

Dead Body, Surviving Interests: The Role of Consent in the Posthumous Use of Sperm

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INTRODUCTION	1
CHAPTER I: IDENTIFYING THE ISSUE	3
I Introduction	3
II The Issue	3
III New Zealand's Existing Framework	5
A The Human Assisted Reproductive Technology Act 2004	5
B The HART Act Framework	5
C Posthumous Reproduction under the HART Act	6
D ACART and ECART	6
E Guidelines for the Storage, Use, and Disposal of Sperm from a Deceased Man 2000	7
F <i>Re Lee</i>	8
IV Summary	9
CHAPTER II: AUTONOMY AND INTERESTS	10
I Introduction	10
II Principle of Autonomy	10
A Procreative Autonomy	11
B Evidentiary View of Autonomy	12
C Integrity View of Autonomy	13
III Interests of the Deceased	14
A Experiential Interests	14
B Critical Interests	15
IV Precedent Autonomy	15
V The Role of Autonomy in Posthumous Reproduction	16
VI Summary	18
CHAPTER III: THE CONCEPT OF CONSENT	19
I Introduction	19
II Consent in the Dead	19
A Contemplation of Death	19
B Reproduction and Death	20
C Consent and the Subject Matter	20
III Explicit Consent	21
A A Place for IVF?	22
B Written Explicit Consent	22
C Oral Explicit Consent	23
D Summary	24
IV Inferred Consent	24
A Factorial Considerations	26

V Presumed Consent	28
VI No Consent	28
VII Summary	29
CHAPTER IV: JURISDICTIONAL ANALYSIS AND REFORM	31
I Introduction	31
II The United Kingdom	31
A Diane Blood	31
B The Human Fertilisation and Embryology Legislation	32
III Australia	33
IV Israel	35
V Where to for New Zealand?	37
A Regulating Retrieval of Sperm	38
B Regulating Use of Sperm	38
1 Application and use by the surviving spouse or partner	39
2 Express objection to be respected	39
3 Explicit consent to be accepted	39
4 Inferring consent	40
5 Stand-down period, adequate information, and counselling	40
6 Relevant bodies to make authorisation	41
VI Proposed Guidelines: ‘The Use of Gametes from Persons who are Deceased or Incapacitated Prior to Death’	41
VII Summary	42
CONCLUSION	44
BIBLIOGRAPHY	46

INTRODUCTION

Death is inescapable but central to the human condition. We all are rather apprehensive of the experience of dying. Reasons for this may range, but wholly, individuals are concerned that they leave this world both with dignity and no regrets from their time spent. We are all placed on this earth for individual purposes that we aim to fulfil. Therefore, death tends to carry a very special and symbolic meaning to an individual, aiming for it to express and confirm the values such life was lived by.¹ Achievement of those values is dependent on individual choice, namely, autonomy. Autonomy itself does not exist as a legal source or right, it is rather an undeclared innate principle, one that we recognise as a concept equally in legal, moral, and political philosophy. For the purposes of this paper, I am concerned primarily with its role in the legal realm. In the medical arena, autonomy is generally protected through the legal requirement of informed consent to treatment.²

Considering posthumous reproduction from a legal, ethical and philosophical perspective reveals that it is a procedure which is increasingly challenging, difficult and sensitive. One of the many distinctive concerns with this practice lies in consideration of consent. Traditionally, posthumous reproduction was simply recognised because of accident or fate whereby the mother died during childbirth, or the father died after conception and pregnancy.³ An act of fate eliminates the ethical and legal problems we encounter today, for the death was never anticipated. Modern-day posthumous reproduction, however, tends to come in the form of urgent applications for the removal and use of sperm following an unexpected or sudden death.⁴ Alike to the former, death is not anticipated, however, neither is conception nor pregnancy. Because these deaths predominantly tend to be unanticipated, an important feature has been an absence of the dead or irreversibly unconscious man's prior consent to the procedure.

In this dissertation, I aim to unpack what level of consent to the treatment of posthumous reproduction, using a deceased man's sperm, is required to protect the innate principle, autonomy. There are many ways that autonomy can be interpreted, understood, and afforded

¹ Ronald Dworkin *Life's Dominion: An Argument about Abortion and Euthanasia* (London, Harper Collins, 1993) at 211.

² Rebecca Collins "Posthumous Reproduction and the Presumption Against Consent in Cases of Death Caused by Sudden Trauma" (2005) 30 *Journal of Medicine and Philosophy* 431 at 432.

³ Alison Douglass "Assisted Human Reproduction: Posthumous Use of Gametes" (Masters of Bioethics and Health Law Thesis, University of Otago 1998) at 11.

⁴ See *Re Creswell* [2018] QSC 124; *Re Lee* [2017] NZHC 3262; *Re Edwards* [2011] NSWSC 478.

weight in different contexts. Throughout this paper, I will argue that this fundamental principle extends in a limited way from our lives to death. In finding that consent is required, there is a further question as to what evidence is legitimate or necessary to count towards that consent. This could perhaps include written, spoken, or inferred consent, or even a presumption of refusal. These are uncertainties which I seek to unpack and answer philosophically in this dissertation, but conclusively, I find that a model of inferred consent to regulate this procedure is most appropriate.

This dissertation will be divided into four parts. I will begin the analysis in Chapter I by reviewing the pre-existing New Zealand framework for posthumous reproduction. In doing so, I will identify the legal ambiguity we are faced with as a nation and explain why there is a need for a comprehensive regulatory framework to provide clarity and consistency in the way applications for posthumous reproduction are dealt with.⁵ In Chapter II, I will unpack the philosophy behind autonomy and personal interests. The illustration of different interests an individual has during their lifetime advances autonomy's existence beyond death. Chapter III draws in on different concepts of consent: explicit consent, inferred consent, presumed consent, and no consent. The ensuing chapter reviews relevant jurisdictions to illustrate the implementation of those concepts. The common constituent elements that can be drawn from each will assist in the drafting of new guidelines specifically for the posthumous use of sperm in New Zealand.

⁵ Advisory Committee on Assisted Reproductive Technology "Posthumous reproduction - A review of the current *Guidelines for the Storage, Use and Disposal of Sperm from a Deceased Man* to take into account gametes and embryos" (2018) at ix.

CHAPTER I: IDENTIFYING THE ISSUE

I Introduction

Ayla Cresswell, aged 25 years young tragically loses her boyfriend Josh Davies, aged only 23 years. With what Ayla thought was a life ahead full of growth, love and procreative hope come to a complete halt. An emergency application was made by Ayla alongside the support of Josh's family to the Supreme Court of Queensland to have Josh's sperm urgently retrieved from his body.⁶ An IVF provider held Davies' testes and sperm following retrieval whilst in a lull as to whether the sperm could then be used posthumously to impregnate Ayla. Ayla's and supposedly Josh's wish was granted and Ayla was given permanent possession over the property, namely, Josh's sperm.

Prior to this landmark ruling, Queensland's legality on posthumous reproduction was ambiguous,⁷ as it remains in New Zealand. In New Zealand, a mixture of legislation, orders, and regulating guidelines leaves families, friends, and deceased's partner's utterly uncertain as to their chances of the posthumous retrieval and use of a loved one's gametes.⁸ At present, the combination of these laws and rules have been sufficient for the judiciary to allow the retrieval of sperm from a deceased man without explicit consent.⁹ It remains questionable how an interpretation of this material for the use of sperm would unfold. This chapter frames the primary issue which I attempt to solve in this paper. That is, locating the need to determine the level of consent that should be required for the use of posthumous reproduction in New Zealand's legal framework. Wholly, it will lead me to explain why there is a need for reform.

II The Issue

Posthumous reproduction is perhaps a morbid topic, but the issues surrounding it are increasingly challenging and sensitive. It has been possible for a few decades to obtain and freeze a man's sperm after his death to later fertilize an egg.¹⁰ So, clearly, the use of a man's sperm after

⁶ *Re Cresswell* [2018] QSC 142.

⁷ Queensland does not have its own legislation on this issue, it rather operates under the federal guidelines, the National Health and Medical Research Council *Ethical guidelines on the use of assisted reproductive technology in clinical practice and research* (2017), leaving the courts with wide discretion.

⁸ See Human Assisted Reproductive Technology Act 2004; Human Assisted Reproductive Technology Order 2005; *Guidelines for the Storage, Use, and Disposal of Sperm from a Deceased Man* (February 2000) Prepared by the National Ethics Committee on Assisted Human Reproduction (NECARHR).

⁹ *Re Lee* [2017] NZHC 3262.

¹⁰ LiveScience "Using a man's sperm after death: It's possible, but is it ethical?" (24 October 2015) Fox News <<http://www.foxnews.com/health/2013/06/11/making-babies-after-death-it-possible-but-is-it-ethical.html>>.

his death is attainable, but it is contested whether this is ethical. Human-assisted technologies are continuously and rapidly developing. These advances have produced new understandings of reproduction, parenthood, and status of the child, as well as sparking the debate over the adequacy of the property model over reproductive materials.¹¹ Despite the importance of these disputes, the scope of this paper is limited to the issue of consent in the posthumous use of sperm. Legal frameworks are struggling to sustain the ethical, moral, social and legal issues that arise in line with such advances.¹² Posthumous reproduction unavoidably depends on individual case analysis and we are lacking a universal tool to apply to such cases. Given the nature of consent over posthumous reproduction in New Zealand presently, any situation could potentially qualify to allow retrieval and use. Each person's wishes, actions, and desires will all differ prior to death and thus law-makers must tread with caution in a formulation of guidelines to encapsulate all circumstances.

Because the primary focus of this paper is exclusively on the posthumous *use* of sperm there are two immediate parameters. The first concerns retrieval. There will always be a practical distinction between obtaining authority to retrieve sperm and use it. Questions of retrieval of sperm are derivative in a sense; whether an applicant is successful in gaining permission to retrieve will depend on their likelihood of approval for use in the future. So, currently, the courts are bridging a 'gap' between the potential for use and retrieval.¹³ Thus, any future legal test that shall be imposed on decision making at the retrieval stage will be largely informed by the substantive test in the application to use stage. It is likely that the urgency of the retrieval period can account for this, as sperm must be retrieved within 36 hours after death to enhance success fertilization,¹⁴ meaning legal proceedings are not viable. Due to this, the courts tend to prolong the consideration of use to a later date. In this paper, I aim to fuse these processes to be addressed conjointly. The second parameter concerns the social context that posthumous reproduction exists in. It is inevitable that third-party interests including a surviving partner, family, and prospective child will conflict with the interests of the deceased in a case for posthumous reproduction. I acknowledge that to solve this ethical imbalance in full it would require a balance of all interests; that is beyond the scope of this paper. For the purposes of this dissertation I will be solely focusing on the interests and autonomy of the progenitor; the largest piece of this puzzle.

¹¹ Rebecca Collins, above n 2, at 432; See *Re Lee*, above n 9.

¹² Advisory Committee on Assisted Reproductive Technology "Posthumous reproduction", above n 5, at iii.

¹³ *Re Lee*, above n 9, at [100].

¹⁴ Shai Shefi and Others "Posthumous sperm retrieval: analysis of time interval to harvest sperm" (2006) 21 Human Reproduction 2890 at 2892.

III New Zealand's Existing Framework

A The Human Assisted Reproductive Technology Act 2004

The Human Assisted Reproductive Technology Act 2004 (“HART Act”) governs all assisted reproductive procedures in New Zealand.¹⁵ The fundamental purposes of this Act include securing the benefits of reproductive procedures, prohibiting unacceptable assisted reproductive procedures, and prohibiting the performance of assisted reproductive procedures without the ethics committees continuing approval.¹⁶ In addition, the principles of the Act listed in s 4 are of high relevance; providing guidance to any person exercising powers or performing functions under the HART Act.¹⁷ Each principle holds great significance which is attributed to the few amounts. Of importance, s 4(d) states that “no assisted reproductive procedure should be performed on an individual and no human reproductive research should be conducted on an individual unless the individual has made an informed choice and given informed choice.”¹⁸ This principle clearly states that the posthumous retrieval of sperm is prohibited unless there is informed consent. Being a principle in the absence of specific legislative steps of enforcement, it is relatively dubious.

B The HART Act Framework

The HART Act distinguishes and classifies three separate categories of procedures: established procedures, prohibited actions, and assisted reproductive procedures.¹⁹ Established procedures are those that are so frequent and unequivocal that they are permitted to be carried out in a clinic without the prior consent of the Ethics Committee on Assisted Reproductive Technology (“ECART”).²⁰ This includes for example, in vitro fertilisation (“IVF”) and gamete donation.²¹ These established procedures are generally permitted on a social acceptance basis as they became scientifically possible in clinical practice.²² Prohibited actions such as implanting a cloned embryo into a human, are never to be carried out.²³ Assisted reproductive procedures require

¹⁵ Human Assisted Reproductive Technology Act 2004, s 3.

¹⁶ *Ibid.*

¹⁷ Section 4.

¹⁸ Section 4(d).

¹⁹ Human Assisted Reproductive Technology Order 2005.

²⁰ Human Assisted Reproductive Technology Act, s 25.

²¹ Human Assisted Reproductive Order, sch 1.

²² Nicola Peart “Life Beyond Death: Regulating Posthumous Reproduction in New Zealand” (2015) 46 VUWLR 725 at 731.

²³ Human Assisted Reproductive Act, s 8(1) ‘Every person commits an offence who takes an action described in Schedule 1’. Schedule 1 refers to prohibited actions.

approval from ECART prior to execution. Those procedures are the remainder of activities that aren't established or prohibited techniques.²⁴ This classification of procedures catches posthumous reproduction, indicating that society is not abundantly supportive of assisted reproductive procedures.

C Posthumous Reproduction under the HART Act

Although the collection of gametes from a deceased man or woman is an established procedure,²⁵ the use of sperm collected from someone who has since died and did not consent to the specific use before their death is not an established procedure under the HART Act.²⁶ This procedure, therefore, requires approval from ECART before any application can go ahead. This of course dramatically slows down the process of posthumous reproduction, but it is univocal that posthumous reproduction carries many ethical boundaries that need to be considered on each set of facts.

D ACART and ECART

The HART Act establishes the Advisory Committee on Assisted Reproductive Technology ("ACART").²⁷ Parliament has delegated ACART policy-making duties specific to reproductive technology in New Zealand. The committee has two primary functions. The first, to provide independent advice to the Minister of Health.²⁸ The second, to issue Guidelines and advice for ECART to follow for procedures and research requiring case-by-case ethical approval.²⁹ ACART additionally monitors the application and health outcomes of assisted reproductive procedures and established procedures, as well as developments in human reproductive research.

ECART is the second committee established conjointly by the HART Act and the Minister of Health.³⁰ This expert body is required to comprise of at least one person with expertise in assisted reproductive procedures, and at least one person with expertise in human reproductive research.³¹ ECART must not give approval to procedures unless it is satisfied that the activity is

²⁴ See Human Assisted Reproductive Order, ss 16, 18 and 19.

²⁵ Schedule 1, pt 1, cl 5.

²⁶ Schedule 1, pt 2, cl 5.

²⁷ See Human Assisted Reproductive Act, ss 32 and 35.

²⁸ Ministry of Health "Posthumous reproduction consultation launched" (3 July 2018) Ministry of Health - Manatū Hauora <<https://www.health.govt.nz/news-media/news-items/posthumous-reproduction-consultation-launched>>.

²⁹ See Human Assisted Reproductive Act, s 36. Also see ss 16, 19, and 28.

³⁰ Human Assisted Reproductive Act s 5 definition of 'minister'; s 27.

³¹ Section 27(3)(b).

consistent with the relevant guidelines and/or advice provided by ACART.³² ECART must, therefore, decline any application if the proposed activity is not covered by ACART’s guidelines or advice. Any refusal by ECART must then be referred to ACART.³³

The extent of ACART’s powers are exemplified in their current review of the ‘Guidelines for the Storage, Use, and Disposal of Sperm from a Deceased Man to take into account gametes and embryos’ (“2000 Guidelines”)³⁴ ACART released their first of two consultation documents in July 2018 which recognises the need for a change in the way posthumous reproduction is regulated in New Zealand. The new Guidelines aim to consider all gametes and embryos, rather than just sperm as we have currently. The purpose of the consultation is to obtain feedback from the public on “significant policy issues about whether and in what circumstances posthumous reproduction is acceptable”,³⁵ before developing new guidelines.

E Guidelines for the Storage, Use, and Disposal of Sperm from a Deceased Man 2000

Relevant Guidelines on posthumous reproduction involving a male’s gametes were established in New Zealand in 2000.³⁶ These guidelines were created by ACART’s predecessor, both before The HART Act and The HART Order. Specifically, in relation to the issue of consent they state, “Collection of sperm from a comatose or recently deceased person without that person’s prior written consent is ethically unacceptable”.³⁷ This gives an indication that consent *should* be required, but it is arguable whether the words have the strength of explicitly rejecting collection without consent. Because there is no legislative guidance under the HART Act, ECART must rely on these non-binding guidelines.

The 2000 Guidelines are further at issue as they exclusively deal with posthumous conception only in relation to the storage, use, and disposal of sperm. These guidelines lack both adequacy and modernity to reflect the growing popularity of posthumous reproduction. They fail to include other important segments of posthumous reproduction such as the retrieval of sperm, and the entirety of retrieval, storage, use and disposal of ova. In the words of ACART’s chairperson Gillian Ferguson, ‘the current Guidelines on the Use, Storage and Disposal of Sperm from a

³² Section 19(2).

³³ Section 18(2).

³⁴ Advisory Committee on Assisted Reproductive Technology “Posthumous reproduction”, above n 5.

³⁵ Advisory Committee on Assisted Reproductive Technology, “Posthumous reproduction”, above n 5, at iv.

³⁶ See *Guidelines for the Storage, Use, and Disposal of Sperm from a Deceased Man (February 2000)* Prepared by the National Ethics Committee on Assisted Human Reproduction (NEACHR).

³⁷ At 2.3.

Deceased Man written in 2000 are out of date and do not address a number of potential fertility treatment options that are now clinically feasible and requested by the public'.³⁸ Thus, a large question for this dissertation is whether the 2000 Guidelines are out of date, or alternatively, substantively wrong. This argument will help to frame both the demanding level of consent for posthumous reproduction, and subsequently, the appropriate legal test to give that effect.

F Re Lee

The most recent posthumous reproduction case we have had in New Zealand was decided by the High Court in late 2017.³⁹ This case concerned the legality of retrieval of sperm from a deceased man, with the following intention of later use to conceive. Ms. Lee applied ex parte for an urgent order for a pathologist to remove sperm from her husband's body, Mr. Long, to store. Mr. Long died intestate, without any known explicit wishes towards posthumous reproduction specifically. There was, however, an abundance of evidence brought before the court to indicate that Mr. Long would have allowed the retrieval of his sperm. This included the fact that Ms. Lee was pregnant at the time of the death of Mr. Long with their first child; Ms. Lee and Mr. Long had hopes of having a second child and expanding their family (which had been communicated to family members and friends); and Mr. Long had given 2 samples of sperm on a previous occasion due to initially experiencing fertility frustration.⁴⁰

Due to the urgency in the retrieval of sperm, the order was initially given and Heath J revisited the application in the High Court. Heath J found that the court had the inherent jurisdiction to enable Ms. Long to make a substantive application to ECART. This was partly due to it not being inconsistent with any statutory or regulatory provision, but it was also pivotal on the point that sperm is only viable for a short period of time following a death.⁴¹ The Court is doing "no more than filling a legislative gap to provide a means by which the sperm can be collected and stored pending a substantive application to the Ethics committee as to its subsequent use."⁴² In sum, it avoided frustration.

³⁸ Ministry of Health, above n 28.

³⁹ See *Re Lee*, above n 9.

⁴⁰ For completeness, it is important to note that none of Mr. Lee's sperm was stored during the process of fertility treatment, thus there was no sperm available for Ms. Long to rely on. This was her only option.

⁴¹ *Re Lee*, above n 9, at [100].

⁴² *Re Lee*, above n 9, at [100].

New Zealand courts have recognised that these ethical debates around posthumous reproduction are not suited to judicial intervention.⁴³ Parliament has entrusted the competing policy considerations and ethical considerations in the two committees established under the HART Act.⁴⁴ It is predominantly for these committees, and not the courts to make such decisions. The fact that Parliament created these specialist bodies in the first place appreciates the recognition that “the mix of scientific, ethical, cultural, spiritual and moral factors are not readily justiciable.”⁴⁵ Furthermore, these bodies are put on a pedestal where the decisions have no right of appeal.

IV Summary

It would be wrong to allege that the law on posthumous reproduction is unworkable. There is certainly room for clarification nevertheless. Both ACART and ECART are appropriately placed in the monitoring, analysis, and decision-making of divisive assisted reproductive procedures like the present. The tools that those bodies are required to use to do so, however, are insufficient.

Despite the explicit principle in the HART Act prohibiting assisted reproductive procedures in the absence of informed consent,⁴⁶ it is questionable whether it is weighty enough to do so in practice. The Guidelines attempt to restore this trivial position, yet, again it is tentative whether the term ‘ethically unacceptable’ gives the effect of prohibition on posthumous reproduction without informed consent from the deceased. The weight of that guiding standard has already been undermined recently in the courts,⁴⁷ enhancing its existing weakness.

For the lack of a step-by-step statutory provision or ACART guidance, it is uncertain as to what the level of consent (if any at all), is, and would be required for the use of sperm posthumously. Clarification is necessary first to provide comprehension to applicants of what is required; this will strive to reduce an influx of applications to ECART as the procedure becomes more publically recognised. Secondly, it will provide consistency and confidence for future requests.

⁴³ *Re Lee*, above n 9, at [92].

⁴⁴ *Re Lee*, above n 9, at [92].

⁴⁵ *Re Lee*, above n 9, at [93].

⁴⁶ Human Assisted Reproductive Technology Act, s 4(d).

⁴⁷ See *Re Lee*, above n 9.

CHAPTER II: AUTONOMY AND INTERESTS

I Introduction

The central principle to many ethical arguments in medical law is patient autonomy; the factor of incapacitation or death complicates that argument further. Self-determination, including our choices to be a parent (or to not be), are vital rights which afford the protection of the law. It is in dispute as to whether those rights extend to the dead. In this chapter, I will first introduce the principle of autonomy and procreative autonomy in general terms. That discussion subsequently initiates my argument that although autonomy does not in full survive beyond death, procreative autonomy does. I pursue this argument through an explanation that our lives are guided by sets of interests, and that because a set of those interests survive beyond physical death, consent is required to protect autonomous choices made in line with those interests.

This analysis relies heavily upon Ronald Dworkin's application of the role of autonomy in dementia patients with advance directives.⁴⁸ Dworkin advocates too, that there are a set of interests surviving beyond incapacitation which is why we should give effect to a former competent person's advance directive. The principle of autonomy is manipulated to solve the ethical concerns with advance directives made by now incapacitated patients. I strive to explain how this principle can too be used to solve the dispute with consent for posthumous reproduction.

II Principle of Autonomy

The principle of autonomy is paramount in all aspects of life whether it be small endeavours of attending a lecture or large endeavours such as getting married. Autonomy gives every individual the right to self-determination and self-rule. Self-determination is the process whereby an individual exclusively controls their own life. So, an individual is self-determined if they are free to make their own decisions.

The right to self-determination, however, must not be overstated. Using a medical context, it should not be construed to mean that whatever a patient wants, is to be done.⁴⁹ On one hand, a patient's negative right is almost absolute, meaning that as individuals we are able to refuse

⁴⁸ See generally Ronald Dworkin "Autonomy and the Demented Self" (1986) 64 *The Milbank Quarterly* 4.

⁴⁹ R D Orr and M Siegler "Is posthumous semen retrieval ethically permissible?" (2002) 28 *J Med Ethics* 299 at 301.

medical treatments we no longer want to endure. This would include, for example, a terminal cancer patient refusing chemotherapy. A positive right, on the other hand, is not near absolute.⁵⁰ Although we can consent to certain procedures, we do not have the freedom to decide our access to any treatment we desire. For example, we cannot demand access to anti-depressants if a clinician does not think it is suitable. The clinician is also an autonomous agent, who can refuse if they did not think anti-depressants were appropriate. A positive right of self-determination heavily relies on others and it would be an incorrect interpretation of autonomy to regard individual decisions as an exclusion of all else.

A Procreative Autonomy

In the scope of posthumous reproduction, autonomy simply means allowing an individual to decide their reproductive fate. This is often referred to as the “right to procreate”.⁵¹ Our autonomy in reproduction is a negative right not to be prevented from reproducing rather than a positive claim of right to procreate. This is imposed as it would be impractical if every individual had a positive right to procreate, implying that every individual was to have access to reproductive technologies until they had achieved their desired number of children. Such right would be unsustainable technologically and ethically.

Autonomy is rightfully respected in fundamentally similar medical procedures. Very few choices are more private, intimate or integral than those involving the use of one’s body.⁵² It can come into play in two ways: medical procedures may require prior consent or medical procedures may be refused. This is explainable in the context of organ donation. In New Zealand, the orthodox position requires consent from an individual before their organs can be removed from their body.⁵³ Our commitment to autonomy in society means we do not conscript organs from the dead, nor do we presume the consent of the living to donate after death. The idea that organs should not be taken from somebody’s body without his or her consent would seem to also apply to the retrieval of sperm. Conversely, autonomous refusals are classified as a fundamental right; any individual can refuse receipt of an organ donation even if they were required one to sustain life.⁵⁴

⁵⁰ Ibid.

⁵¹ Alison Douglass, above n 3, at 45.

⁵² Peter H Schuck “Rethinking informed consent” (1994) 103 The Yale Law Journal 899 at 924.

⁵³ Human Tissue Act 2008, s 22.

⁵⁴ New Zealand Bill of Rights Act 1990, s 11.

It is universally agreed that individuals are autonomous,⁵⁵ that individuals have the ability to make important decisions defining their own lives for themselves.⁵⁶ Although, autonomy arguments are not straightforward when applied to the living, let alone adding the complication of applying the principle to a person who is incapacitated or dead. The question, therefore, becomes: if autonomy is our organising principle for our treatment to living people, to what extent does autonomy determine our treatment of deceased people? Dworkin adequately provides two different accounts of autonomy to guide a possible answer.

B Evidentiary View of Autonomy

The first is the evidentiary view. This view holds that we should respect decisions people make for themselves even if those decisions appear to be ill-judged because each person generally knows what is in their best interests better than anyone else.⁵⁷ We often think that when someone makes a questionable decision that we should correct that decision but it would be wrong to do this. According to the evidentiary view, it is best that we recognise the right to autonomy in the long run than to interfere with people's lives whenever we think they have made a mistake.⁵⁸ This view plainly upholds autonomy during one's life; that individual is free to make choices and develop a life plan based on their wishes and morals as to a good life.

The consequence of accepting this account of autonomy is that we refuse to extend the right of autonomy to decisions made by those incapacitated or dead. The reason for this is that it cannot be said that a person who is either incapacitated or dead is able to make decisions in line with what they think is their best interests.⁵⁹ An incapacitated or dead individual has, by virtue of mental deterioration, completely lost the competence to engage in moral reasoning and dispute; they will never be able to make prudent decisions.

As pointed out by Dworkin,⁶⁰ this view is insufficient in explaining the general value of autonomy. Autonomy allows someone to act in what he takes is his/her best interests, but it also allows him/her to act *against* such interests. A common example is a choice to smoke. The individual is acting in a manner that is blatantly against their best interests, as we all know the grim

⁵⁵ John Coggon and José Miola "Autonomy, Liberty, and Medical Decision-Making" (2011) 70 Camb Law J 523 at 4.

⁵⁶ Ronald Dworkin *Life's Dominion: An Argument about Abortion and Euthanasia*, above n 1, at 222.

⁵⁷ Ronald Dworkin *Life's Dominion: An Argument about Abortion and Euthanasia*, above n 1, at 223.

⁵⁸ Ronald Dworkin "Autonomy and the Demented Self", above n 48, at 7.

⁵⁹ Ibid.

⁶⁰ Ronald Dworkin "Autonomy and the Demented Self", above n 48, at 8.

consequences of smoking. Other examples include more admirable reasons such as a Jehovah's Witness refusing a blood transfusion in line with their religious views. Regardless, if autonomy requires us to respect these decisions, the evidentiary view fails to recognise that the point of autonomy is to protect an agent's welfare. It would not be just to say that because a capable, or even incapable person makes decisions contrary to their best interests, such decision-making should be made by others.⁶¹

C Integrity View of Autonomy

The alternate view is based on integrity. This account is far more plausible than the former, emphasising that the value of autonomy derives from the capacity it protects. That is, the capacity to express one's values, commitments, life goals, and enjoyable interests. So, this view focuses not on individual decisions in isolation but rather the placing of each decision in a more general scheme of the individual's life they are creating. Through this view, Dworkin contends we grant freedom to people to act in ways that are clearly contrary to their interests.⁶² This is because autonomy allows people to "lead their lives out of a distinctive sense of their own character, a sense of what is important to them".⁶³ To revisit the Jehovah's Witness example - we allow refusal of blood transfusions even if it will result in death. This view respects informed choice; allowing the individual to live their life structured by his or her values even if those values are not comprehensible or shared ourselves.⁶⁴

If we are to accept this integrity account of autonomy we emphasise the existence and priority of fulfilling our life-long goals rather than our simple day-to-day pleasures. In the context of an incapacitated person, for example, their right to autonomy would turn on their capability to make decisions that are reasonably continuous, similar, and analogous to the general character of their prior life. If those decisions, no matter how stubbornly reasoned, utterly conflict, representing no sense of self, then he/she has presumably lost the capacity to the point of autonomy to protect.⁶⁵ For why should he/she continue to the right to autonomy if such interests are clearly not in his/her best interests.

⁶¹ Ronald Dworkin *Life's Dominion: An Argument about Abortion and Euthanasia*, above n 1, at 224.

⁶² Ibid.

⁶³ Ibid.

⁶⁴ Ronald Dworkin "Autonomy and the Demented Self", above n 48, at 8.

⁶⁵ Ronald Dworkin *Life's Dominion: An Argument about Abortion and Euthanasia*, above n 1, at 1225.

III Interests of the Deceased

To further unpack the relevance of the two views of autonomy, the distinction of interests Dworkin embodies must be revealed. Dworkin argues that there are two sets of interests that one has during their lifetime and after death.⁶⁶ Dworkin frames this argument using the example of dementia patients and their advance directives. Advance directives, alike to posthumous reproduction carry large ethical issues, particularly when determining how mentally debilitated patients such as those with dementia should be treated. The conflict arises when determining whether a patient should be treated according to their present best interests or their former wishes. Dworkin attempts to solve the incompatibility of this based on an individual's right to autonomy. Because that right generally only applies when individuals are of sound mind. Consequently, this means dementia patients are generally non-autonomous individuals as they do not have a clear understanding of their past actions nor long-term aims. There is, however, a set of interests that is not to be sacrificed with mental health, Dworkin argues.⁶⁷ An advance directive serves as a statement to those interests and therefore should be upheld when an individual is no longer able to articulate their interests. The distinction between these sets of interests provides useful for the present context as consent for posthumous reproduction functions principally the same as an advance directive. Consent serves to depict and protect autonomous decisions made by a sound minded individual. That consent should be equally respected after death as those decisions were made in line with a certain set of interests.

A Experiential Interests

The first set of interests valued in autonomy are experiential interests. Experiential interests (or preferences) are the things that we simply find enjoyable in life; things we feel compelled to do because we find them both pleasurable and essential to a good life.⁶⁸ These experiences may not always be pleasurable, rather, they may be negative or painful. However, they wholly do not result in a fundamental mistake or affect our lives in a dramatically adverse manner. Our experiential interests may come in the form of a love for cooking or the strain of sitting a hard assessment for example. The value of these interests, judged in isolation, depends precisely on the fact that we find them pleasurable, exciting, or perhaps, dismal as *experiences*. So, it could be understood that an individual, no matter their mental health status, would continue to always hold experiential interests at least up until death; the very nature of living is an experience alone.

⁶⁶ Ibid.

⁶⁷ Ibid.

⁶⁸ Ronald Dworkin *Life's Dominion: An Argument about Abortion and Euthanasia*, above n 1, at 201.

B Critical Interests

The second set of interests, critical interests, are much more convoluted and paramount than the former.⁶⁹ Critical interests are comprised of hopes and aims which give genuine meaning and coherence to our lives.⁷⁰ We pursue large projects such as strong friendships, achievement of career goals or a family to enhance our lives to its full potential. Such endeavours may not always be pleasurable, though, we believe they will benefit our lives entirely in the long run. We all seek to satisfy these critical interests, most importantly, autonomously, even if we are unaware of doing so. Not everyone will have a conscious sense of these interests as one may of their experiential interests, especially when our life seems unplanned with a lack of guidance. Nevertheless, individuals are piloted by a general style of life they personally think is appropriate for their character.⁷¹

We all want and desire to have enjoyable moments in each day; to do things we find pleasurable. However, many come to the realisation that there are larger, more significant opportunities and roles to be fulfilled.⁷² It is, therefore, comprehensible that experiential preferences are more salient in our day-to-day life decision making, whereas our critical interests may be both crucial during our lives and how our lives unfold post-mortem. I feel it is difficult to explain the regret of one's life, say the day before he dies if the only interests people have are experiential interests. For if a person lives life only with experiential interests, one could only regret their daily experiences rather than their life in full.

IV Precedent Autonomy

Understanding the role of experiential and critical interests makes it comprehensible to accept the integrity account of autonomy; granting freedom to individuals to live their lives in accordance with their values, commitments, life goals, and enjoyable interests. Though in whole, both the integrity and evidentiary view are equally unfavourable and non-applicable in deceased person; they essentially afford no right to autonomy in such individuals.⁷³ This is solvable, however. Thus far, we have been considering 'contemporary' autonomy; one's autonomy existing in the present

⁶⁹ Rebecca Dresser "Dworkin on Dementia: Elegant Theory, Questionable Policy" (1995) 25 *Hunter Center Report* 32 at 33.

⁷⁰ *Ibid.*

⁷¹ Ronald Dworkin *Life's Dominion: An Argument about Abortion and Euthanasia*, above n 1, at 202.

⁷² See Ronald Dworkin *Life's Dominion: An Argument about Abortion and Euthanasia*, above n 1, at 201-202.

⁷³ Ronald Dworkin "Autonomy and the Demented Self", above n 48, at 11.

as an incapacitated or dead person. Consideration of a patient's 'precedent' autonomy, the person he/she was before incapacitation or death is better suited in the context of posthumous reproduction.⁷⁴

If a person prior to incapacitation or death created a living will (i.e., an advance directive) to outline their desires for specific procedures or activities after their death, we would assume that should be respected. On the evidentiary view of autonomy, we will find that respect for precedent choices are weak. This is because "people are not the best judges of what their own best interests would be under circumstances they have never encountered in which their preferences and desires may drastically have changed".⁷⁵ The integrity view does, however, recognise that we should honour both prior wishes and choices. "It seems essential to someone's control of his whole life that he is able to dictate what will happen to him when he becomes incompetent",⁷⁶ as this shall reflect their overall character and style of life throughout his/her existence.

V The Role of Autonomy in Posthumous Reproduction

It goes without saying that being a parent engages autonomy. There are three possible roles that autonomy can play in this interest. The tripartite consists of full autonomy, autonomy in protecting critical interests, or no autonomy. The primary question, therefore, remains as to which of those levels of autonomy survives beyond our death. Application of Dworkin's theories on dementia patients and advance directives to dead persons contends that autonomy does survive death. That autonomy, however, does not survive in full. There are two manoeuvres which explain why.

First, we concern ourselves with the role of experiential interests in autonomy. Decisions about reproduction indeed reflect experiential interests. For example, an individual may have the desire to experience (or not) being pregnant, or the wish (or not) to raise a child. Although present during life, the living cannot have experiential interests in relation to post-mortem events. Death and experience are mutually exclusive,⁷⁷ meaning we must be physically present to experience things and death negates that possibility of experiencing anything. Thus, death not only involves the human body but experiential interests too.

⁷⁴ Ibid.

⁷⁵ Ronald Dworkin *Life's Dominion: An Argument about Abortion and Euthanasia*, above n 1, at 226.

⁷⁶ Ronald Dworkin "Autonomy and the Demented Self", above n 48 at 11.

⁷⁷ Hillary Young "The Right to Posthumous Bodily Integrity and Implications of Whose Right it is" (2013) 14 MARQ Elders Advisor 197 at 212.

Secondly, our critical interests are likewise engaged in decisions about reproduction. For example, the aspiration to create future generations, or the desire to not contribute to overpopulation.⁷⁸ Reproduction is a critical interest that contributes to one's personhood and identity. The desire to be a parent can be analogised to other fundamental life goals to highlight its importance. For example, an individual may want to live their life as a Catholic, or to save the yellow-eyed penguins before they die; the same way an individual may want to be a parent. Although those undertakings may involve unpleasant experiences in the process, it wholly contributes to that individual's life purpose as fulfilling those meaningful actions prevents their life being worse off. The distinction of these interests from the former is explained by the fact that these interests may relate to future events whereas experiential interests relate only to present events.⁷⁹ Such future events may be post-mortem. Post-mortem existence of critical interests means that not only do people care about what happens after they die, but they also have a moral claim in determining what happens to them after they die,⁸⁰ as "what happens after death can (depending on the particular person's own idea of self-development) complete the development of the self."⁸¹

Incapacitation of a dementia patient is principally equivalent to incapacitation or death in the context of posthumous reproduction. In either circumstance, the patient is no longer capable of expressing their wishes and reliance must be made on prior autonomous decisions for treatment. For this reason, it can be said that autonomy survives death the same way it does in incapacitated patients with dementia, as Dworkin argues. Autonomy in a posthumous context involves consideration of whether the man has given directions, express or perhaps inferred, about what he wishes his reproductive future to be after he ceases to exist. The decision to reproduce is so deeply and personally important that it is difficult to see how procreative autonomy is extinguished upon death.⁸² If the deceased man has given directions that he accepts the use of his sperm posthumously, those wishes should be respected if the deceased partner wishes to and is

⁷⁸ Hillary Young "Presuming Consent to Posthumous Reproduction" (2014) 27 J.L. & Health 68 at 73.

⁷⁹ Hillary Young "The Right to Posthumous Bodily Integrity and Implications of Whose Right it is" above n 77, at 212.

⁸⁰ Ibid.

⁸¹ T. M. Wilkinson "Individual and Family Decisions About Organ Donation" (2007) 24 Journal of Applied Philosophy 26 at 31.

⁸² Belinda Bennett "Posthumous Reproduction and the Meanings of Autonomy" (1999) 23 MelbULawRw 286 at 204.

permitted to procreate with his gametes. Similarly, if the male has explicitly objected to such use this should equally be respected.

This analysis, therefore, eliminates both full autonomy and no autonomy from the tripartite in application to posthumous reproduction. Although full autonomy is plausible, it is unnecessary. This is because there are no experiential interests involved in the way they are in other medical procedures. An example of where full autonomy is necessary would be in the decision whether to undergo a lifesaving leg amputation. That is because in having that procedure, there are both critical and experiential interests engaged. Experiential repercussions involve phantom limb sensation or losing the ability to walk. Critical interests would concern that individual's ability to fulfil personal long-term goals and values such as being a marathon runner. In terms of no autonomy, critics of Dworkin such as John Harris, argue that autonomy does not exist in a deceased person, but that is rather a principle exercised in the living only.⁸³ Harris argues that living individuals hold 'person-affecting' interests only (namely, experiential interests).⁸⁴ In the context of organ retention Harris finds that these person-affecting interests do survive posthumously, however, because 'I', 'you', or 'they' as a 'person' no longer exist, those interests cannot affect the deceased's well-being the same way they do during life.⁸⁵ So, although what happens to our bodies after we die is person affecting, the deceased are not the person affected. Rather, it is third parties such as the receiver of the sperm or family members distressed by the process who are affected. This view, therefore, claims that a deceased person has no autonomy requiring protection.

VI Summary

In this chapter, I first determined the applicability of autonomy to a deceased person, specifically in the context of a case for posthumous reproduction. Because a deceased person continues to hold critical interest's post-mortem there is a role for autonomy. This autonomy comes in the form of control over reproductive choices. I have established in this chapter that a deceased typically would have interests in their reproduction after their death; that it conforms with the values, wishes and style of life they chose to pursue and would expect to be upheld and continued. To recognise and give credit to autonomy over these interests, the legal tool of consent must be engaged. I will discuss in the succeeding chapter how consent performs this role.

⁸³ John Harris "Organ procurement: dead interests, living needs" (2003) 10 J Med Ethics 130 at 132.

⁸⁴ Ibid.

⁸⁵ Ibid.

CHAPTER III: THE CONCEPT OF CONSENT

I Introduction

Consent is how the law gives effect to the principle of autonomy. Therefore, the level of respect that given to autonomy in a dead person will influence the consent required to protect that interest. In Chapter II, I explained that autonomy, though not in its full capacity, survives even when a body dies. There is a critical interest, namely, a procreative autonomy that demands protection. In this chapter, I will break down a spectrum of consent that could be legally required for the procedure of posthumous reproduction. Each model of consent on the spectrum serves to represent and subsequently protect alternate levels of autonomy an individual may possess. In this chapter, I will specifically draw in on the notion of ‘inferred consent’ and discuss how this is the most complex yet viable method of consent reflecting a deceased’s level of autonomy.

II Consent in the Dead

A Contemplation of Death

There is a general social reluctance to talk about death and dying. It is the most negative experience we endure no matter whether it is the death of a loved one or the thought of dying ourselves. This creates a stigma in openly addressing the multitude of issues that surround death.⁸⁶ It is prevalent that the reluctance to discuss death can have adverse consequences; the situation of determining posthumous reproduction is only one of many. One particular study showed that an overwhelming amount (95.9%) of participants had never discussed reproduction after death with their loved ones.⁸⁷ In an ideal world, we would all discuss our death and how we would prefer our affairs to be dealt with afterward. Discussions of mortality can be encouraged, however, in reality, they do not occur, resulting in families and friends attempting to make guesses as to a deceased’s wishes. Even if these discussions did take place, we would never be able to exclude all the misunderstandings and uncertainties of advance directives.⁸⁸ This is because discussions will rarely extend to a written directive,⁸⁹ and reliance on verbal discussions is

⁸⁶ Catherine McGrath and Others “A narrative account of the impact of positive thinking on discussions about death and dying” (2006) 14 Supportive Care in Cancer 1246 at 1246.

⁸⁷ Sara E. Barton and Others “Population-based study of attitudes toward posthumous reproduction” (2012) 98 Fertility and Sterility 735 at 737.

⁸⁸ James A. Tulsky “Beyond Advance Directives: Importance of Communication Skills at the End of Life” (2005) 294 JAMA 359 at 364.

⁸⁹ Unless we are considering the instance of a contemplated death such as a terminal illness.

impractical as they are unfortunately subject to misinterpretation, exaggeration, or understatement dependent on the applicant for posthumous conception.

B Reproduction and Death

Ordinarily, in the living sense, reproduction is valued due to its genetic and nurturing experience. Among the reasons people choose to procreate during their lifetime are:⁹⁰ the participation in the creation of a new life, affirming mutual love, and providing personal and valued experiences.⁹¹ Moreover, the role of the father involves the ability to nurture, love and influence the development of a child. Fatherhood is ordinarily seen as much more than just a donor of genetic material. Where reproduction is planned, occurring autonomously, that choice will be reflecting deeply embedded critical and experiential interests, meaning such choice for an individual is solemn. If conception alternatively, is unexpected, those interests may not carry the same effect or be fulfilled in the same way.

Posthumous reproduction prevents the very elements that make being a parent extraordinary. Let alone a posthumous parent being unaware of their child's existence, they will never be able to nurture, love and influence the development of that child. It, therefore, becomes clear that the experiential interest of becoming a parent does not extend beyond death. The critical interest in fatherhood does, however. As discussed in Chapter II, an interest in procreation is not limited to the physical experience of having a child, it extends, and importantly to whether procreation contributes to the individual's morals, values, and desires by which they have chosen to live their life by. The survival of that interest is rooted in the claim that an individual can have critical interests in post-mortem events as these events may influence or complete development of the self.

C Consent and the Subject Matter

The spectrum of consent, in order of most restrictive to most permissive, consists of:⁹²

- (a) Explicit consent
 - (i) Written
 - (ii) Verbal
- (b) Inferred consent

⁹⁰ Katheryn D. Katz "Parenthood from the Grave: Protocols for Retrieving and Utilizing Gametes from the Dead or Dying" (2006) 2006 University of Chicago Legal Forum 289 at 305.

⁹¹ Alison Douglass, above n 3, at 20.

⁹² Not a universal spectrum of consent, rather for the purposes of this dissertation.

- (c) Presumed consent
- (d) No consent

It is not an easy task to anatomize these distinct hierarchies of consent. It proves difficult because of the large ambiguity as to *what* an individual is required to consent. A puzzling question that must be adhered to is whether the legal test for a concession of posthumous reproduction requires consent to parenthood *generally* or *posthumous* parenthood. The answer initially seems obvious but it is far from it. The desire to be a parent (whilst living) cannot be transmuted to mean that individual desired or wished to be a posthumous parent. A loving and personable relationship with a child cannot ever be achieved posthumously as the physical element that postulates the relationship in the first place is absent. Because my thesis prioritises the individual autonomy of the deceased I would argue that philosophically it is most appropriate that the deceased were held to an interest of *posthumous* parenthood; this would negate ethical uncertainty and uphold the deceased's critical interests absolutely. It would be a much simpler task to infer consent of the want to be a parent during the individual's life but it is ethically questionable whether this is appropriate. The large discrepancy between parenthood during life and parenthood after death creates a difficult manoeuvre when addressing what level of consent is required for posthumous reproduction. Throughout my analysis, I will discuss the two divergent subject matters interchangeably with respect to the relevant models of consent. There will inevitably be both problems and weaknesses no matter which I choose to later propose.

III Explicit Consent

Explicit consent is a form that is used in many legal realms, most commonly in the criminal and medical domain.⁹³ Explicit consent generally encompasses consent that is clearly articulated either in writing or orally. Provision of explicit consent by an individual affords certainty in the protection of their autonomy and respective interests. The question is whether that consent would hold a similar effect after death. Under Dworkin's model, consent is equally important during our lives as it is after our death; the reasons for respecting consent stay the same.⁹⁴ That is because our critical interests live on. This accords the view that death cannot simply be an 'off

⁹³ See for example, Health and Disability Commissioner Act 1994, s 2; The Code of Health and Disability Consumers Rights 1996, right 5, 6, 7; Bill of Rights Act 1990, ss 10 and 11; Human Tissue Act 2008; Contraception, Sterilisation, and Abortion Act 1977, s7; Crimes Act 1961, ss 128A, 116.

⁹⁴ See generally Ronald Dworkin, "Autonomy and the Demented Self", above n 48.

switch’, meaning, the values and interests by which an individual lives their life cannot be easily dismissed after their death.⁹⁵

A A Place for IVF?

Due to the urgent circumstances that demands for posthumous reproduction often arises, explicit consent to *posthumous* parenthood is unlikely to ever be present. It is not eliminated wholly from the equation, however, most certainly serving an imperative role in IVF clinics as well as being conceivable in patients with terminal illnesses. The formalities that are mandatory in compiling gametes for the purposes of IVF instantaneously make provision for the consent of posthumous parenthood. For example, our Guidelines require IVF clinics to provide options on their consent forms for what should happen to the stored sperm in the event of the death of the sperm provider.⁹⁶ The deceased is then given the opportunity to make their post-mortem procreative interests enforceable. *Bazley v Wesley Monash IVF Pty Ltd*⁹⁷ is an illustration of the interplay with explicit consent and IVF. Mr. Bazley had his sperm stored after a diagnosis of liver cancer with the intention to have more children. Unfortunately, Mr. Bazley’s consent form stated that Wesley Monash IVF’s policy requires a written and witnessed directive from the patient regarding the future use of stored semen, which Mr. Bazley did not read, and never made. Because that directive was never made the clinic was required to destroy the sperm in line with the NHMRC ethical guidelines after his death.⁹⁸ I have chosen to not assess consent in the IVF context as it warrants a different analysis. I will, however, continue to assess explicit consents applicability in the case of sudden death for the purposes of the framework. The possibility is not futile.

B Written Explicit Consent

The only way to ensure posthumous reproduction is wholly consistent with the desires of the dead or incompetent man is to require that his consent is in writing. In this sense, the function of explicit written consent can be analogised to a written will.⁹⁹ A will concerns the disposition of our property affairs after death and a consent form concerns disposition of our bodies after death.

⁹⁵ Sheelagh McGuinness (2008) “Respecting the living means respecting the dead too” 28 Oxford Journal of Legal Studies 297 at 305.

⁹⁶ *Guidelines for the Storage, Use, and Disposal of Sperm from a Deceased Man (February 2000)* Prepared by the National Ethics Committee on Assisted Human Reproduction (NEACHR) at 2.2.

⁹⁷ *Bazley v Wesley Monash IVF Pty Ltd* [2010] QSC 110.

⁹⁸ For completeness, the guidelines that were relevant to Mr. Bazley’s stored sperm at the time were the National Health and Medical Research Council *Ethical guidelines on the use of assisted reproductive technology in clinical practice and research September 2004 (Revised 2007)* at s 8.4.

⁹⁹ Rebecca Dresser, above n 69, at 435.

We respect wishes as to the nomination of property and distribution of capital heavily,¹⁰⁰ thus, the use of a written consent form in posthumous reproduction could achieve the same thing. For post-mortem wishes concerning the body surely carry a higher importance as they are directly connected to a person's identity; property affairs are merely materialistic.

First, in terms of posthumous parenthood, a written directive would necessitate transcription overtly outlining the decedent's willingness to have the specific procedure (posthumous use of his sperm) in the specific circumstances (after death). By obtaining this precise information there is little to no risk in acting against the deceased's wishes or interests. Conversely, regarding parenthood generally, a written directive would require hard, unambiguous evidence such as a letter or note to a concerned party indicating that they want to be a father. Likewise, provision for 'any future children' in a deceased's will would too, be sufficient.

C Oral Explicit Consent

Recognition of a patient's current statement is the utmost certainty that a medical practitioner, or any person for that matter, in any context, will receive. It best reflects an individual's autonomous decision making and there is no element of doubt.¹⁰¹ The interference of incapacitation or death, however, means that it is virtually impossible to use a patient's current statement as consent. This becomes clear when we consider the example of an individual consenting to (or refusing) sexual intercourse; both people are physically and mentally present. There is though the possibility that immediately prior to or near death or incapacitation, the individual conveyed consent. This is a report of their previously stated wishes, i.e., oral consent. It may be just as appropriate to deem oral consent as satisfactory as written consent. For example, the man may not feel that promises he makes to his spouse or significant other need be in writing.¹⁰²

Oral consent is not a form of consent that has been discussed in considerable depth in posthumous reproduction literature. I believe this is due to two reasons. The first is the practicality issue. The likelihood of someone verbally deliberating posthumous parenthood, let alone, death, is slim. Because death is a taboo and awkward subject, people do not often express their wishes as to their affairs after death vocally. The second reason is that measuring the

¹⁰⁰ See generally, the Wills Act 2007.

¹⁰¹ That is following the integrity view of autonomy and not questioning the patient's best interests.

¹⁰² Browne Lewis *The Ethical and Legal Consequences of Posthumous Reproduction: Arrogance, Avarice and Anguish* (Routledge, New York, 2017) at 18.

accuracy and truthfulness of evidence of oral consent will always be difficult. Oral consent can only be taken at face value, meaning there will always be the uncertainty as to whether the deceased really did say the alleged. Moreover, the parties involved will typically have a conflicting interest. Perhaps if more than one party evidenced to the oral consent courts and the public at large would be complacent.

First, oral consent to *posthumous* parenthood would operate in a similar manner to written consent. To be functional in the event of an unexpected death, meeting this standard would require an earlier statement by the deceased to the like of “I consent to the use of my sperm to conceive a child after my death”. If we were rather to accept oral consent of a deceased’s wish to parenthood *generally* it would be as simple as the deceased explicitly stating they want to have children. For instance, “I want to be a dad”. This is distinct assent to fatherhood rather than a mere wish.

D Summary

Rejection of the need for explicit consent in this context is logical in consideration of the level of autonomy we are seeking to preserve. Explicit consent is practically problematic as it does not follow from the respect of autonomy in posthumous reproduction. As concluded in Chapter II, a dead person does not continue as an entire autonomous being after the event of death. Because full autonomy no longer exists, full protection, in turn, need not exist. I have provided examples of how both written and oral explicit consent would operate in posthumous reproduction. Those examples afford outright autonomy which is not philosophically attractive in this context. Procreative autonomy, as a critical interest is a surviving element that consent will be upholding and therefore we require a legal standard to reflect that. Of course, if explicit consent were available, it would be more than sufficient. The default standard, however, need not be this strict.

IV Inferred Consent

Inferred consent is a middle ground on the spectrum outlined in the preliminary of this chapter and is often described as a ‘hybrid’ approach to consent.¹⁰³ Compromise for inferred consent is generally made for two reasons. First, the formal requirements of explicit consent are impractical. Secondly, the prevailing view is that there must be at least some form of affirmative evidence that the deceased wanted to procreate after death for posthumous reproduction to be ethically

¹⁰³ Katheryn D. Katz, above n 90, at 304.

permissible.¹⁰⁴ The permissive approach, a presumption in favour of consent does not support this. This debate, therefore, warrants an intermediate position. This position would permit the posthumous use of sperm on the reasonably inferred consent of the deceased.

This approach encapsulates that in the absence of explicit consent it is unfair to place an onus on individuals to state their opposition to posthumous reproduction. Thus, an opt-in system where the default position is that the deceased has refused posthumous reproduction functions justly. As a result, this approach recognises that some affirmative evidence of the deceased's intentions is needed to displace that presumption. This will generally be executed by the surviving partner or family grasping at circumstantial evidence. This evidence commonly includes conduct or words spoken by the deceased prior to incapacitation or death. Alternatively, or conjointly, a focus may be directed on the deceased's values and general style that they lived their life by.

A model of inferring consent continues to be favourable on the acceptance that critical interests persist beyond death. Unavoidably, under this model, there will be a struggle to give complete respect to the existing autonomy, wishes and critical interests of the deceased. This model, however, does its best to respect patient autonomy whereby the relevant person or body can make decisions in accordance with the reasonably inferred wishes of the patient. This may be the best alternative in disastrous circumstances.

I question whether evidence to infer *posthumous* parenthood will ever be practically achievable. Our very social construct of death has an enormous bearing over mortality discussions. They rarely occur, meaning friends and families, more often than desired, must make inferences as to the wishes of their loved ones in post-mortem events. Protecting procreative autonomy would warrant somewhat clear and convincing evidence as to whether the deceased wanted this procedure. Ethically, this would require exposure to factors that infer the state of mind of posthumous parenthood. To my mind, I cannot think of any contextual factors that would be available to make an inference to achieve that other than rare circumstances such as IVF for example. Although it is philosophically appropriate to make an inference to a posthumous state of mind, it is simply impractical. The closest thing accessible is an inference to parenthood generally, and perhaps that must be accepted as a second-best option in the absence of morbid conversations.

¹⁰⁴ Ibid.

A transparent example of making an inference of consent to parenthood *generally*, on the other hand, would be if a couple was actively attempting to conceive a child, evidenced through the removal of contraception. Similarly, if a couple had discussions about IVF or engaged in preliminary appointments. In those cases, the presumption of non-consent *may* be displaced. In the absence of any words or actions, evidence could be scraped from the values by which the deceased lived his life. This typically would involve retrieving information from the deceased's family and friends, most importantly, the deceased's former partner, on the nature and character of the deceased's lifestyle to determine whether parenthood is something the deceased would have wanted. This still has a bearing on upholding and reflecting the deceased's critical interests to a limited extent.

A Factorial Considerations

If a model of inferring consent to parenthood *generally* were to be employed, there will inevitably be various social, moral and ethical factors required to be brought forward as evidence to make an inference of the deceased's state of mind to constitute consent. It is likely that these factors would be subject to a high threshold to best meet the possible desire of the deceased to *posthumous* parenthood.

The grounds are open to a multitude of diverse factors. No reasonable person could contemplate or encompass all potential dynamics that may be influential on an individual's evidential consent. Here I have selected a few of those most commonly raised,¹⁰⁵ or are likely to be contemplated. These factors will be indicative (or not) as to the deceased's willingness, intention and acquiescence to procreation. These factors include:¹⁰⁶

- (a) Plans for childbearing
- (b) Parental status
- (c) The type of death
- (d) Relationship status

¹⁰⁵ See *Re Creswell*, above n 6; *Re Lee*, above n 9; *Re Bazley*, above n 97. A contrast between *Re Creswell* and *Re Lee* can be made as to relationship status.

¹⁰⁶ Jason D Hans "Attitudes Toward Posthumous Harvesting and Reproduction" (2008) 32 *Death Studies* 837 at 846.

(a) Plans for childbearing

Evidently, plans for childbearing will be naturally conclusive of a desire to be a parent. Evidence that the couple planned to have a child together at some point soon would be vital in an application for posthumous reproduction.¹⁰⁷ In the absence of explicit consent by the deceased, it has often been asserted that intent can be implied by the fact that most people who are in serious, committed relationships want to reproduce with their partner.¹⁰⁸ If there are no plans for childbearing, it is highly doubtful that an inference could ever be made.

(b) Parental status

Prior parent status of the deceased raises several factors. First and foremost, if the deceased were already a parent, it is manifestly conclusive that the deceased wanted to be a parent.¹⁰⁹ Secondly, and contrarily, if there is an existing child, the frequently made argument of satisfaction of genetic lineage in procreation has already been fulfilled.¹¹⁰ I disregard this idea, as there are more important reasons that an individual chooses to become a parent than genetics, such as providing for their existing child with a sibling.¹¹¹ The fact that a deceased did not have a child prior to death does not result in the intention to never procreate, of course, it just lacks assurance.

(c) The type of death

If death were anticipated, perhaps it would be more reasonable to deny requests in the absence of explicit consent. When death is imminent, there is a reasonable expectation that the deceased would have made clear any post-mortem wishes; we can infer silence on the matter eludes a lack of desire to procreate. If death is unexpected, especially in younger individuals, it is not reasonable to rule silence as a lack of procreative desire.

(d) Relationship status

On the one hand, the prior relationship status of the deceased is unlikely to have a bearing on whether the deceased wanted to procreate or not, rather, it will impact ascertainment of *whom* they wanted to procreate with. If we accept that procreation is a critical interest, that interest will exist no matter whether the individual fulfils it or not. Traditionally, and in many religions, the

¹⁰⁷ See *Re Cresswell*, above n 6, at 181.

¹⁰⁸ Jason D Hans, above n 106 at 848.

¹⁰⁹ Dependent on the fact that the child prior to death was conceived and brought into this world autonomously.

¹¹⁰ See Shelly Simana “Creating life after death: should posthumous reproduction be legally permissible without the deceased’s prior consent?” (2018) 5 *Journal of Law and the Biosciences* 329 at 341-45.

¹¹¹ See *Re Lee*, above n 9.

very purpose of marriage is to procreate. In a reflection of modern New Zealand society and statutes, however,¹¹² an unmarried, de facto partner would not render the likelihood of an intention to procreate than those in a legal partnership. The relationship length, on the other hand, may be more influential in uncovering a deceased's desire to procreate with a certain person - the surviving partner applying for use. If an individual does hold a desire to procreate, it will be more convincing in circumstances of a long-term than a short-term relationship. For example, a 10-year de facto relationship in comparison to a 6-month relationship would carry more weight when determining *whom* the deceased wanted to procreate with. This is because it is presumptuous that the longer the relationship, the more serious and therefore likely contemplation of parenthood is.

V Presumed Consent

Further along the permissive end of the spectrum, there is the displaceable presumption in favour of consent. Under this model, posthumous reproduction should be allowed unless the decedent had explicitly refused to allow sperm retrieval and use, or where there is no reasonable evidence that the deceased person desired children. There need be no distinction between general parenthood and posthumous parenthood under this model. For if there is an opposition to posthumous parenthood, that objection would continue beyond death. There is the option of a deceased wanting to be a mere sperm donor rather than a 'father'. I ethically do not think that falls in line with the whole purpose of posthumous reproduction and is something I will not concern myself with. Even if there were available evidence to displace this presumption, I do not think it warrants a role in posthumous reproduction whatsoever. There is a critical interest at play which should be respected. For that reason, there should never be a presumption against it that needs to be overcome.

VI No Consent

I disagree with the pursuit of medical procedures, or any matter entirely without at least attempting to gather some form of consent from an individual.¹¹³ In general, failing to recognise that consent is important fails to recognise that we are autonomous beings. A provision of no consent specifically for posthumous reproduction, therefore, must afford the view that consent simply does not exist in a dead person. In the context of organ donation, Harris argues that

¹¹² See for example, the Property (Relationships) Act 1976, s 2D.

¹¹³ Whether that consent be explicit, inferred, or proxy.

because there is no consent in the dead, organs should, therefore, be automatically available.¹¹⁴ This transmuted to posthumous reproduction would hold that gametes are to be automatically available for retrieval and use after death, affording deceased persons' nil autonomy. To allow automatic access to the body, whether it be organs, tissue or gametes, no weight is given to the deceased's interests and autonomous choice; ruling that dead person as no longer being autonomous nor worthy of continuity of interests. This is likely an unfavourable view for many living, autonomous beings. To hear that when you die your interests or control over your body will be completely disregarded, is distressing. For those reasons, I expectantly reject the use of this model.

VII Summary

This chapter has identified an ethical dilemma and considered how we might respond to this dilemma. Whilst consensual evidence under the explicit model and a displaceable presumption in favour of consent model would likely require *posthumous* parenthood intentions, it is indeterminate for inferred consent. Based on my analysis in Chapter II it is crucial to ensure that a deceased's reproductive autonomy and subsequently, critical interests be endorsed in a case for posthumous reproduction. The restrictive model, explicit consent, whether written or spoken, triumphs this. As repeated amid this chapter, that ethically viable model is unworkable in emergency circumstances. Additionally, I find both the two models on the liberal end of the spectrum wholly dishonourable to an individual's autonomy. On the model of a presumption of consent, given that both posthumous retrieval and use of sperm is not the common procedure to which a dead body is subject to, it seems utterly unreasonable to say that an individual's silence on the matter results in consent.¹¹⁵ Similarly, a provision of 'no consent' should never be considered nor endorsed.

For these reasons, it leads me to the conclusion that an application of inferred consent would impartially reflect autonomous decisions on procreation, yet most importantly, uphold the decedent's critical interests. Accepting this model also appreciates the rational movement not only in New Zealand but in assisted reproductive technologies too. Consensus on this point, however, is unlikely to ever be definitive due to the differing philosophical reasons and contextual

¹¹⁴ John Harris "Organ procurement: dead interests, living needs" (2003) 10 J Med Ethics 130 at 131.

¹¹⁵ Anne Reichman Schiff "Arising from the Dead: Challenges of Posthumous Procreation" (1997) 75 N.C.L Rev. 901 at 946.

circumstances that may arise. Therefore, we need a set of guidelines that increases awareness and provides a convenient and straightforward consent mechanism.

CHAPTER IV: JURISDICTIONAL ANALYSIS AND REFORM

I Introduction

The regulatory framework of posthumous reproduction varies across countries. Some countries such as Germany and France ban the practice in whole.¹¹⁶ Contrarily, certain countries allow it with specific limitations or have no regulatory framework at all. Reasons for variance between different jurisdictions can often be explained by the well-founded public views, cultural history and political values that influence respect for autonomy in deceased persons.¹¹⁷ This chapter traces the regulatory frameworks of the United Kingdom, Australia, and Israel. I exclusively use these three jurisdictions as they illustrate the primary three points on the consent spectrum. The United Kingdom functions restrictively, requiring explicit written consent, Australia's guidelines offer an inference of consent, and Israel's guidelines provide an enforceable example of presumed consent. Through breaking down the frameworks of these jurisdictions it becomes clear how the distinctive requirements of consent can vary the level of autonomy given to an individual in a regulatory context. In turn, I will use these jurisdictional frameworks, primarily Australia, to influence my proposal of new guidelines for the posthumous use of sperm in New Zealand. My preceding ethical and philosophical discussion, that an extent of autonomy presides after death, will guide this.

II The United Kingdom

A Diane Blood

The issues around posthumous reproduction in the United Kingdom came to light in 1996. Diane Blood was refused by The Human Fertilisation and Embryology Authority to conceive using her deceased husband's stored sperm.¹¹⁸ This refusal was on the grounds that Mrs. Blood had no written consent from Mr. Blood to neither the posthumous storage nor use of his sperm, as the then Act required.¹¹⁹ The Authority's decision was strongly upheld by both the High Court and Court of Appeal.¹²⁰ In the end, however, the Court of Appeal gave Mrs. Blood permission

¹¹⁶ Elodi Pajot and Others "Mapping French people's views regarding posthumous reproduction" (2017) 35 *Journal of Reproductive and Infant Psychology* 524 at 526.

¹¹⁷ Shelly Simana, above n 110, at 331.

¹¹⁸ As established under the Human Fertilisation and Embryology Act 1990.

¹¹⁹ Human Fertilisation and Embryology Act 1990.

¹²⁰ *R v Human Fertilisation and Embryology Authority, ex p Blood* [1996] 3 WLR 1176; *R v Human Fertilisation and Embryology Authority, ex p Blood* [1997] 2 WLR 896 (CA).

to have Mr. Blood's sperm transferred to Belgium to enable her to have the treatment she desired, recognising her European Community law right to receive treatment in another state.¹²¹ As depicted in Blood's case, the law on the posthumous use of sperm in the United Kingdom is firstly clearer than New Zealand, but also a lot stricter; stating that 'a person's gametes must not be used for the purposes of treatment services unless there is an effective consent by that person'.¹²²

B The Human Fertilisation and Embryology Legislation

Both IVF and assisted reproduction, in general, are regulated under the Human Fertilisation and Embryology Act 2008 following amendment of the Human Fertilisation and Embryology Act 1990 ("HFEA legislation")¹²³ The HFEA legislation does not explicitly include the collection of gametes, rather it concerns preservation, storage, use and disposal of gametes and embryos.¹²⁴ The notion of consent is fundamental in the HFEA legislation, requiring written consent in those areas.¹²⁵

Regulation over the use of the gametes is unambiguous under the HFEA legislation. Schedule 3 requires that consent is given in writing, to be signed by that person giving consent, and consent must not be withdrawn.¹²⁶ Furthermore, consent must specify the purposes for which the embryos and/or gametes are to be used and what is to be done to them if the provider dies or loses the capacity to vary or withdraw such consent.¹²⁷ By the provider receiving proper information and an opportunity to obtain counselling about the implications of their choice, this is fulfilled.¹²⁸ This information must also include the options of varying the terms of consent or withdrawal up until the time the embryo is used.¹²⁹

¹²¹ *R v Human Fertilisation and Embryology Authority, ex p Blood* [1997] 2 WLR 896 (CA) at 698.

¹²² Human Fertilisation and Embryology Act 1990, sch 3.

¹²³ Human Fertilisation and Embryology Act 2008 amended the Human Fertilisation and Embryology Act 1990. Principally the Act remains the same, amendments to sch 3 do not affect the analysis for these purposes. I refer to both the 1990 and 2008 Acts collectively as 'legislation' as they are both still in force and I use the Acts interchangeably.

¹²⁴ Nicola Peart, above n 22, at 744.

¹²⁵ Human Fertilisation and Embryology Act 1990, sch 3.

¹²⁶ Human Fertilisation and Embryology Act 2008, sch 3.

¹²⁷ Human Fertilisation and Embryology Act 2008, s 39(1)(c). Formerly the Human Fertilisation and Embryology Act 1990, s12 (1)(c) and sch 3 required that written consent had not been withdrawn to the storage and use of gametes. That was the law which applied in *R v Human Fertilisation and Embryology Authority, ex p Blood* [1997] 2 WLR 896 (CA).

¹²⁸ Human Fertilisation and Embryology Act 1990, sch 3, para 3.

¹²⁹ Paragraph 4.

These provisions make it clear that the posthumous use of gametes without the deceased's specific consent is prohibited in the United Kingdom. With these tight restrictions, it is distinguished that the HFEA legislation would not allow the use of verbal consent to suffice for consent, let alone an implication based on words, conduct or values of the deceased.¹³⁰ This statutory regime is therefore unlikely to be met in sudden or unexpected death. Posthumous reproduction in the United Kingdom seems to cater rather for instances of IVF and terminal illnesses where retrieval has been made prior to death.

The HFEA legislation upholds the full autonomy of a deceased person, ensuring that consent is given in its fullest form before the use of sperm is lawful. The HFEA legislation provides a parallel threshold in protecting the right to autonomy in a dead person to a living. However, as discussed in Chapter III, philosophically we do not require this amount of protection as it is only one thread of autonomy that survives beyond death, namely, critical interests. In the case of posthumous reproduction, it is the procreative interest demanding protection. It is not to say that the HFEA legislation would be entirely unworkable in New Zealand, it is rather viable to accept a model of consent that better correlates with the level of autonomy we are trying to preserve and reflects the unforeseen circumstances that posthumous reproduction occurs in.

III Australia

The emergence of *Re Cresswell* exemplifies that cases of posthumous reproduction are presently active in Australia.¹³¹ Because Australia is a federal country, assisted reproduction depends on each independent state's jurisdiction;¹³² it is not governed wholly like the United Kingdom. Because of the complexity of federalism, I will not go into detail on the legal position in each separate state of Australia. I will rather highlight the guidelines which are applicable throughout Australia.¹³³ These non-mandatory guidelines are usually departed from by the courts in favour of state legislation, however, they remain valuable in reflecting an intermediate position of consent for the purposes of this dissertation.

¹³⁰ Nicola Peart, above n 22, at 746.

¹³¹ See *Re Cresswell*, above n 6.

¹³² New South Wales, Victoria, Western Australia and South Australia have legislation in relation to assisted reproduction. The Australian Capital Territory, Queensland, and Tasmania do not have assisted reproductive legislation, and the Northern Territory follows South Australia's legislation.

¹³³ National Health and Medical Research Council *Ethical guidelines on the use of assisted reproductive technology in clinical practice and research (2017)*.

All fertility clinics in Australia must adhere to the communal National Health and Medical Research Council's Ethical Guidelines ("NHMRC Guidelines") whilst also complying to any statutory regime in place.¹³⁴ The first of these guidelines were implemented in 1996, labelled 'Ethical Guidelines on Assisted Reproductive Technology'.¹³⁵ These have since been subject to revision and development.¹³⁶ The NHMRC Guidelines can work contradictorily to some of the state-imposed legislation; they are substantially more generous. For retrieval of sperm under the NHMRC Guidelines, the request must come from the spouse or partner of the deceased, the intention of retrieval must be for posthumous reproduction, and there need be evidence that the dying or deceased person *would* have supported the posthumous use of their gametes by their surviving partner.¹³⁷ If not, there must at least be no evidence that the deceased had previously expressed opposition to the procedure.¹³⁸ Use of posthumously retrieved sperm is dealt with disjointedly.

No matter the level of consensual evidence available, the NHMRC Guidelines require that sufficient time has passed before conception or pregnancy.¹³⁹ This reflects the necessary time needed to make informed decisions without the interference of stricken grief and emotions. Thus, the spouse or partner seeking to use the sperm must be provided with adequate information to understand the potential psychological, social and health implications to both herself and the child to be born. This is to be supplemented by counselling and an independent body must be satisfied considering all these circumstances, that the individual can use.¹⁴⁰

The certainty of consent for use is presented as a hierarchy. First, if the deceased has left clearly expressed directions consenting to the use; the request has been made by a spouse or partner for their exclusive use; and the sufficient time passage requirements have been met, posthumous use

¹³⁴ If state laws conflict with the NHMRC Guidelines then the state law takes precedence. Thus, they are particularly important for those jurisdictions that have no legislative provision of their own such as Australian Capital Territory, Queensland, and Tasmania.

¹³⁵ See National Health and Medical Research Council *Ethical Guidelines on Assisted Reproductive Technology 1996*.

¹³⁶ National Health and Medical Research Council *Ethical guidelines on assisted reproductive technology in clinical practice and research (2004)*; *Ethical guidelines on assisted reproductive technology in clinical practice and research (2004) (revised 2007)*; *Ethical guidelines on assisted reproductive technology in clinical practice and research (2017)*.

¹³⁷ National Health and Medical Research Council *Ethical guidelines on the use of assisted reproductive technology in clinical practice and research (2017)* at 8.22.3.

¹³⁸ At 8.21.1.

¹³⁹ At 8.23.

¹⁴⁰ At 8.23.1.

of stored sperm may be used by clinics to achieve pregnancy.¹⁴¹ The NHMRC Guidelines do not stop there, however. First, they rightfully consider that if there is a clear objection to the posthumous use of sperm, that must be respected.¹⁴² They continue, that in the absence of clearly expressed directions, posthumous use will still be achievable if there is some evidence to indicate that the deceased person *would* have supported the *posthumous* use of their gametes by their surviving partner. If that is unachievable, authorization can be made if there is no evidence as to objection by the deceased.¹⁴³

The NHMRC Guidelines encompass three levels of consent discussed in the preceding chapter; explicit in written form, inferred, and presumed consent. For the purposes of this dissertation, they importantly epitomise the intermediary position of inferred consent where the posthumous use of sperm is permitted if there is some evidence indicating support by the deceased.¹⁴⁴ I concluded in Chapter III that acceptance of inferred consent is philosophically plausible in the context of posthumous reproduction because although the deceased is not a fully autonomous being, their procreative autonomy continues in existence and requires more protection than a model of presumed consent. This set of guidelines will, therefore, have a large influence over my proposed guidelines for New Zealand. It is important to note that the NHMRC Guidelines, in inferring consent, require evidence to *posthumous* use, something I earlier deemed desirable but unrealistic in the circumstances. The NHMRC Guidelines do, however, realise that if such evidence is unachievable the evidential threshold can be lowered to presumed consent. Rather than lessening the value of autonomy of the deceased I choose to accept the best alternative of evidence of a state of mind of parenthood.

IV Israel

Israel functions under a permissive approach in favour of the posthumous use of gametes whereby it does not currently have any specific legislative direction, creating large legal uncertainty on the issue. The guidelines that Israel do have provide an illustrative example as to how a model of presumed consent functions in affording a deceased person little to no recognition or protection of autonomy.

¹⁴¹ At 8.22.1.

¹⁴² At 8.22.2.

¹⁴³ At 8.22.3.

¹⁴⁴ At 8.22.3 'where the deceased person has not left clearly express directions regarding the posthumous use of their stored gametes or embryos, where permitted by law, clinics may facilitate the posthumous use of stored gametes or embryos to achieve pregnancy, if: ... there is some evidence that the dying or deceased person would have supported the posthumous use of their gametes by the surviving partner...'

In 2003, non-obligatory guidelines were imposed by the presiding Israeli Attorney General outlining the legal position of posthumous sperm retrieval (“IAG Guidelines”).¹⁴⁵ The decision to create The IAG Guidelines and subsequently allow the procedure was in response to the increasing number of applications for retrieval of sperm by the deceased’s surviving partners and parents.¹⁴⁶ The IAG Guidelines are specific to who can make an application, that being a partner or spouse, where all other family members of the donor will be denied¹⁴⁷. Notwithstanding this, reportedly the courts in Israel have still been willing to grant parents’ permission to the posthumous retrieval and use of their deceased’s son’s gametes.¹⁴⁸ This, of course, raises further ethical issues as it requires the cooperation of another woman to engage in a surrogacy arrangement.

The use of sperm retrieved is determined on a case by case manner, however, in reality, the procedure will be performed with or without consent. The evaluation to be carried out by the court is based on the effect on the presumed wishes of the donor and the effect of the procedure on the donor’s dignity.¹⁴⁹ Meaning, if not otherwise indicated or objected, it can be presumed that the deceased would have wanted his partner to have his child. In other words, there is a presumption in favour of consent. This operates on the assumption that couples who live together (whether married or not) naturally and customarily intend to have children at some point in the future; that the deceased would have wished for his partner to still have those children despite the interference of death.¹⁵⁰ This assumption is based on the cultural and social fabric in Israel.

Israel’s regulation around posthumous reproduction provides the benefit of exemplifying an entirely contrasting ethical position to what is administered in the United Kingdom; a model of presumed consent. There is no requirement for the implementing body to make any attempt in obtaining evidence of the deceased’s prior choices or wishes, giving little, if any worth to the

¹⁴⁵ The Attorney General’s Directives to the Government (Directives 1.2202) *Posthumous Sperm Retrieval and Use* (27.10.2003).

¹⁴⁶ R Landau “Posthumous sperm retrieval for the purpose of later insemination or IVF in Israel: an ethical and psychosocial critique” (2004) 19 Hum Reprod 1952 at 1952.

¹⁴⁷ Yael Hashiloni-Dolev “Posthumous Reproduction (PHR) In Israel: Policy Rationales Versus Lay People’s Concerns, a Preliminary Study” (2015) 39 Cult Med Psychiatry 634 at 637.

¹⁴⁸ Shelly Simana, above n 110 at 338.

¹⁴⁹ Yael Hashiloni-Dolev and Silke Schicktanz “A cross-cultural analysis of posthumous reproduction: The significance of the gender and margins-of-life perspectives” (2017) 21 at 25.

¹⁵⁰ Vardit Ravitsky “Posthumous Reproduction Guidelines in Israel” (2004) 34 The Hastings Centre Report 6 at 6.

deceased's autonomy. Only if there is evidence of objection is a deceased's autonomy relatively acknowledged. As a result, a deceased's person's critical interests around procreation are neglected. The motive behind Israel's concept of individual consent and autonomy appears to be the ingrained cultural and political circumstances, particularly pronatalism.¹⁵¹ It is understood that Israel's liberalism is contingent on the underlying core assumptions of the Jewish tradition that most individuals desire to have offspring to ensure their legacy. This correlates with the biblical commandment to be 'fruitful and multiply'.¹⁵² Additionally, Israel has a well-established militaristic social construct which is central to posthumous reproduction. The procedure is relevant for many partners and parents of soldiers who died whilst serving for the Israeli Defence Forces.¹⁵³

V Where to for New Zealand?

This dissertation has traced two spectrums: one of autonomy and one of consent. In this chapter, I have provided international jurisdictional examples of how those two spectrums can be morphed in practice. Consideration of the regulations in the United Kingdom, Australia, and Israel provide an insight into what New Zealand's legal position could look like dependent on the level of consent chosen to (or not to) protect the deceased's right to autonomy. New Zealand must develop its own response to the regulation of posthumous reproduction. This will be influenced by contemporary societal and cultural values amongst the nation. ACART's recent consultation will expectantly assist in ascertaining these views.¹⁵⁴ In this dissertation, I have made rejections equally to the model of explicit consent, a presumption in favour of consent, and no consent, for different reasons. These models may be demanding in other disciplines, however, for the purposes of posthumous reproduction they fail to adequately protect the on-going autonomy of the deceased and reflect the social circumstances. If the focus is to protect continuing elements in the autonomy of the deceased, namely, critical interests, a model of inferred consent will best achieve that. In Chapter III I addressed the unsolvable contrast between accepting evidence towards a desire to be a parent *during* one's life and evidence towards a desire to be a parent *after* one's life when making an inference to consent for posthumous reproduction. Making an inference to the deceased's desire to be a posthumous parent would

¹⁵¹ See Vardit Ravitsky and Ya'arit Bokek-Cohen "Life After Death: The Israeli Approach to Posthumous Reproduction" in *Bioethics and Biopolitics in Israel: Socio-legal, Political and Empirical Analysis* (Cambridge University Press, Cambridge, 2018) 202 at 202.

¹⁵² Shelly Simana, above n 110, at 331.

¹⁵³ See Vardit Ravitsky and Ya'arit Bokek-Cohen, above n 151, at 202.

¹⁵⁴ See Advisory Committee on Assisted Reproductive Technology "Posthumous reproduction", above n 5.

best reflect an individual's interests. That is philosophically desirable, but our social context makes this practically unachievable at this stage. Because we don't talk about our deaths the next best option is to accept evidence of a desire to parenthood generally.

A Regulating Retrieval of Sperm

Due to the urgent nature of retrieving gametes in the instance of a newly deceased body, retrieval and use of sperm must sensibly be assessed in isolation. Heath J in *Re Lee* was of the opinion that there is a legislative gap in recognising the need to collect sperm from a corpse within a limited period of motility.¹⁵⁵ Thus, his Honour had to resort to the High Court's inherent jurisdiction to protect Mrs. Long's lawful right to apply to ECART for assisted use of the sperm.¹⁵⁶ "There is no realistic prospect that an Ethics Committee could be convened in every case where an application of the type made by Ms. Long was made on an urgent basis".¹⁵⁷ Regardless, this 'statutory gap' needs to be filled. This could be achieved by giving courts statutory authority under The HART Act to permit extraction in circumstances of a prima facie fruitful application to ECART for the later use of those gametes in question.¹⁵⁸ The posthumous collection of gametes would, therefore, be classified as an established procedure, performable without ethical approval from ECART.¹⁵⁹ Applications for the later use of that material, however, would remain in the category of assisted reproductive procedures, requiring ethical approval by ECART.¹⁶⁰

B Regulating Use of Sperm

I propose guidelines for the posthumous use of sperm in the case of a sudden incapacitation or death, aiming to replace a section of those policy options currently subject to review in the first ACART consultation document.¹⁶¹ The focus of reform is directed to the posthumous *use* of sperm rather than *retrieval* as it is the more ethically substantive question calling for legal answers. In this part, I will explain the purpose of some of the main elements I propose in my guidelines.

¹⁵⁵ *Re Lee*, above n 9, at [100].

¹⁵⁶ At [101].

¹⁵⁷ At [101] per Heath J.

¹⁵⁸ See Judicial Review Procedure Act 2016, s 15(1) 'at any time before the final determination of an application, the court may, on the application of a party, make an interim order of the kind specific in subsection (2) if, in its opinion, it is necessary to do so to preserve the position of the applicant'.

¹⁵⁹ Judicial Review Procedure Act, s 25.

¹⁶⁰ *Ibid.*

¹⁶¹ Advisory Committee on Assisted Reproductive Technology "Posthumous reproduction", above n 5, at 26.

1 Application and use by the surviving spouse or partner

In the absence of explicit consent otherwise, applications only from the deceased's surviving spouse or partner would be accepted. Requests from the individual's parents or other parties would not be entertained. This would mean that any resulting children would be akin to those who would have come about had the deceased lived.¹⁶² This restriction is in line both with the liberal guidelines in Israel and Australia where the deceased's female partner is the sole individual authorised to use the sperm and the deceased's parents are precluded from use.¹⁶³ Contemplation of posthumous reproduction to a partner is itself a strain. Inferring a desire to allow children to be born, for example, by an infertile sibling, cannot be inferred as easily and with reasonable certainty unless there are exceptional circumstances. It cannot be ignored that there is and will continue to be applications by the deceased's parents. Often these cases will concern a minor, or involve other ethically demanding factors out of the scope of this dissertation.¹⁶⁴

2 Express objection to be respected

The right to refuse medical treatment is fundamentally placed in the New Zealand Bill of Rights Act 1990 and The Code of Health and Disability Consumers Rights 1996.¹⁶⁵ If there is a refusal on behalf of the deceased prior to death, whether that is written, verbal or inferred, it should always be respected. If we choose to protect a deceased's autonomy to apply the treatment, we must equally be prepared to protect their refusals.

3 Explicit consent to be accepted

Although the dead body does not require full protection by the law to precedent autonomy, in the rare chance of a written directive or verbal consent to posthumous reproduction, that wish must be honoured. Difficulties may be encountered if the deceased explicitly consented for retrieval and use to be left in the hands of his family in the absence of a surviving partner or spouse. The different outcomes of explicit consent are widespread and cannot simply be contemplated in this paper. The focus of these proposed guidelines remains on an individual unexpectedly dying, leaving a significant other.

¹⁶² Advisory Committee on Assisted Reproductive Technology "Posthumous reproduction", above n 5, at 31.

¹⁶³ See the Attorney General's Directives to the Government (Directive 1.202) *Posthumous Sperm Retrieval and Use* (27.10.2003); the National Health and Medical Research Council *Ethical guidelines on the use of assisted reproductive technology in clinical practice and research* (2017) at 8.22.3.

¹⁶⁴ See Emily Ford and Jane Matthews "Cameron Duncan died of cancer at 17; 15 years later he could become a father" (8 July 2018) <<https://www.stuff.co.nz/national/health/105297367/talented-teen-filmmaker-cameron-duncan-died-of-cancer-at-17-15-years-later-he-could-become-a-father>>.

¹⁶⁵ See the New Zealand Bill of Rights Act 1990, s 11; the Code of Health and Disability Consumers Rights 1996, Right 7(7) 'every consumer has the right to refuse services and withdraw consent to services'.

4 *Inferring consent*

Discussion in favour of a model of inferred consent was outlined in Chapter III and the preliminary of this chapter. In the event of death, an individual's autonomy loses its full right to protection because parts of autonomy itself are lost. The claim that individuals have critical interests in determining how certain events, or their life wholly pans out rejects the notion that the dead are non-autonomous beings altogether. Requiring only a form of semi-consent from a deceased reflects that the individual has semi-autonomy. On the integrity account of autonomy, we emphasise the existence and priority of fulfilling those critical interests if they are made prior to their death as one would in a will; allowing individuals to control their life through dictating what will happen after their death.

Although not a complete assurance and protection of the deceased's autonomous decisions, wishes, and values, inferring consent of *parenthood* is a reasonable proxy. Evidence may be drawn from the deceased's prior words and conduct or those values that he lived his life by. To ascertain such, ECART may refer to socially common factors indicative of consent for parenthood. Collectively, the goal would be to use these factors to translate the wish of parenthood to one of *posthumous* parenthood. Although guidelines in both Australia and Israel allow for inferred consent to retrieve and use sperm posthumously, they fail to stipulate any guidance in how to embark that assessment. The threshold under the NHMRC Guidelines is particularly broad, merely requiring 'some evidence that the dying or deceased person would have consented'.¹⁶⁶ If New Zealand were to implement a model of inferred consent it would be necessary to provide a deeper level of guidance to ECART to ensure a level of consistency and certainty in each case.

5 *Stand-down period, adequate information, and counselling*

The purpose of a stand-down period before the use of sperm would allow time for the surviving spouse or partner to address the grieving process and to undertake counselling about posthumous reproduction. It is debatable as to how long that period should be for. I would suggest a year as that is generally considered as the initial period of psychological adjustment and bereavement after the loss of a loved one.¹⁶⁷ Counselling and informative sessions during this

¹⁶⁶ National Health and Medical Research Council *Ethical guidelines on the use of assisted reproductive technology in clinical practice and research (2017)* at 8.21.1.

¹⁶⁷ Jennifer A. Tash and Others "Postmortem Sperm Retrieval: The Effect of Instituting Guidelines" (2003) 170 *The Journal of Urology* 1922 at 1923.

period should include assessment of the psychological and mental health status of the woman, her financial position, conversations about the medical interventions needed to reach pregnancy, and the repercussions of raising a child alone without a genetic father.¹⁶⁸

6 Relevant bodies to make authorisations

Authorisation as to the collection of gametes and the use of gametes need be dealt with not only on separate occasions but too by separate bodies. The urgency of retrieval following a death will never be suitable for ECART review. The use of sperm is a much more ethically demanding process so must always, as an ‘assisted reproductive procedure’, be subject to ECART approval.¹⁶⁹

VI Proposed Guidelines: ‘The Use of Gametes from Persons who are Deceased or Incapacitated Prior to Death by a Surviving Spouse or Partner’

Principles of the Human Assisted Reproductive Technology Act 2004

1. When considering an application for the use of sperm collected during incapacitation or death of an individual, ECART must be guided by the principles of the Human Assisted Reproductive Technology Act 2004.¹⁷⁰

Express Directions

2. Where the deceased person has left clearly expressed directions that object to the posthumous use of their gametes, this must be respected in full.
3. Gametes may be used posthumously if the deceased has made an advance written directive or indicated verbally that he consents to the procedure.

Inferential Basis

4. In the absence of a written directive or verbal consent, reference can be made to evidence that the dying or dead person would have supported procreation with his surviving partner, including words, conduct, values, and wishes of the deceased. This may include:

¹⁶⁸ Ibid.

¹⁶⁹ Human Assisted Reproductive Technology Act 2004, ss 16, 18 and 19.

¹⁷⁰ Human Assisted Reproductive Technology Act 2004, s4; See Advisory Committee on Assisted Reproductive Procedures *Guidelines on Extending the Storage Period of Gametes and Embryos (2012)*; *Guidelines on Surrogacy involving Assisted Reproductive Procedures (2013)*; *Guidelines on the Creation and Use, for Reproductive Purposes, of an Embryo created from Donated Eggs in conjunction with Donated Sperm (2010)*.

- a. Whether the deceased had plans for childbearing with that spouse or partner in the immediate future: evidence of plans for children will be favourable.
 - b. The prior parental status of the deceased: it will be favourable if the deceased has an existing child to their relationship.
 - c. The nature of the deceased's death: cases of terminal illness or expected deaths will be unfavourable.
5. After consideration of a, b, and c, reference to the relationship status and length between the parties prior to death will be relevant for the purposes of establishing the applicant's ability to use: long, table relationships will be favourable.

Procedural Requirements

6. Given the enduring consequences of the decision, conception or pregnancy should not be attempted until:
- a. A period of at least 1 year (or another sufficient period) has passed so that grief and related emotions do not interfere with decision-making;
 - b. The surviving prospective parent has been provided with sufficient information to facilitate an accurate understanding of the potential social, psychological and health implications of the procedure;
 - c. The surviving prospective parent has undergone counselling.
7. An independent body, ECART, has reviewed the circumstances and supports the proposed use.

VII Summary

Evaluation of the regulation of posthumous reproduction in the United Kingdom, Australia and Israel provides insight on the way autonomy is afforded protection by the law, either falling or standing dependent on the level of consent legally enforced. Respectively, the United Kingdom strongly enforces consent in using an explicit model to afford ample protection to autonomy; the NHMRC Guidelines in Australia manipulates the legal tool in multiple ways, choosing to protect different stages of autonomy that a deceased person may have; and Israel acknowledges little to no autonomy in a deceased reflected through their non-existent consent requirement. My proposed guidelines for the posthumous use of sperm attempt to clarify how the posthumous use of sperm should be regulated in New Zealand. Adopting a model of inferred consent functions to protect an individual's continuing procreative autonomy from life through to death.

I recognise that it is not the perfect solution. Though, in this controversial realm, perfect will never exist.

CONCLUSION

Advances in assisted reproductive technologies raise many complex and sensitive ethical and legal issues;¹⁷¹ the posthumous use of a deceased man's sperm is only one of many. Yet, it is one that is prevalent and increasing in public knowledge. This prompts the demand for review and development of the law in this area. New Zealand's current ambiguous position over the posthumous use of sperm cries for the refurbishment of guidelines which I recommend to accord with the philosophical underpinnings of a deceased individual's right to consent. The current review of the 2000 Guidelines by ACART reflects this need for change in how we regulate posthumous reproduction;¹⁷² New Zealand truly lacks guidance on this practice. Not only is there a statutory gap frustrating the collection of sperm posthumously, but the fundamental ethical concern of use is also in dire need of clarification for ECART's application, the courts' consideration, public accountability and importantly, a familial direction in potential inquiries.

Whilst in many aspects autonomy has obtained a supreme status, in the event of death, its status is only limited. To support this claim, I refer to the critical interests that each individual has. Critical interests primarily involve the desire to write our own life script. That is imperative of course during life, but too after death, ensuring that our passing, and what happens after we cease to exist, accords appropriately with that life script. Because those critical interests persist, a thread of autonomy also survives. The critical interest concerned within a case of posthumous reproduction is procreation, something that is so closely attached to a person's identity and life purpose.

In this paper, I aimed to present a parallel of autonomy to the consent that right requires. To illustrate this I outlined a spectrum of models of consent that could be demanded from an individual in posthumous reproduction. The most restrictive model, explicit consent serves to recognize the full capacity of autonomy in the dead as it is whilst we are living; the intermediate model, inferred consent, appreciates that dead persons do not require or exercise the same level of autonomy as the living rather there is only one thread of autonomous decisions that warrant protection; the permissive model, presumed consent only acknowledges that thread of autonomy

¹⁷¹ Alison Douglass, above n 3, at 115.

¹⁷² See Advisory Committee on Assisted Reproductive Technology "Posthumous reproduction – A review of the current *Guidelines for the Storage, Use and Disposal of Sperm from a Deceased Man* to take into account gametes and embryos" (2018).

in a state of objection; and never requiring consent ignores the possibility of autonomy in a decedent altogether.

I have argued that accepting a concept of inferred consent best reflects the remainder of autonomy that individual's carry to their death, namely, their critical interests in procreation. I have confronted the practical barrier of inferring consent from the deceased's state of mind as to *posthumous* parenthood. Until posthumous reproduction is a regularly communicated state of affair, it will never be realistic to place such inferential burden on an applicant. I settle but advocate inference from a deceased's desire to be a parent *generally*. The guidelines I have drafted are distinct to the use of gametes from a man who is dying or deceased, upon application of a surviving spouse or partner. By no means are these guidelines encompassing the range of ethical issues that would be raised in an application for the posthumous use of sperm. They are an attempt to formulating how a model of inferred consent could be executed in New Zealand.

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