

## *Cases from MedStar Washington Hospital Center*

# The Case of Ms D: A Family's Request for Posthumous Procurement of Ovaries

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### ABSTRACT

The MedStar Washington Hospital Center clinical ethics team became involved in a case when the family requested the posthumous removal of a patient's ovaries for future reproductive use. This case presents a novel question for clinical ethicists, since the technology for posthumous female reproduction is still in development. In the bioethics literature, the standard position is to refuse to comply with such a request, unless there is explicit consent or evidence of explicit conversations that demonstrate the deceased would have wanted this option pursued. Ms D's case, we suggest, offers an exception to this default position; complying with the family's request could have been ethically permissible in this case, had it been medically feasible.

### A CASE WITH A NEW ELEMENT

A declaration of whole brain death often causes an emotionally distressing situation for members of the patient's family, especially when they are holding onto hope for a miraculous recovery. Ethics consultants may be called to help handle a family's objections when they perceive the medical team as giving up too quickly, and consultants can assist in discussions about the end of life and the next steps.

The case of Ms D included these features, but included a new ethical challenge: *How should we respond to a family's request for the posthumous removal of ovaries for future reproductive use?* The request prompted us to consider specifics about how the medical team should properly support a family who wants to honor their deceased loved one in this manner, the patient's reproductive intentions, and the ethics of posthumous consent for reproduction.

In this article and the analyses that follow, we report how we worked through these issues. We argue that, other things being equal, complying with the family's request could have been ethically permissible in this case (were it medically possible). Within the bioethics literature, the standard position is to refuse to comply with a request to assist in posthumous assisted reproduction, unless there is explicit consent or evidence of explicit conversations that demonstrate the deceased would have wanted this. Ms D's case, we suggest, offers an exception to this default position.

### THE CASE

Ms D, a 31-year-old woman, was admitted to our hospital with an initial complaint of anemia. She had a complicated past medical history due to vascular Ehlers-Danlos syndrome, a genetic condition that caused the walls of her blood vessels to be fragile and rupture, which led to numerous cardiac in-

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cidents throughout her life. Her medical history included aortic and mitral valve replacements, and she took Coumadin and aspirin regularly. A few days after being admitted, Ms D experienced nausea, vomiting, and a change in mental status. She was transferred to the neurosurgical intensive care unit (ICU) and received a computed tomography (CT) scan and magnetic resonance imaging (MRI). Shortly thereafter, she became obtunded (had diminished alertness and responsiveness to pain). The MRI revealed that she was bleeding in her cerebellum (a large portion of the brain, in the back of the head between the cerebrum and the brain stem, that coordinates voluntary movements, posture, and balance) with no identifiable cause. She remained on a ventilator in the ICU. Ms D's poor prognosis due to the combination of abnormal coagulation, intracranial hemorrhage, and subsequent multisystem organ dysfunction were explained to her family.

Several days passed without significant change, and the medical team suspected that Ms D qualified for whole brain death based on neurological criteria. The medical team needed to complete the final confirmatory test, an apnea test. At a family meeting with the patient's mother and life partner of the last 11 years, the intensivist explained that, on account of the patient's severe brain injury from a baseball-sized clot and the results of other tests (such as lack of responsiveness to light and tickling at the back of the throat), the medical team was relatively certain that the patient had already died. The mother said that, speaking from her faith perspective, God needed more time to work a miracle. The lead ethicist suggested that if a miracle were going to occur, performing an apnea test now would not prevent it. After completing the test, the medical team informed the family that Ms D had died.

The ethics consult did not end after this meeting. Before leaving, Ms D's life partner and mother requested that the medical team remove and preserve the patient's ovaries for future reproductive use. The life partner said he had paperwork from Ms D's visit to a fertility clinic as evidence that she would have wanted him to take this step. The partner said that he and Ms D planned on starting a family with her eggs, his sperm, and a friend who offered to serve as a surrogate. We scheduled a family meeting for the next day. To prepare, the team worked together to research the scientific and medical feasibility of posthumous reproduction with a woman's ovaries, ovarian tissue, or eggs. Our preliminary searches through medical news and scientific databases suggested it was not possible.<sup>1</sup> The lead ethicist spoke with the physician in our hospi-

tal who specializes in obstetrics, gynecology, and clinical genetics—Melissa Fries, MD (whose article, "Analysis: OB/GYN-Genetics," follows this article<sup>2</sup>). Fries doubted the feasibility of posthumous reproduction for Ms D.

The following day, the ethicists asked Fries to attend the meeting with the family, and we also invited Veronica Gómez-Lobo, MD, from our neighboring hospital, Children's National Medical Center, who specializes in fertility preservation for pediatric cancer patients (whose article, "Analysis: Fertility Preservation," follows<sup>3</sup>). In the pre-meeting, we discussed how we would break the news to the family that posthumous reproduction was not medically possible. Additionally, it appeared that there could be another insuperable barrier, even if the procedure were possible: Based on the physicians' understanding, reproductive materials were the legal property of Ms D, and a woman's rights regarding her eggs could not be transferred to her next of kin or domestic partner after her death without documentation that this is what she would have wanted ("Analysis: A Legal Perspective," by Jack Schwartz, JD, follows<sup>4</sup>). Given these medical/scientific and legal obstacles, our aim in the family meeting was to inform the family of the lack of reproductive options, make sure the family members were heard, and aid them in their grief.

When the mother and life partner joined us, they showed us the paperwork from Ms D's recent visit to a local fertility clinic. She had gone to the clinic only once, but she had discussed a desire to leave her life partner and her mother with a baby. Fries and Gómez-Lobo explained in detail that there were no feasible reproductive options for Ms D. Her partner mentioned that he had planned on using his retirement savings to pay for *in vitro* fertilization (IVF) with Ms D, and he expressed regret for not taking this step sooner, so they could have created a child before her death. On their way home from this visit, the mother and partner gave the ethicists consent to present Ms D's story in detail for publication.

#### ANALYSIS FROM THE CLINICAL ETHICS TEAM

The ethics behind posthumous reproduction was new to us. Although it is not presently medically feasible to use a patient's oocytes, ovaries, or ovarian tissue for procreation, the ethical questions are not moot. For one thing, we had set up a meeting to discuss the family's request, and we wanted to take their request seriously—meaning we did not want to dismiss it as simply infeasible, and so not

worth discussing. Second, it was possible that, upon hearing about current scientific limitations with posthumous female reproduction, the family would persist in their request to preserve the patient's ovaries just in case the technology became available in the future.<sup>5</sup> Third, the members of our ethics team wanted to think through some of the ethical complexities in the current case to prepare us for subsequent cases; especially since posthumous sperm retrieval is medically possible and not unheard of in clinical settings, we wanted to develop our ethical insights on this topic.

There are two importantly separate issues: whether the medical team and ethicists should *permit* or *prohibit* certain requests from going forward, and what moral responsibilities the requestors have in relation to their request. We could have moral qualms with the ways that patients and surrogates exercise their rights and make requests. We think to ourselves: "They *can* do X, but *should* they do X?" We need to be clear on which practices and policies should be in place, even if, in particular cases, there could be questions about the motivations of or reasons given by individuals who would benefit from those practices and policies. Institutionally, we need to determine whether we should permit the fulfillment of requests for posthumous removal of reproductive materials, and, if so, under what circumstances.

This analysis homes in on the issues that were most pertinent to this case: the nature of our obligations to the family regarding their request and how best to support their interests, the reproductive intentions of the patient prior to her death, and the ethics of posthumous consent to remove ovaries for procreation.

### OBLIGATIONS TO THE FAMILY

Our obligations to the family were at the forefront of our minds as we consulted on this case. We considered the interests of Ms D's mother and her partner especially, since they were the members of the family who were most involved in her life and the ones making the request. They were also the ones feeling the loss of Ms D most intensely.<sup>6</sup>

#### Prolonging the Family's Grief

First, we were sensitive to how their request was a likely reflection of their grief. Data on posthumous sperm cryopreservation indicate that most requests for sperm are abandoned by the requestor after a few months, after the requestor has had more time to

process her or his emotions.<sup>7</sup> Loved ones might pursue reproductive possibilities with a deceased patient's reproductive materials out of intense grief or guilt. On the one hand, this is not necessarily problematic; a requestor's motives for reproducing are generally complex and layered, and wanting to honor the deceased and bring more joy into the requestor's life through posthumous reproduction are understandable desires. On the other hand, this might not be an ideal situation for any child. As the European Society of Human Reproduction and Embryology (ESHRE) Task Force on Ethics and Law notes, "There is a certain danger for the autonomy of the child if the parent looks at the child as a 'commemorative child' or as a symbolic replacement of the deceased."<sup>8</sup>

ESHRE recommends a psychiatric evaluation of the requestor and one-year waiting period before posthumously collected reproductive materials are used.<sup>9</sup> This type of policy could help families make decisions about posthumous reproduction in the most responsible and autonomous manner, so grief does not overwhelm their judgment. At the same time, subjecting families to intense scrutiny about their choice may be an overstep if the medical team ends up interrogating family members and imposing personal values on them unfairly. It would be unfair for clinicians to demand families to prove they have the purest possible motives for pursuing posthumous reproduction, when policing motives and reasons in this way falls outside of the bounds of clinicians' expertise. It also sets up a concerning precedent, since the motives for pursuing other forms of reproductive technology are not subject to this high level of policing. We regularly allow families to make suboptimal decisions (within bounds) that implicate clinicians; giving families this leeway is part of what it means not to be imperialistic or imposing with our personal values.

#### Procreative Liberty of the Partner

Broadly, "procreative liberty" refers to having the ability and opportunity to pursue reproductive options according to one's own values and preferences. Whether procreative liberty rights exist, and the extent of those rights, are debatable.<sup>10</sup> If Ms D's partner has a right to reproduce and have a child, though, this does not mean that he has a right to have a child with Ms D, specifically. Even if we grant that using Ms D's body for reproductive purposes could be ethically permissible, this conclusion is a far cry from saying that Ms D's family has a *right* to her body.

### Financial Burden

Lastly, a sensitive issue that arose in the family meeting was Ms D's partner's plan to empty his retirement account for the sake of paying for reproductive technology. Given how high stakes this decision could be for him (and for anyone looking to empty retirement savings), we would want to be sure he had time to reflect, so he could make the most informed decision possible. This concern about finances also could be a reason to implement a waiting period for using reproductive materials in the wake of a loved one's death.

### INTENTIONS OF THE PATIENT

When the ethics team discussed Ms D's case, we wondered whether she intended for her family to pursue posthumous reproduction. The question of her intention is worth considering because her family believed that their request fit with what Ms D intended to happen after her death. She did not explicitly express her intention to have her ovaries removed and preserved posthumously for reproductive use, but we do have some evidence of what Ms D *did* intend to happen with her body: (1) she recently visited a fertility clinic after discussing IVF and surrogacy with her mother and partner; (2) she affirmed her desire to be an organ donor via designation on her driver's license and through conversations with her family.

Did she intend to have her body used for the benefit of others? Yes; specifically, she intended to help those waiting for organs for transplant. Did she intend to *consider* reproductive options with her genetic material? Yes; her visit to the fertility clinic indicates that she was open to this possibility. Beyond these, we are limited in what we can say Ms D's intentions were. If the medical team was not convinced that the patient intended her body to be used in this manner, the clinicians could experience moral distress with this request. On the other side, there could be moral distress for the family if they are prevented from honoring what they believed Ms D's intentions to have been.

### POSTHUMOUS CONSENT

In a 2005 survey of Utah residents, 397 women and 307 men between the ages of 18 and 84 were asked what they would find acceptable (and presumably would authorize) related to posthumous ovarian tissue donation. While almost 75 percent of the respondents thought it was acceptable to donate unfertilized oocytes for scientific study, the percent-

age dropped to approximately 57 percent when respondents were asked about the donation of oocytes for fertilization and implantation for posthumous reproduction.<sup>11</sup> The study indicates that many people have nuanced preferences on the topic that would make a difference in what they would consent to regarding the posthumous donation of reproductive materials.

In the bioethics literature, there is a presumption against inferring consent for posthumous reproduction; for this option to be ethically viable, it is argued that explicit consent is necessary. The ESHRE summarizes this view: "Because of the special value of autonomy in the context of reproduction, an opting-in system is preferred to an opting-out system"; it even suggests that "the presence of cryostored gametes or embryos shows that a parental project existed, but it does not demonstrate that the deceased accepted the continuation of the project after his or her death."<sup>12</sup> A statement from the Ethics Committee of the American Society for Reproductive Medicine reads: "Until there is more experience with posthumous reproduction, this Committee thinks that a policy of allowing posthumous reproduction only when the deceased has specifically provided an advance directive and the surviving spouse or other designee agrees is a sound one."<sup>13</sup> Along similar lines, Orr and Siegler comment, regarding a case in which a man tried for 10 years to impregnate his wife, "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."<sup>14</sup> But could the moral presumption against allowing posthumous reproduction, absent explicit consent, ever go the other way?

The moral emphasis on respecting autonomy, even after death, drives the opt-in system for organ donation in the United States. It is worth addressing the analogy/disanalogy between posthumous reproduction and organ donation. In our opt-in system for organ donation, we allow families to authorize the procurement of organs when the deceased had been silent regarding her or his wishes. We err on the side of trusting the family to know what the individual would have wanted, even if she or he were silent on it. We furthermore want to honor their decisions as a familial unit in how they choose to respect the loved one who died.<sup>15</sup> Similar reasoning could be applied to the case of posthumous removal of reproductive materials.

Robert Orr and Mark Siegler argue, "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.”<sup>16</sup> According to Orr and Siegler, the lack of an altruistic motive behind requests for posthumous procurement of reproductive materials makes a crucial moral difference. This argument has numerous flaws, however. Consenting to autopsy will often not have any clear altruistic motive, and not all organ donations will be purely or even primarily altruistic.<sup>17</sup> Additionally, not all posthumous reproduction requests will be devoid of altruistic motive. A family or partner could want to pursue this option because they want to “do right” by the individual who died and give her or him what she or she would have wanted, even if doing so requires rigorous efforts and sacrifice on their part. They might also believe that they can offer a loving family and a good life to a child who would otherwise not exist. Ms D’s partner and mother wanted to pursue posthumous reproduction partly for each other’s sake.<sup>18</sup>

Nonetheless, based on the prevailing standard of not presuming consent on behalf of the deceased, it appears that we should not recommend that the medical team comply with the family’s request in Ms D’s case, since we do not have explicit consent from her to use her body in this manner. Arguably, proceeding with posthumous reproduction absent explicit consent could (1) undermine the autonomy interests of the deceased and (2) be disrespectful to the individual who has died, or set precedent for disrespectful treatment of the dead. We contend that the moral presumption against permitting posthumous reproduction, absent explicit consent, is not absolute. The first set of concerns about harming<sup>19</sup> a deceased patient by undermining her or his autonomy is ultimately misplaced, but the second set of concerns about being respectful provides appropriate ethical guidelines in these situations. We will still need to analyze the nuances and specifics of each case to determine what is and is not respectful to the individual. In this case, we tentatively concluded that pursuing posthumous reproduction in Ms D’s case was ethically permissible.

### **Autonomy Interests and Duties to the Deceased**

Rebecca Collin notes that, according to the prevailing standard, “the presumption against consent effectively prohibits posthumous reproduction in the very situations where it is most likely to be requested,” since it is unlikely that someone would have made his or her preferences explicit on this issue.<sup>20</sup> So how do we determine whether the duty

to respect autonomy applies in this case? We often speak of duties to the dead in the sense that we are concerned about doing right by the dead *for their own sake*. But does it make sense to speak of “her own sake” when the patient is deceased? Does she have a “sake” to speak of?

Joel Feinberg argues that there can be posthumous harm, even when there is no existing individual to experience those harms. He believes that a “person is harmed when someone invades (blocks or thwarts) one of his interests.”<sup>21</sup> Feinberg suggests that we can have duties to the deceased that are not exactly for their own sake, since they have no good of their own; yet, our sense of moral obligation is not merely a concern for moral character (for example, against cultivating callousness towards promises) or duties to the living (for example, helping with the grieving process), either. Rather, Feinberg contends that we still owe it to the dead to fulfill their interests because those interests do not lose their moral significance, even when the interest-bearer is not able to enjoy their fulfillment.<sup>22</sup> Feinberg’s view of interests, though, is not without its complications. In response, Ernest Partridge argues, “Death cancels not only the possibility of [subjective] satisfaction but also the very point of fulfillment”—in other words, interests only have moral pull when there is an interest-bearer to whom they pertain.<sup>23</sup>

Part of the difficulty in resolving this issue is that we do not know for certain what happens to a person after her or his death; different philosophical, cultural, and religious worldviews will provide answers, but there is no way of knowing for certain. It is epistemically closed off to us—that is, we do not know and could not know whether interest-bearers (and thus, their interests) persist past death. As such, we cannot know if we are capable of harming the dead. Since we cannot know what happens to us and our interests after death, whether there are duties to the dead for their own sake (such as respecting their previously expressed autonomy interests) is, *in principle, unknowable*. Duties that are unknowable cannot possibly obligate us. We cannot abide by a principle of caution (for example, by acting on the presumption that we can harm the dead), since any number of unknowable duties could conflict or cancel each other out. We have no way to deliberate on unknowable duties. This is not to say that we should not care about our treatment of the dead; we still have (*prima facie*) moral obligations to carry out wills, preferences regarding organ donation, prior promises, and proper burial or cremation. The point is that these obligations do not

amount to duties for the dead's own sake. So why then do we have any moral obligations in relation to the deceased? The properly placed concern is one of respect: We should show proper acknowledgment of the loss of the individual's life.

### **Respectfulness toward the Deceased**

Many of our "death practices," such as those dealing with the distribution of assets and determining what to do with a deceased person's body, are built around trying to respect who the person was. Through respecting the dead in this manner, we show our appreciation for the value of life, as well as (perhaps) admiration for and gratitude toward the person who lived. Respecting the dead therefore contributes to cultural and interpersonal virtues, as we commit to not taking death lightly. Partridge argues that it is part of our "moral personality" to imagine ourselves outside of our particular circumstances, which includes considering how we want our body to be treated and our family to fare after we die.<sup>24</sup> It would be inconsistent with our moral stances toward living persons if we ceased to care about how they were treated after death.

When it comes to Ms D's case specifically, we have evidence that her family was trying to honor her memory and respect her prior values in their request. Their request apparently took into consideration who she was, what she wanted for her family in the future, and what steps she planned to take in terms of her own reproduction. Their request to retrieve and preserve the patient's ovaries would not require any more bodily intrusion than would be part of normal organ procurement procedures, and the patient had consented to the latter—leading us to the conclusion that this level of bodily intrusion would not be disrespectful according to the patient's own values. Given these considerations, pursuing posthumous reproduction in Ms D's case, even absent explicit consent, would be ethically permissible.

### **CONCLUSIONS AND RECOMMENDATIONS**

In this analysis, I have discussed some of the ethical issues that were most pressing at the time of the consult, as well as issues that arose later. Although there is a widely agreed-on position in bioethics that we should not fulfill these requests absent evidence that this is explicitly and specifically what the deceased would have wanted, Ms D's case suggests that there are exceptions to this general rule. Whether to comply with these requests, when feasible, should be determined on a case-by-case basis.

These requests should be taken seriously and not dismissed out of hand, openly or privately.

We offer the following recommendations, which are not meant to be comprehensive:

- Medical teams should not give families false hope about possibilities that are not feasible, given current technological limitations and legal barriers that could exist. Opening the door to these discussions when there is no possibility these persons will have what they want could lead to unnecessarily prolonged grief.
- A mandatory waiting period for different stages of posthumous reproduction procedures (for example, procuring ovarian tissue, using the tissue for the production of eggs) could enable autonomous decision making for the family.
- Talk with the family about what the patient intended to happen to his or her body after death. Find relevant evidence of the patient's intentions, such as through an organ donation registry or documentation at a fertility clinic.
- See whether there is explicit consent for posthumous reproduction. When a patient donates gametes prior to death at a fertility clinic, it is standard procedure to ask what the patient wants to happen to the gametes after death.
- If there is no explicit consent for posthumous reproduction, ask the requestor if he or she ever had explicit conversations on this possibility with the deceased. If the requestor can provide evidence or a clear accounting of conversations that indicate that the request fits with what the deceased would have wanted, then there is a moral presumption in favor of fulfilling the request.
- If evidence about what the deceased would have wanted is missing or unclear, there could still be good moral reasons to give the family leeway in making this decision. Some particularities of the case should be considered, including the following:
  - The values and life plans of the deceased, especially in regards to reproduction and posthumous treatment of his or her body, tell us how to pay respect to this individual specifically.
  - Consider which institutional policies and practices already exist when it comes to families' and partners' requests in relation to a deceased patient's body. Depending on the nature of the case, current policies and practices could be altered to accommodate what the clinical team and ethicists think ought to be permitted or disallowed.

## PATIENT AND FAMILY CONSENT

This case has been anonymized, but no other details have been de-identified or modified. The family provided consent for the patient's case to be used and discussed in this publication, which they believe the patient would have wanted.

## ACKNOWLEDGMENTS

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## NOTES

1. A.W. Loren et al., "Fertility Preservation for Patients with Cancer: American Society of Clinical Oncology Clinical Practice Guideline Update," *Journal of Clinical Oncology* 31, no. 19 (July 2013): 2500-11; Ethics Committee of the American Society for Reproductive Medicine, "Fertility Preservation and Reproduction in Patients Facing Gonadotoxic Therapies: A Committee Opinion," *Fertility and Sterility* 100, no. 5 (November 2013): 1224-31; I. Demeestere et al., "Live Birth after Autograph of Ovarian Tissue Cryopreserved During Childhood," *Human Reproduction* 30, no. 9 (2015): 2107-9; A. Mizukami et al., "The Acceptability of Posthumous Human Ovarian Tissue Donation in Utah," *Human Reproduction* 20, no. 12 (2005): 3560-5; B.K. Campbell et al., "Restoration of Ovarian Function and Natural Fertility Following the Cryopreservation and Autotransplantation of Whole Adult Sheep Ovaries," *Human Reproduction* 29, no. 8 (2014): 1749-63.

2. M. Fries, "Analysis: OB/GYN-Genetics," in this issue of *The Journal of Clinical Ethics* 27, no. 1 (Spring 2016).

3. V. Gómez-Lobo, "Analysis: Fertility Preservation," in this issue of *The Journal of Clinical Ethics* 27, no. 1 (Spring 2016).

4. J. Schwartz, "Analysis: A Legal Perspective," in this issue of *The Journal of Clinical Ethics* 27, no. 1 (Spring 2016).

5. Interestingly, Michael Soules suggests that "ovarian cryopreservation technology has proceeded far enough that it can now be considered reasonable to offer cryopreservation to [sic] women shortly after death or during a persistent vegetative state." See M.R. Soules, "Commentary: Posthumous Harvesting of Gametes—A Physician's Perspective," *Journal of Law, Medicine & Ethics* 27 (1999): 362-5, 362-3.

6. In analyzing obligations to members of patients' families, their genetic counseling needs should not be overlooked. It is important to remember, though, that a family could knowingly, willingly, and happily choose to pursue reproductive technologies even when there is a high likelihood that any resulting child will have significant medical difficulties or impairments. Interested readers can

find arguments along these lines in the following: A. Asch, "Describing Bioethics: Convergence and Contrast with Disability Rights," in *Handbook of Disability Studies*, ed. G. L. Albrecht, K. D. Seelman and M. Bury (Thousand Oaks: Sage, 2001), 298-316; A. Ho, "The Individualist Model of Autonomy and the Challenge of Disability," *Bioethical Inquiry* 5 (2008): 193-207.

7. ESHRE Task Force on Ethics and Law, "ESHRE Task Force on Ethics and Law 11: Posthumous Assisted Reproduction," *Human Reproduction* 21, no. 12 (2006): 3050-3.

8. *Ibid.*, 3052.

9. *Ibid.*

10. For an overview and discussion of these debates, see E. Brake and J. Millum, "Parenthood and Procreation," *Stanford Encyclopedia of Philosophy* (Fall 2014), ed. E.N. Zalta, <http://plato.stanford.edu/archives/fall2014/entries/parenthood/>.

11. Mizukami et al., "The Acceptability of Posthumous Human Ovarian Tissue Donation in Utah," see note 1 above, 3562. Notably, the survey respondents were asked about transferring embryos to a separate couple desiring pregnancy. Respondents were not asked about the specific issue in Ms D's case—a surviving partner wanting to create an embryo for transfer to a gestational surrogate.

12. ESHRE Task Force on Ethics and Law, see note 7 above, 3051.

13. Ethics Committee of the American Society for Reproductive Medicine, "Fertility Preservation and Reproduction in Patients Facing Gonadotoxic Therapies," see note 1 above, 1229.

14. R.D. Orr and M. Siegler, "Is Posthumous Semen Retrieval Ethically Permissible?" *Journal of Medical Ethics* 28 (2002): 299-303.

15. The U.S. Department of Health and Human Services states: "If the deceased had not registered and there was no other legal consent for donation such as a driver's license indicator, the OPO [organ procurement organization] will seek consent from the next of kin." See U.S. DHHS, "Organ Donation: The Process," <http://www.organdonor.gov/about/organdonationprocess.html>. This standard has its supporters among ethicists, but there are others who are inclined toward a stricter standard that gives less leeway to families in making a decision to donate an organ. A stricter standard, for example, would demand that some evidence be provided that organ donation is what the deceased would have wanted.

16. Orr and Siegler, "Is Posthumous Semen Retrieval Ethically Permissible?" see note 14 above, p. 301.

17. G. Moorlock, J. Ives, and H. Draper, "Altruism in Organ Donation: An Unnecessary Requirement?" *Journal of Medical Ethics* (28 March 2013): online, open access. doi:10.1136/medethics-2012-100528, <http://jme.bmj.com/content/early/2013/03/27/medethics-2012-100528.full>.

18. In his discussion of posthumous gamete retrieval, Soules remarks: "What may seem like a simple and altruistic request has many complex ramifications," Soules, "Commentary: Posthumous Harvesting of Gametes," see note 5 above, p. 364. Here we have a physician whose perception of altruism with these requests is directly at odds with Orr and Siegler's. Furthermore, "al-

truism” is philosophically complex, and as a concept it has competing definitions and criteria, which makes attributions of altruism tricky and debatable (see Moorlock, Ives, and Draper, “Altruism in Organ Donation, see note 17 above). Moreover, lack of altruism (whatever that ends up meaning) does not negate consent or authorization in many other decisions and contexts. Surrogates are otherwise not expected to make decisions with an aim towards benefitting others; focusing on the interests of the family unit and the patient is expected, supported, and morally justifiable.

19. Our discussion focuses on harming, but there are relevant philosophical distinctions among harm, harming, wrong, and wronging. Wronging someone usually is said to involve violating rights or fundamental interests, but then we would need to show that rights and interest persist past death. To say we can do something wrong in relation to the dead is a different claim; this is to suggest that we could do something ethically impermissible in our treatment of the dead, and the impermissibility of acts can depend on ethical considerations besides those involving rights or fundamental interests of the deceased. For an analysis that highlights some of the reasoning that can be used to argue that the dead can neither be harmed nor wronged, see the following book: J.S. Taylor, *Death, Posthumous Harm, and Bioethics* (New York, Routledge, 2012).

20. R. Collins, “Posthumous Reproduction and the Presumption against Consent in Cases of Death Caused by Sudden Trauma,” *Journal of Medicine and Philosophy* 30 (2005): 431-42.

21. J. Feinberg, “Harm and Self-Interest,” in *Law, Morality and Society: Essays in Honour of H.L.A. Hart*, ed. P.M.S. Hacker and J. Raz (Oxford, U.K.: Clarendon Press, 1977), 284-308.

22. J. Feinberg, “The Rights of Animals and Future Generations,” in *Philosophy and Environmental Crisis*, ed. W. Blackstone (Athens, Ga.: University of Georgia Press, 1974), 43-68.

23. E. Partridge, “Posthumous Interests and Posthumous Respect,” *Ethics* 91, no. 2 (January 1981): 243-64.

24. *Ibid.*, 261.