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Posthumous homologous artificial insemination: a bioethical analysis of family planning

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Abstract

This article discusses issues related to *post mortem* homologous artificial insemination. Taking as reference ethical norms that ensure the couple's free choice in family planning, the objective was to understand how such regulations would influence the accomplishment of this parental project. Using the hypothetical-deductive method, a literature review on bioethics and biolaw was carried out, in addition to a documentary research on the website of the Federal Council of Medicine. Then, reflections on the principle of autonomy of patients undergoing assisted reproduction techniques were made, considering some of the repercussions of this technique on family and succession law. Finally, a description of the method of clinical casuistry is presented, being used by clinics as a parameter to make decisions and advise the surviving spouse about the problem of posthumous conception.

Keywords: Insemination, artificial, homologous. Posthumous conception. Bioethics. Personal autonomy. Family development planning.

Resumo

Inseminação artificial homóloga póstuma: análise bioética do planejamento familiar

Este artigo trata de questões relacionadas à inseminação artificial homóloga *post mortem*. Tomando como referência normas éticas que asseguram a livre escolha do casal no planejamento familiar, objetivou-se descobrir de que forma tais regulamentações influenciariam na concretização desse projeto parental. A partir do método hipotético-dedutivo, realizou-se revisão de literatura em bioética e biodireito, além de pesquisa documental no sítio eletrônico do Conselho Federal de Medicina. Refletiu-se, então, sobre o princípio de autonomia dos pacientes submetidos às técnicas de reprodução assistida, levando em conta algumas das repercussões dessa técnica sobre o direito de família e sucessões. Por fim, descreveu-se o método de casuística clínica, utilizado pelas clínicas como parâmetro para tomar decisões e aconselhar o cônjuge sobrevivente acerca da problemática da concepção póstuma.

Palavras-chave: Inseminação artificial homóloga. Concepção póstuma. Bioética. Autonomia pessoal. Planejamento familiar.

Resumen

Inseminación artificial homóloga póstuma: un análisis bioético de la planificación familiar

Este artículo trata aspectos relacionados a la inseminación artificial homóloga *post mortem*. Con base en la normativa ética que garantiza la libre elección de la pareja en la planificación familiar, el objetivo fue identificar la influencia de la legislación en la realización de este proyecto parental. A partir del método hipotético-deductivo, se realizó una revisión bibliográfica sobre bioética y bioderecho, además de una búsqueda documental en el sitio web del Consejo Federal de Medicina. Con esto, se reflexionó sobre el principio de autonomía de los pacientes sometidos a técnicas de reproducción asistida, teniendo en cuenta algunas de las repercusiones de esta técnica en el derecho de familia y de sucesiones. Por último, se describió el método de la casuística clínica utilizado por las clínicas como parámetro en la toma de decisiones y asesoramiento al cónyuge sobreviviente en el tema de la concepción póstuma.

Palabras clave: Inseminación artificial homóloga. Concepción póstuma. Bioética. Autonomía personal. Planificación familiar.

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Science and technology advancements contribute more and more to the expansion of methods related to infertility. In this scenario, assisted reproductive technology (ART) stand out, raising numerous ethical debates with legal ramifications.

This study deals with *post mortem* homologous assisted reproduction (AR) from the following question: how do bioethical guidelines about posthumous human reproduction influence family planning? To answer the question, I conducted a literature review of specific scientific articles on bioethics and biolaw, both in the field of medical law, using the hypothetical-deductive research method.

Moreover, to investigate how the ethical regulations existing in Brazil regarding the matter could influence the achievement of a parental project, I analyzed these regulations and other documents related to medically assisted reproduction on the website of the Federal Council of Medicine (CFM).

The article was divided into three parts:

1. First, I addressed how to construct the principle of private autonomy of patients undergoing ART in relation to informed consent forms (ICF);
2. Subsequently, I addressed the dilemmas related to posthumous homologous artificial insemination, especially the doctrinal debate on the effects of the technique on family planning and the future child's inheritance rights;
3. Next, I analyzed the decisions of clinics, centers or services that apply ART, as well as those of the surviving spouse in relation to their fundamental rights. Using the clinical casuistry method in the bioethical sphere, the study investigated questions about the possibility of using or not the AR technique *post mortem*. Finally, the main influences of bioethics related to the free celebration of the marital plan were outlined.

Autonomy and informed consent in assisted reproduction

AR technology is the set of treatments or procedures that enable assisted human reproduction. These include the handling of human oocytes or embryos, which demands several types of increasingly complex interventions, such as ovarian stimulation, egg retrieval, sperm retrieval, and *in vitro* fertilization [1].

According to Leite and Henriques [2], Trounson and Mohr achieved the first pregnancy by cryopreserving human embryos in 1983. Later, the evolution of this technique, which consists in the freezing of biological cells and tissues, made what is now known as posthumous reproduction possible, that is, the fertilization or implantation of the cryopreserved genetic material of the man or woman (after his or her death) in the surviving spouse.

The authors state that some countries lack specific ART laws, such as Brazil, China, Egypt, and India, and instead have adopted "reference guides" on the subject via administrative resolutions or recommendations. However, while semen, embryo, and oocyte cryopreservation is allowed in all, posthumous reproduction is prohibited in China and Egypt [2].

In countries with specific legislation, such as Spain, the cryopreservation technique is allowed in the same way. Italy, on the other hand, has banned embryo freezing and *post mortem* reproduction [2]. Therefore, the complexity of the subject is emphasized, especially the issue surrounding the legitimacy of the deceased spouse's or partner's will, expressed during life, to generate or not a descendant.

But, after all, who or what can determine whether or not someone, even if already deceased, can have children? This is exactly where law, medicine, and bioethics overlap. Thus, before dealing with the issue of will, it is necessary to understand two specific determinants: the meaning of human autonomy and the means to realize it.

Regarding autonomy, the Constitution of the 1988 Federative Republic of Brazil (CF) offer essential references [3], which, via its Article 5, item X, consecrates intimacy and private life as inviolable fundamental rights. The latter is even typified as a personality right in Article 21 of the 2002 Brazilian Civil Code (CC) [4].

Article 226, § 7, of CF/1988 [3], allows couples' free decision, assuring the right to family planning, initially conceptualized in Article 2

of Law 9,263/1996 [5], as a set of actions for the regulation of fecundity that guarantees equal rights to the constitution, limitation, or increase of progeny by the woman, the man, or the couple. This constitutional protection is based on the very dignity of the human person and on the principle of responsible parenthood.

It is also a fundamental principle, stipulated in Chapter I, section XXI of the Code of Medical Ethics (CEM) [6], in these terms: in the process of professional decision-making, according to their dictates of conscience and legal provisions, physicians shall accept the choices of their patients concerning the diagnostic and therapeutic procedures expressed by them, provided that they are appropriate to the case and scientifically recognized.

Note that it is insufficient to guarantee autonomy but also necessary to ensure its free voluntary exercise, based on the information provided by physicians. These professionals will not be obliged to render services that go against the dictates of their consciences dictates, except if they have no other options, that is, in the absence of another physician, in case of urgency or emergency, or if their refusal brings damage to patients' health, according to item VII of the same provision [4].

Moreover, autonomy is a general principle enshrined in principle-based bioethics of respect for people's self-determination in view of their free capacity to choose among existing alternatives. Muñoz and Fortes [7] note that we find no autonomy if patients have a single alternative or when they lack the freedom to act according to their desired option.

The 1978 *Belmont Report* [8], the first document of bioethical studies, prepared by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, defined autonomy as the principle of respect for persons, who should be treated as autonomous agents. This document established that maturity, the cognitive capacity to understand what is being treated, and an adequate environment—which has no stressful situations, emergencies, or urgencies—are conditions for the full exercise of autonomy. This set is also part of Article 5 of the 2005 *Universal Declaration on Bioethics and Human Rights* [9].

However, it is emphasized that the main form of materialization of these precepts, especially for the purposes of this study, is via the ICF, conceptualized in item 4 of CFM Recommendation 1/2016 [10] as an act of decision, agreement, and approval of patients or their legal representatives, after they receive the necessary information and explanation under the responsibility of physicians, regarding their diagnosis or indicated therapeutic procedures.

Still, the ICF is not restricted to medical prognosis or diagnosis and goes beyond procedures that involve risks, as it is required as a prerequisite for the performance of specific techniques, especially those related to free body manipulation, to guide an eventual situation based on prior decision-making. This principle must be observed in any situation involving the doctor-patient relationship, whose reflections in the field of marital reality deserve to be considered at the time of family planning, both in marriages and in stable unions.

Biolaw and posthumous assisted reproduction

Contemporary discussions about family planning involve distinct cores and an intimate and collective conviction, which constantly mutate in face of the development of new technologies at the service of life or health over time. Therefore, the desire to start a family must be remembered along with the issue of reproductive technologies, which soon generates many facets related to the possibility of having children or not, adopting them, or not having them, which are always marked by the legal void that comes from the absence of legal provisions.

According to Pedrosa Neto and Franco, for the application of AR techniques, couples' stability and affection should be considered, *since it will be the emotional basis allowing the child's healthy growth, and not the formality of this union* [11]. However, there is a multitude of relevant factors. For example, the succession and sharing of the deceased partner's property or family planning or the lack of it. In addition, there are several open concepts related to human procreation,

including the most varied doctrinal understandings regarding the configuration of a stable union.

In view of this, I opted for only further developing the conjugal plan within the constancy of marriage for the conception of biological children with the use of homologous AR techniques, considering the legal presumption of filiation already established by Article 1,597, III of CC/2002[4]. To this end, it should be remembered that sperm, oocyte, embryonic, and gonadal tissue cryopreservation is allowed in Brazil in the form of CFM Resolution 2,168/2017[12], which will be mentioned constantly hereafter.

According to this resolution, currently, the couple *must manifest their will, in writing, as to the destination to be given to the cryopreserved embryos in case of divorce or dissolution of stable union, serious illnesses or death of one or both of them, and when they wish to donate them*[12]. Also, according to this regulation, these embryos will be cryopreserved for up to three years; otherwise, after this period, *they can be discarded if this is the express wish of the patients*[12].

The issue is complex but should be faced with this specific ICF to meet such formality properly in view of the very nature of this indispensable document to perform any ART, according to Chapter I, Item 4, of the mentioned CFM Resolution 2,168/2017[12]. Later on, in Chapter VIII, assisted reproduction is allowed *post mortem* provided that there is specific prior authorization from the deceased for the use of the cryopreserved biological material, according to the legislation in force.

Based on that, in case the respective genetic material (sperm or egg) is cryopreserved, the possible interferences of the use of said technique on family planning after the death of one of the spouses is discussed from two distinct crucial aspects concerning: (1) the succession of the future child; (2) the clinical decision-making on the performance of the *post mortem* conceptive technique. These will be analyzed in the following items.

Inheritance effects and posthumous insemination

Article 1,798 of CC/2002[13] legitimates as successors persons who are born or already conceived at the time of the opening of the succession, that is, when death occurs, not contemplating those conceived after the death of the inheritor.

Nevertheless, according to Enunciation 267 of the III Journey of Civil Law, this rule must be extended to embryos formed by ART, covering, thus, the hereditary vocation of the human person to be born, whose patrimonial effects are subject to the rules provided for the petition of inheritance[13].

According to Ribeiro, there are situations in which the death of individuals fails to terminate their wishes expressed in life, as occurs with wills, which operates its effects after death. Therefore, it is legally possible to admit that one of these hypotheses is a manifestation of continuing the parental project, even if one of the intended parents dies.

Albuquerque Filho claims that there are at least three distinct doctrinal currents regarding the effects of this technique: 1) the exclusionary one, which recognizes no rights to the child conceived *post mortem and recommends prohibiting the practice;* 2) the relatively exclusionary one, *which recognizes rights related only to* filiation and no rights related to the inheritance of the pre-dead; 3) the inclusive one (defended by the author), which recognizes family rights, including inheritance rights, for the following reasons: *the genetic material, semen and egg, belongs to the couple, whether married or in a stable union, who intend to have the child thus engendered. Biologically, therefore, there is no doubt about paternity and maternity and, in case there is, the laboratory or doctor who performed the post mortem insemination technique will have full scientific conditions to clarify it, including for the purpose of the later registration of the born child*[15].

In line with Albuquerque Filho, I argue here that the first and second positions fail to correspond to the proper doctrinal conviction.

Therefore, based on an interpretation in accordance with CF/1988, I adopt the understanding that the treatment of family relations must be more humanized. The fundamental rights of future parents, sustained by couples' bonds of affection and the dream of raising a child, should be respected. From conception, the child should have access to the right to life, safety, integrity, and family life, safe from any form of discrimination.

One should reject the segregation of institutes of filiation and succession simply to curtail rights because, in view of the principle of equality of filiation, and once children's condition is recognized, all rights are due to them, such as the right to a name and inheritance [4], under penalty of retrogression.

Another theory is that eventual offspring would only be contemplated by means of testamentary succession, that is, by means of a will, when, instead of contemplating the future offspring of other people, it would benefit its own child with the surviving spouse, if conceived up to two years after death, based on an extensive interpretation of Articles 1,799, Item I, and 1,800, § 4, of CC/2002 [16].

For Madaleno, one should not speak of lawful succession, that is, that which occurs according to the order of hereditary vocation established in CC/2002 [4] *since the future child would lack capacity of succession because, for such, they would have to be alive or conceived on the date of the opening of the succession* [17].

Dias [18] adopted a contrary position when defending, in this case, the possibility of legitimate succession, under the argument that, if the law determined the transmission of inheritance to heirs (CC 1,784), even if yet unborn (CC 1,798) or unconceived (CC 1,799, I), nothing justifies excluding their right to succession. For the author, it is unreasonable to exclude from succession a person who is son or daughter.

Albuquerque Filho [19] and Delfim [20] corroborate this understanding. The latter states that the *child resulting from post mortem homologous artificial insemination should have exactly the same rights that are assured to their biological sibling conceived or born before the 'parent's death* [20].

However, here another undoubtedly controversial aspect arises, related to the indefinite period for the *post mortem* implantation of the embryo or the male gamete in the mother's womb, a matter that, once again, is the target of doctrinal divergence, including legislative omission.

In this case, Albuquerque Filho [21] reveals that *it would be up to the successor when they manifested their wishes by authentic document or will to establish the waiting period for the birth of children, which must not exceed the two years established for the conception of the possible offspring of a third party, or, in the absence of a previously established period, to apply, by analogy, the period set forth in Art. 1,800, § 4, of the Civil Code, that is, two years as of the opening of the succession*.

There are several understandings regarding the existence or not of inheritance rights from *post mortem* artificial insemination but this discussion is preceded by another. In the context of assisted reproduction clinics, there are discussions about whether or not to perform the method if, for whatever reason, there is no express authorization from the deceased spouse specifically for this purpose, provided for in the ICF.

This is because, as can be seen, Chapter VIII of CFM Resolution 2,168/2017 [12] says nothing about the need for written authorization from the deceased for the use of frozen material. However, the I Civil Law Journey, held by the Federal Justice Council [22], issued Enunciation 106, understanding that it is mandatory. Thus, for the paternity of the deceased husband to be presumed, it is mandatory that the woman, when subjecting herself to an ART with the genetic material of the deceased, be in the condition of a widow, and it is also mandatory that the husband's written authorization to use his genetic material after his death had been given.

However, the effects of the first part of this provision are questionable since the legal presumption of paternity is already provided for and assured by the aforementioned Article 1,597, III, of CC/2002 [4] but without any provision on the surviving spouse's widowhood status. For Madaleno, even *post mortem artificial insemination authorized by the husband will no longer operate with the clarity of the legal presumption, and the judge must rule it out in face of the widow's new affective union and seek the genetic truth by DNA examination* [23].

In case of death of the female spouse, statement 633 of the VIII Journey of Civil Law [24] reaffirmed the possibility of performing insemination by means of the so-called substitute pregnancy (free temporary cession of the uterus), now regulated by the same Resolution CFM 2,168/2017 [12], provided that the wife or partner has expressed consent in life [24].

In this sense, the National Council of Justice (CNJ) instituted Provision 63, of November 14, 2017 [25], which provides for specific procedures to be adopted by the offices of civil registration of natural persons, including those related to birth resulting from *post mortem* AR. Note article 17, § 2, according to which a specific previous authorization term from the deceased for the use of the preserved biological material, drawn up by public or private instrument with a notarized signature, must be presented [25].

Thus, from a systemic interpretation of these provisions, in view of the nature and form of the ICF, even from a practical standpoint to avoid potential litigation, it is recognized here the need for the written form of this authorization. The lack of legislation on the subject is an undeniable problem, which further highlights the role of the Judiciary in resolving the lawsuits filed with the purpose of authorizing it.

From then on, the concern arises about the fact that, despite this omission in the ICF, it would still be possible to carry out the procedure based on the evidential framework of the records by proving the will expressed in other documents, for example, letters or even captions in photographs, or writings. This would occur especially because this type of planning takes place in circumstances of greater privacy, thus succeeding in demonstrating that the couple planned to have children. Here, it is not about a presumption of will, but rather factual proof.

However, the problematization of this issue is not new, nor is it concentrated in only one country or region. Shapiro and Sonnenblick [26] claim that *these discussions have received increasing prominence since 1984, after the death of Frenchman Alain Parpalaix at the age of 26, two days after his marriage to Corinne Parpalaix*. Alain, diagnosed with testicular cancer, deposited his semen in a sperm bank but failed to expressly indicate the future destination of the genetic material, which is why said bank refused to deliver it to his wife after her husband's death [26].

For the first time in history, the issue had to be faced by the French Justice, which, based on the fundamental right to procreate, understood that the absence of Alain's written declaration failed, by itself, to prevent the fulfillment of his will. Furthermore, in view of the testimonies of his wife and his parents—who were in the best position to determine "their son's deepest wishes"—it was decided to return all the sperm to a doctor chosen by the widow Corinne [26].

The first known record of *post mortem* insemination in Brazil received notoriety after a death certificate rectification action filed by Camila Noronha Martins Custódio, represented by her genitor Geralda Mônica de Cássia Noronha. The latter was married to Camila's father, Rui Manoel Martins, who, diagnosed with myeloid leukemia, died a few months after marrying Geralda in 1996. Subsequently, his wife, following the will of the deceased, was subjected to artificial insemination with previously frozen semen and conceived Camila, who was born in September 1997.

For this reason, it was requested the correction of the father's death certificate so that the existence of the couple's daughter would be recorded there, which was denied in first instance and subsequently on appeal, also by the Fourth Chamber of Private Law of the Court of Appeals of the State of São Paulo in the judgment of Appeal 166,180,4/7-00 [27], on the grounds that the change in the death certificate would be unfeasible until the *post mortem* paternity investigation, which is indispensable.

In 2010, Roberto Jefferson Niels, at the time married to Katia Lenerneier, was diagnosed with cancer and decided to freeze his semen due to the risk of infertility caused by chemotherapy but died before the embryos were implanted. The wife then asked the clinic to perform a *post mortem* insemination with her husband's semen but her request was denied by the laboratory under the argument that it had no express authorization to do so. After filing a lawsuit before the 13th Civil Court of Curitiba/PR, an injunction was granted to authorize the execution of the procedure [28].

A similar situation occurred again recently, when Samille sought an AR clinic for the implantation procedure of embryos frozen with genetic material from her deceased husband. The clinic refused to perform the technique

for the same reason explained in the previous case. In one interview, she states that she had received no guidance from the clinic to fill in the specific field in the ICF about the destination of the embryos in case of death of one or both of them.

Thus, the ICF begins to receive a new meaning, encompassing a multidisciplinary character that expands or restricts the continuation of the marital plan. This should never be based on simple selections printed on a form, but rather on options that are clarified according to the reality known only to patients subjected to AR techniques.

Decision making in bioethics

Clinic vs. surviving spouse

In the previous section, the dilemmas of posthumous fertilization in the context of inheritance law were presented. This section deals with decision-making within the clinics, centers or services directly involved with performing this procedure.

One of the effects of the practice is irreversibility. Since once insemination has been performed on the surviving spouse, it is impossible, at least intentionally, to return to the previous state. On the other hand, delays in performing the practice may even result in the loss or disposal of the cryopreserved material, depending on the contractual arrangements with the clinic.

Still, one can deduce that most couples expect to be alive when the frozen materials of one or both of them are used and, logically, ignore what should be done in case of the occurrence of the "death event." Hence the question: what would be their real will?

In this respect, Strong, Gingrich, and Kutteh have rightly pointed out that *in other areas of medicine in which decisions must be made in the absence of prior explicit consent, making decisions based on the patient's inferred consent is recognized as a way to respect the patient's autonomy* [30]. This is the case, for example, in cases defining the provision of life-prolonging treatment for patients in a persistent vegetative state who have no advance directive of will.

Usually, family members are asked whether patients have ever expressed their wishes about life support treatment in such circumstances. If patients' prior statements and values confirm that they would like the treatment to be stopped, then this inferred consent could be an important part of an ethical justification for denying it [30].

When there is no explicit prior consent registered at the clinic, but the surviving spouse and other close family members agree that the pre-dead would have authorized the performance of *post mortem* insemination, a conflict of languages occurs: one emotional, coming from family ties, the other technical, by the medical clinic or specialized service with the duty to comply with ethical limitations. In both cases, there is insecurity. One cannot, therefore, fail to apply specific bioethical decision-making methods, including as a means of counseling discussions with surviving spouses.

It should be remembered that there are currently several methodological proposals related to the decision-making process in this area. These proposals present perspectives of analysis of moral dilemmas constantly put to the test by the complexity of the relationships inserted in the assistance practice.

Despite this, such propositions transit in a common way under the nucleus of the attribution of existential finalistic meanings, referring to the performance of different actors, notably, in face of the clinical condition of patients and the potentiality of autonomous exercise of their interests. On the other hand, it is necessary to indicate who is legitimately responsible for the value choices that each concrete case proclaims.

In general terms, the use of the clinical case method proposed by Albert Jonsen and Stephen Toulmin is taken as an example here. Casuistry analyzes ethical problems *by means of equating procedures based on paradigms, analogies, and expert opinions about the existence and strictness of moral obligations in particular situations* [31].

This tool considers different phases of analysis of conflicting situations, based on questions that basically involve the medical technique, patients' autonomy/quality of life, and situational aspects. This goes along with the characteristic of the types of languages inserted in the *post mortem* insemination situations described above.

It is certainly not the aim here to define a solution to the problem but rather to present a plausible guideline for dealing with the issue, considering the questions in Chart 1.

Chart 1. Questions about medical indications, patients' preferences, and situational aspects for case analysis

Medical Indications	Patient Preferences	Short-term aspects
1. What is the patient's problem? History? Diagnosis? Prognosis?	1. What did the patient express about their preferences in treatment?	1. Are there family issues unduly influencing therapeutic decisions?
2. Is the problem acute? Chronic? Critical? Emergency? Reversible?	2. Was the patient informed about the benefits and risks of the treatment? Did they understand the information? Did they give their consent?	2. Are there issues with healthcare providers influencing therapeutic decisions?
3. What are the goals of the treatment?	3. Is the patient mentally capable? Do they have legal competence? Is there evidence of another type of condition that suggests an inability to decide?	3. Is there unreasonable interference from economic or social factors?
4. What is the possibility of success?	4. Did the patient express their preferences in advance?	4. Are there religious or cultural factors weighing on their choices?
5. What are the plans if therapy fails?	5. Who is the patient's representative if they are unable to decide? Does the representative follow appropriate rules for the substitute decision?	5. Is there a justification for the violation of medical confidentiality?
6. How will the patient benefit from the care provided by the team?	6. Is the patient reluctant with the treatment? Is the patient unable to cooperate? Why?	6. Are there resource allocation problems?
7. How can damage be prevented?	7. Were the patient's rights of choice respected to the fullest ethical and legal extent?	7. What are the legal implications of therapeutic decisions?
		8. Does the case involve research? Teaching?

Source: Elaborated by the author based on the tables developed by Zoboli [31]

The importance of these questions is based on the construction of parameters to segregate moral concepts, which are usually broad and loaded with subjectivity, and which usually tend to be hidden or even inconsistent, according to the life experiences of each of those involved.

Thus, the counseling method which can assist in clinical decision-making should be common practice in eventual court actions. This method forms a typology of reasonings to aid the interpretation of the gap between legal criteria and the diverse range of judicialized medical and moral cases and concepts encountered in practice. This is the case when there is no written statement of will regarding the *post mortem* use of previously frozen genetic material.

Thus, from the punctual reflections around a possible inferred consent, one asks, for example: what is the possibility of success? Has the patient been informed about the benefits and risks of treatment? Did they understand the information? Did they give their consent? Has the patient expressed their preferences in advance? Who is the patient's representative if the patient is unable to decide? Does the representative follow appropriate rules for the substitute decision? Were the patient's rights of choice respected to the fullest ethical and legal extent? Are there religious or cultural factors weighing on their choices?

These questions are important because the survivor's decision-making can be clouded by the pain caused by the grieving process [32].

Final considerations

The scientific and technological advances in medicine have never been so related to family planning, either as hope in achieving the right to human procreation or to bring new issues related to filiation and diverse family structures, which the legislative provisions are certainly unable to follow or contemplate. Proof of this is the evolution of the technique of cryopreservation of embryos

and female or male gametes, which later enabled the so-called posthumous artificial insemination.

This question is part of the field of study of bioethics, which deserves more and more attention in view of the need to intensify reflections of different natures (legal, social, or religious) in face of the diffusion of the use of new life technologies.

The effective respect for individuals' autonomy should guide questions about AR, materialized via the ICF, even after death but, be warned; as the name suggests, the document must be written by the patient, who is the only one who knows their own reality, as long as they have been oriented and clarified by specialized clinics with the proper observations about the medical options related to the procedure.

Moreover, it is necessary to seek knowledge related to the possible legal effects resulting from their decision, especially concerning the future child's assets, filiation, and inheritance rights. Otherwise, one is unable to speak of free consent with clear information, which would represent a true limitation to accomplishing the conjugal plan.

For this reason, it is necessary to establish a deeper dialogue beyond the technical language of the clinics and services that apply AR techniques, restricted to the effective fulfillment of current or future provisions in the resolutions issued by the ICF related to the theme.

In addition to counseling surviving spouses in the grieving process, the emotional language coming from affective family ties should also be considered, based, for example, on the application of the casuistry method for bioethical decision-making. This method can lead to more objective questions about the repercussions resulting from the performance of this technique, depending on the complexity of each circumstance.

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