A n anxious resident paged ethics at 2:00 a.m. His patient, Mr. M, a twenty-nine-year-old man with a history of multiple substance abuse, was in the hospital after cardiac arrest and lack of cerebral perfusion. Sadly, the young man probably met the criteria for brain death, but the final apnea test to confirm the diagnosis could not be done for another forty-eight to seventy-two hours because the Klonopin in his system might confound the results. The resident’s concern, however, addressed a request made by the patient’s mother for a sperm harvest.

The patient’s mother maintained that her son had said he wanted to give her grandchildren. She wished to harvest sperm from him for a future use with an as-yet-to-be-determined surrogate mother. Since no one on the hospital staff was qualified to obtain sperm from a comatose patient, the procedure could not be performed until morning at the earliest. The resident was concerned that Mr. M’s body might not survive even on heart-lung criteria to the morning and wanted guidance on whether the mother’s request could justifiably be honored and, if so, how aggressively the team ought to attempt to maintain Mr. M until the morning.

Mr. M had been living with his girlfriend at the time of his injury, but his mother was his legal surrogate decision-maker. She chose not to involve his girlfriend in the decision-making, and there was no indication that the sperm harvest was requested in order to inseminate the girlfriend. In fact, no one had been specified. Mr. M’s father was never present in the hospital and was not a part of the decision-making. Mr. M was an organ donor but, because of the medications in his system, was ineligible for organ harvesting.

had been the patient’s wish that this occur. In addition, one 2009 case in Texas allowed a donation to the mother, with strong evidence that it was the patient’s desire. In most of these cases, clinicians must employ the judgments of surrogate decision-makers, although efforts are made to ensure that these are truly judgments of the patient’s preferences and not merely the surrogate’s preferences. For example, a waiting period of six months or more can be imposed before using the sperm to inseminate; this presumably allows for cooling-off time to carefully consider the patient’s potential preferences. The moral importance of an autonomous patient request can endure after unconsciousness or death. If it was Mr. M’s clear desire, absent any contrary indication, sperm harvesting might be acceptable in this case.

The patient had not directly discussed sperm harvesting. His remark about grandchildren was only a vague statement about the future. Still, part of the job of the surrogate is to make decisions consistent with the patient’s preferences in situations in which the patient has not considered the specific therapy in question. Arguably, his mother was doing just this. However, her own interests may have clouded her judgment, as she was bereaved and possibly hoping for a “replacement” for her lost son. Her interests may also be mixed between short-term bereavement and long-term desire for family. Without additional evidence, her decision might be suspect.

As an organ donor, Mr. M was willing to allow his body parts to be used to help others live on after his death. Could this also imply a willingness to donate sperm? Organ donor status does not directly apply to a sperm harvest. Still, organ donation provides a chance at life for another person. and arguably, so does sperm donation. A surrogate might argue that permission to remove organs indicates a general willingness to donate body parts, including sperm. Three reasons make this unlikely.

First, the nature of what is being harvested differs—organs are rare, while sperm are not. This provides a stronger consequentialist reason to seek to harvest organs and is probably the rationale for this patient’s willingness to donate organs. No such motivation exists for sperm donation. Second, organ harvests are familiar to the general public, whereas post-brain-death sperm harvesting is rare. It is less likely that the patient would intend sperm donation—donation of a resource that is not scarce through a mechanism that is largely unknown—as a plausible extension of his willingness to donate organs.

Finally, the potentially personal nature of the sperm donation is not present in the organ harvest. For most, the
connection between their personhood and any internal organ is dissimilar to the connection between parent and child. That parent-child connection is significantly diminished in anonymous sperm donations, but this child is to be part of the deceased donor’s family. It should be concluded, therefore, that willingness to donate organs does not give insight into desire for a sperm harvest.

There was not sufficient evidence to claim that a harvest would accord with the patient’s wishes. “I want to give you grandchildren” could indicate a desire to ensure that his mother had grandchildren by whatever means necessary, or it could mean a desire to have and raise children, a desire to make his mother happy, a desire to have the sort of life where raising children would be possible and comfortable.

The consulting team should recommend that the attending physician confirm whether Mr. M had ever given any clear communication about sperm harvesting. If he had not made comments any clearer than what was already known, there would be no reason to think he would have given consent for a harvest and the procedure would not be justifiable.

**commentary**

by Annie-Laurie Auden

Surrogate decision-making in health care is murky at best. The report *Surrogate Decision Making*, from the American Medical Association’s Council on Ethical and Judicial Affairs (CEJA), states, “Physicians should recognize the proxy or surrogate as an extension of the patient, entitled to the same respect as the competent patient.” Within the context of our case, this statement is imbued with a certain electricity, because to reject the surrogate’s decision might be overtly paternalistic. It would discount her and possibly her son’s views of how a family is structured and raised, substituting a physician’s values for those of the patient’s loved one. And yet, if the surrogate’s request were not in accordance with the patient’s wishes, it very well could be in glaring opposition to them. If so, this is a request whose repercussions would outlive the patient by a generation.

Protections are in place to prevent physicians from becoming agents of harm and to prevent ill-intentioned or ill-equipped surrogates from misguiding a patient’s treatment plan. The wishes of a surrogate are to be honored unless they are for medically inappropriate treatments, including treatments that fall outside the scope of generally accepted health care standards. According to CEJA, a physician may challenge a surrogate’s decision if “the challenge is based on a belief that the decision is clearly not what the patient would have decided or... cannot reasonably be judged to promote the patient’s wellbeing.” In this case, the surrogate’s decision deviates from accepted health care standards and goes beyond issues pertaining to the patient’s care to make determinations about other people’s lives. Going forward with sperm retrieval would extend the powers of surrogacy to decisions not typically handed over to surrogates. It would allow the patient’s mother to select the woman who would provide a genetic complement to her son. Upholding the request would effectively allow the patient’s mother, rather than a mate and partner of the patient’s choosing, to raise his children in his absence.

Perinatal sperm retrieval and posthumous insemination are currently permitted in the United States without express written consent from the deceased patient. But doctors ought to refuse to be part of the process unless it has been explicitly requested by the patient. In a world of newly emerging medical technology and increasingly ill-defined structures of family and intimacy, individuals’ dominion over their genetic material should be carefully protected. Although the patient’s mother claims to be acting in concert with her son’s wishes to provide her with grandchildren, this issue requires firm boundaries because it allows for misdirected surrogacy over entire childhoods. Such determinations should not be left to a surrogate decision-maker. The conflict of interest is too great, and the implications of the decision too far reaching.

Not requiring written consent might, theoretically, allow grieving parents to harvest and store their deceased teenage sons’ sperm for the future generation of “grandchildren.” Such parents have a right to bear other children of their own, but their son’s genetic makeup belongs to him alone. Perinatal sperm recovery for the purpose of in vitro fertilization also teeters harrowingly closely to cloning. Unlike organ donation, which bequeaths living tissue so that another person’s life may be maintained but does not create a new being, perinatal sperm recovery for the purpose of in vitro fertilization uses genetic material to recreate what is lost. Domination over another individual’s genetic potential is an entirely separate matter and one whose inherent perpetuity warrants an explicit advance directive.

Surrogacy is an imperfect solution to what can be a terrible situation. As a position of power, it must be limited, especially given the unprecedented possibilities posed by incipient medical technology. Health care surrogates should make decisions regarding the patient’s care only. They should not be given the right to determine what is done with the patient’s quiescent genes, let alone his or her unactualized offspring.

DOI: 10.1002/hast.249