by paramedics with a self inflicted gunshot wound to the head. Six hours later he was pronounced dead in the intensive care unit. He is the only child of his parents. Just before he died, they asked the intensivist to impregnate his widow. They said they were certain he would want his biological line continued, and they thought his estranged wife, who had been contemplating reconciliation, would be willing to have his child.

A clinical ethics consultant was asked to review the situation and make recommendations. After talking with the parents and widow, he was unable to elicit any substantiating evidence that the man would want his widow to bear his child. He recommended against the requested sperm retrieval.

CASE 2
A 36 year old previously healthy man was admitted with pneumonia. He developed adult respiratory distress syndrome requiring assisted ventilation. After 14 days of aggressive treatment, he became obtunded and developed multiorgan system failure, and his wife was informed that he would not survive. She asked if semen could be collected so that she might yet have his child. An ethics consultation was requested.

They had been trying unsuccessfully to have a child for over 10 years. Two months before this illness they saw an infertility specialist and were to begin in vitro fertilisation with her next menstrual cycle. Although this history indicated his desire to become a father, this alone could not be construed as consent for either sperm collection in this circumstance of impending death or for posthumous collection. The uncertainty of
whether he would want his wife to be a single mother after his death even with an impassioned plea from his family. It is an interesting commentary on contemporary society that even when a person has specifically documented in writing that he or she wants to be an organ donor, transplant teams are unwilling to retrieve organs after explicit agreement from the family. At least in this situation, the wishes of the family are honoured over the explicit wishes of the deceased, perhaps out of concern for liability. But the reverse is not true. If a patient had specifically declined to be an organ donor, transplant teams are unwilling to retrieve organs after his death even with an impassioned plea from his family.

The issues of utility and consent have also dominated discussion of practising medical techniques on newly dead bodies. While a strong case has been made for the utility of such an approach, it has been called “unlawful and unethical” if it is done without family consent. 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 rights. 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.

LEGAL ISSUES

The development of new technology often raises ethical questions about its use. Sometimes these “should we...?” questions seem to be settled by statutory or case law, but usually only after an extended time of legal uncertainty. For example, death defined by neurologic criteria was first proposed in 1968, but settlement of the legal uncertainties did not begin in the US until the proposal for a Uniform Determination of Death Act in 1981. While legislative or judicial determinations often give an imprimatur to a particular action, this does not always fully answer the ethical questions.

There has been some legislative and judicial activity on issues of the status of frozen embryos, parentage after the use of anonymous or designated donated sperm, inheritance after posthumous conception, and other related issues. According to a recent review, however, there have been no laws or cases which give clear guidance about posthumous sperm collection. Based on existing standards of consent, the authors conclude that spousal requests for sperm collection after death should be declined unless there is prior consent or known wishes of the decedent. Their interpretation of the legal climate focuses on the intent of the man, but does not address the issues of treatment of the dead body or the well-being of the potential child.

DISCUSSION

How should we view a request for sperm collection after death? Does it resemble the family’s right to give permission for procedures after death such as autopsy, organ donation, and practising medical technology? If so, can we honour family requests for this procedure? Or might the welfare of the potential child be an overriding consideration?

Although the sperm retrieval procedure itself is far less invasive, destructive, or disfiguring than is an autopsy, the invasiveness seems less important than the man’s preferences and the long term consequences for the woman and the child. Autopsy and organ retrieval have more immediate consequence to the dead body, but very little ongoing consequence to the deceased or his family. But sperm retrieval has major consequences for his family and also for his own legacy. In our view, there is a difference in kind between autopsy and organ retrieval on the one hand, and sperm retrieval. Giving consent for autopsy or for organ retrieval for transplantation is giving to benefit others. But requesting sperm retrieval after death without the consent of the dead man is not the same; in fact it is not giving at all—it is instead taking, because its aim is to benefit the person making the request. While retrieval of organs after death without the explicit consent of the decedent is likewise taking, it is different in that the family who is giving consent is altruistically giving the organs for someone else’s benefit. The parents or woman who request sperm retrieval after death without the explicit consent of the dead man are making a request for their own benefit. Thus, proxy “consent” in this situation is not consent at all.

In our view, if a man had steadfastly refused to have a child while alive, it would be ethically wrong to honour a request to retrieve his sperm for use after his death. At the other extreme, if we had a clear written or verbal statement from him that he would want to father a child after his death, it might be justifiable to assist this endeavour. If, however, as will likely be the situation in most cases, we do not know his wishes, we must rely on the best available information. In our view, it would usually be appropriate to decline such requests. This stance of non-retrieval without the patient’s prior consent or known wishes is supported by the American Society for Reproductive Medicine. They go on to say that “such requests pose judgmental questions that should be answered within the context of the individual circumstances and applicable state laws”. While this decision might intensify the grief of the widow, and the poignancy of this refusal would seem to heighten the tragedy of his death, it is the ethically most defensible position based on the presumed rights of the dead or dying patient.

Even with consent, how strongly should we consider a 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 his wishes about his wife having his child after
his death. Although she was probably in a position to know his
wishes better than anyone else, her own self interest could
have clouded her understanding of what his wishes would
have been in circumstances that he never discussed and prob-
ably never contemplated. His sister’s statement lent some sup-
port 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 post-
humously conceived offspring. Even when consent is avail-
able, 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.

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