NOTE

ONLY USEFUL AS A UTERUS: HOW TO SHAPE STATE AND PERSONAL SAFEGUARDS ON THE IMPLEMENTATION OF WHOLE BODY GESTATIONAL DONATION TO PROTECT THE VALUE OF WOMEN AS WHOLE PERSONS

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ABSTRACT

This Note analyzes whole body gestational donation, as proposed by ethicist Anna Smajdor, and the organ donation consent laws that would be implicated by implementation of such a system. Further, this Note analyzes the ethical implications of such laws upon vulnerable groups of people and how the law should protect certain groups from the dangers this system poses. It also presents both suggestions for state legislators to use if this system is implemented, and steps individuals can take to ensure that their wishes are carried out in the event they are unable to make their own medical decisions.

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INTRODUCTION

In 2015, Karla Perez became the first person, since 1999, on record in the United States to be ventilated long enough to deliver her unborn child.[1] Karla was kept on a ventilator for fifty-four days until her unborn child, Angel, was delivered by cesarean section and Karla was declared dead.[2] A different mother, a patient in the United Arab Emirates, was kept on a ventilator for 110 days before her baby was successfully delivered.[3] The longest period of life support for fetal viability appears to have been the 114 days that a nineteen-year-old patient in a persistent vegetative state ("PVS") was provided with somatic support before her baby was delivered.[4] The additional four days of support in that case may be tied to the fact that "a pregnancy complicated by PVS generally may require less

1. Avianne Tan, *Baby Delivered by Brain-Dead Mother on Life Support for 54 Days Leaves Hospital*, ABC NEWS (June 10, 2015, 6:49 PM), https://perma.cc/4TNS-2KAV.

2. *Id.*

3. *See* Abuhasna Said, Al Jundi Amer, Ur Rahman Masood, Abdallah Dirar, & Chedid Faris, *A Brain-Dead Pregnant Woman with Prolonged Somatic Support and Successful Neonatal Outcome: A Grand Rounds Case with a Detailed Review of Literature and Ethical Considerations*, 3 INT'L J. CRITICAL ILLNESS & INJURY SCI. 220, 220–24 (2013); *see also,* Anna Smajdor, *Whole Body Gestational Donation*, 44 THEORETICAL MED. & BIOETHICS 113, 117 (2022).

4. *See generally* Henry Adekola, Zaid Al-Wahab, Leonard Sudakin, Karoline Puder, Bernard Gonik, *One Hundred and Fourteen Days of Somatic Support in a Severely Brain Injured Pregnant Woman: Case Report and Review of the Literature*, 3 J. CLINICAL GYNECOL. & OBSTET. 42, 44 (2014).

somatic support than its brain dead counterpart."[5] Regardless, full gestation generally lasts 280 days,[6] and a brain-dead mother has not yet been kept alive for even half that length of time.[7]

Despite these limitations on somatic support, in an article entitled *Whole Body Gestational Donation*, Anna Smajdor proposed a system of surrogacy that would attempt to rewrite stories like that of Karla Perez.[8] Instead of being ventilated for the viability of their own child, Smajdor proposes the use of brain-dead women as surrogates to deliver the babies of other families who cannot have their own children, or desire to "avoid the risks and burdens"[9] of pregnancy. Brain stem death occurs when "a person no longer has any brain stem functions and has permanently lost the potential for consciousness and the capacity to breathe."[10] Once the brain stem has died, "there's no way of reversing it and the heart will eventually stop beating, even if a ventilator continues to be used."[11]

Smajdor's proposed basis of consent to whole body gestational donation would be registration as an organ donor.[12] This Note analyzes the problems raised by whole body gestational donation ("WBGD") under a blanket organ donation consent and what safeguards can be implemented for the inequalities this proposal raises. Part I summarizes Smajdor's proposed framework for WBGD. Part II analyzes the existing organ donation laws and how Smajdor's proposal would fit within that framework. Part III highlights further legal problems WBGD implementation would raise, including conflict with constitutional precedent. Part IV discusses legal and moral considerations including equal protection issues that lawmakers should weigh when crafting legislation related to WBGD. To conclude, Part V provides recommendations for state legislators and for individuals who seek to minimize risks from WBGD.

I. OVERVIEW OF SMAJDOR'S PROPOSED SYSTEM

Smajdor proposes allowing gestation within patients who have experienced brain-stem death for any prospective families who do not want to endure the "risks and burdens" of pregnancy.[13] Her suggestion comes after a similar proposal by Paul Gerber in Australia who suggested that "newly [brain] dead, women could first be used as baby incubators and then for organ transplants."[14]

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5. *Id.* at 45.
6. *See What is Full Term?*, MARCH OF DIMES (Sept. 2018), https://perma.cc/K3TJ-MFWY.
7. *See generally* Adekola, Al-Wahab, Sudakin, Puder, Gonik, *supra* note 4 (describing what appears to be the longest period of somatic support for a brain-dead mother to successfully deliver a baby, at 114 days).
8. *See generally* Smajdor, *supra* note 3.
9. Smajdor, *supra* note 3, at 114.
10. *Brain Stem Death,* NHS INFORM. (Feb. 5, 2024), https://perma.cc/DK3Z-TFKA.
11. *Id.*
12. Smajdor, *supra* note 3, at 115.
13. *Id.* at 114.
14. *Bioethicist Suggests Using Brain-Dead Women as Incubators*, UNITED PRESS INT'L, INC. (June 24, 1988), https://perma.cc/Q57Q-8QTC.

His proposal was met with strong opposition from medical and religious personnel.[15] Smajdor was motivated to explore this possibility based on the work of Rosalie Ber in 2000 who suggested surrogacy of patients in persistent vegetative states who had provided written consent to serve as such before entering PVS.[16]

In her article, Smajdor highlighted use of brain-stem death patients because brain-stem death is an irreversible diagnosis, and it is the current standard for determining eligibility to donate organs.[17] She notes that "impregnation could be a surgical affair, preceded and followed by appropriate hormonal therapy to ensure maximal chance of success."[18] Essentially, this would be a variation on surrogacy in which the surrogate "*has* no everyday life; her function is solely to gestate."[19] This proposal would be a new variation of gestational surrogacy and would constitute a new method of assisted reproductive technology ("ART").[20]

Smajdor asserts that "in the case of WBGD, the gestating woman is already dead and cannot be harmed. Commissioning parents may decide on abortion or selective reduction in accordance with their own wishes, without having to worry about the effects on the gestating donor."[21] This is not in line with current surrogacy practice in New York, where surrogates cannot be forced to maintain or terminate a pregnancy, including the number of fetuses.[22]

To counter arguments that this plan devalues women, Smajdor also proposes the use of men's livers as potential gestational organs merely because of their "excellent blood supply."[23] The liver contains approximately one pint of blood, or thirteen percent of the total blood in the body, all the time.[24] By comparison, "[i]n the non-pregnant state, the uterus receives 2–3 percent of a woman's blood flow. The pregnant uterus at term, on the other hand, receive[s] around 17 percent of the output."[25] Thus, beyond the fact that the liver is not intended to gestate a fetus, it also does not produce enough blood to sustain a fetus. Indeed, although "implantation of the egg can occur outside of the uterus, no other organ but the uterus can provide the nourishment—and space—for a fetus to develop to term."[26] Such implantation of a fertilized egg outside of a uterus is an ectopic

15. *Id*.

16. Smajdor, *supra* note 3, at 113.

17. *Id*. at 115. *See also Understanding Organ Donation: Brain Death & Donation After Circulatory Death*, LIFESOURCE, https://perma.cc/D2XR-ACDC.

18. Smajdor, *supra* note 3, at 118.

19. *Id*. at 120.

20. *Id*. at 113 ("In 2000, Rosalie Ber advanced a novel suggestion for circumventing the moral problems of gestational surrogacy.").

21. *Id*. at 120.

22. N.Y. FAM. CT. ACT § 581–403 (McKinney)(i)(1)(v).

23. Smajdor, *supra* note 3.

24. *How the Liver Works,* STANFORD MED. CHILDS. HEALTH, https://perma.cc/M8FW-Q7SB.

25. Diane Christopher, *Maternal Physiology 101*, OB-GYN UNIV. COLO. (Nov. 9, 2012), https://perma.cc/9A7T-XGSH.

26. Jennifer Whitlock, *Can You Get Pregnant After a Hysterectomy?*, VERYWELLHEALTH (Oct. 10, 2023), https://perma.cc/4HUZ-99XC.

pregnancy[27] which "can cause major internal bleeding" and is classified as "a life-threatening emergency that needs emergency surgery."[28] Essentially, Smajdor is proposing that brain-dead men be subjected to ectopic pregnancies, a known life-threatening condition, in the hope that some portion of patients would be able to successfully gestate a child to term for prospective parents. Indeed, Smajdor acknowledges that use of the liver would prove fatal to the men whose livers and bodies are used.[29]

Additionally, there are many other pieces of this proposal that have not been tested. It is unclear whether a patient who has suffered brain-stem death could get and stay pregnant.[30] Doctors do not know how long it is possible to keep patients alive on a ventilator,[31] or how long a particular patient will stay alive even with the assistance of a ventilator given that "any heart will eventually stop beating, ventilated or not."[32] Additionally, of those prior cases where women had been pregnant before a brain-death event occurred, the efficacy of maintaining somatic support to reach fetal viability is not certain.[33] In "30 cases reported in the literature between 1982 and 2010 on brain-dead pregnant women whose somatic non-neurological functions were maintained successfully to facilitate fetal maturation in the uterus . . . . 12 viable infants were born and survived the neonatal period."[34] Between 1979 and 2010, "English language medical literature contains only eleven cases of irreversibly brain-damaged women who have been maintained on life-sustaining treatment to benefit a developing fetus."[35] While in rare cases, existing pregnancies have been sustained for prolonged periods, in the vast majority of cases, somatic support is unsuccessful for longer than fourteen days.[36] Further, "vegetative state is not likely to accelerate fetal viability. More often, the maternal vegetative state and the frequently traumatic conditions which caused it, including the introduction of drugs or prolonged oxygen deprivation, will delay or completely extinguish fetal viability."[37] Thus, Smajdor's proposed system

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27. *Id.*

28. *Ectopic Pregnancy*, AM. COLL. OBSTET.& GYNECOL. (July 2022), https://perma.cc/NU8M-NVZD.

29. Smajdor, *supra* note 3.

30. *Id.* ("there are to my knowledge no documented reports of the initiation of pregnancy in brain stem dead patients").

31. *Id.* ("The maximum period for which a brain-dead patient can be somatically supported is unknown.").

32. *Id.* ("The question is when the heart will stop, and whether this can be controlled or postponed.").

33. *See* Rachel A. Farragher & John G. Laffey, *Maternal Brain Death and Somatic Support*, 3 NEUROCRITICAL CARE 99, 101 (2005) ("duration of maternal somatic support [beyond 107 days] has not been extended in 15 years, despite dramatic advances in organ support therapies in the interim.").

34. Said, Amer, Masood, Dirar, & Faris, *supra* note 3.

35. Alexis Gregorian, *Post-Mortem Pregnancy: A Proposed Methodology for the Resolution of Conflicts over Whether a Brain Dead Pregnant Woman Should Be Maintained on Life-Sustaining Treatment*, 19 ANNALS HEALTH L. 401, 402 (2010).

36. Farragher & Laffey, *supra* note 33.

37. James M. Jordan III, *Incubating for the State: The Precarious Autonomy of Persistently Vegetative and Brain-Dead Pregnant Women*, 22 GA. L. REV. 1103, 1130 (1988).

exceeds existing medical technology and assumes the rare exception of prolonged somatic support is the norm. Nevertheless, because assisted reproductive technology is a rapidly evolving area of medicine and the law, the legal community should consider how to respond if WBGD becomes medically possible.

II. COMPARING AND CONTRASTING ORGAN DONATION AND WHOLE BODY GESTATIONAL DONATION

A. BRAIN-DEATH ENDS A PATIENT'S ABILITY TO CONSENT TO SURROGACY PROCEDURES

In surrogacy agreements between two parties who are both conscious, "a surrogate makes the choice to relinquish some control of her body for a set period of time. Not only is this choice voluntary, but it is also negotiable. Surrogates are free to negotiate the type and amount of autonomy they are willing to relinquish."[38] By contrast, in instances of WBGD, the donor is not capable of making her own decisions. Any negotiations, therefore, as to the surrogacy's terms would be skewed in favor of the prospective parents, who are readily able to express their position, while the WBGD patient's wishes would be communicated through counsel on a substituted judgment model or through next of kin who act based on what they believe their loved one would have wanted. Because the patient would be unable to directly express her wishes and consent, while the prospective parents could clarify their position, the agreement would likely lean towards the wishes of the prospective parents who can request modification of contract terms that do not properly align with their position.

Smajdor recommends use of the existing organ donation system for this procedure where "people either give consent proactively in advance or are deemed to have done so in the lack of any evidence to the contrary."[39] There are difficulties in applying both the opt-out system and the opt-in system to WBGD.

Under an opt-out system, as Smajdor proposes, there would be significant room for coercion or societal pressure that could lead women to become whole body gestational surrogates without informed consent.[40] Consent should not be assumed as a default. Using an opt-out system as the default

> enables a 're-branding' of donation as the standard and recommended choice . . . . Likewise, the default option is the easier choice, as it requires less physical effort (i.e., filling out forms) and . . . requires

38. Jhonell Campbell, *Gestational Surrogacy Contract Terms Under the 2017 Uniform Parentage Act*, 9 CHILD & FAMILY L.J. 1, 22 (2021).

39. Smajdor, *supra* note 3.

40. *See* Chelsea Gomez, Chris Glover, & Laura Clemenston, *Pressure to Have Multiple Babies Putting Surrogates 'At Risk'*, CBC NEWS (Mar. 4, 2020 4:00 AM) ("During CBC's three-month investigation into surrogacy, multiple women said their agency sent them new, heart-wrenching parent profiles within days of giving birth. Some of the women said they felt 'hounded' to commit to a new couple right away.").

> less cognitive and emotional effort by removing the need to make an active choice . . . .[41]

Additionally, while some supporters of the opt-out system point to its use in several European countries, a 2012 survey concluded that "donation professionals in all of these countries require family consent prior to recovery of organs."[42] Thus, "the European countries that developed and maintained presumed consent . . . *do not rely on it* to actually recover organs."[43] There may also be an argument that conducting the procedure on brain-dead women under an opt-out consent system could equate to medical rape: unconsented-to penetration, with the potential of pregnancy as a result.[44] It would at minimum meet the standard of gynecological violence,[45] and it could also open the doctor up to civil liability for battery.[46] The danger in using an opt-out system here lies in not knowing whether the patient's silence was consent to the procedure or mere lack of knowledge that opting-out was required. At common law, silence is generally not viewed as acceptance of a contract, in part because of such ambiguity over the silent party's intent.[47] Similarly, in cases regarding sexual crimes, the defense of consent is generally not proven by a party's silence, but must be demonstrated by knowing and voluntary words or actions.[48] With opt-out consent in WBGD, the risk of harm by subjecting the patient to a gestation without their explicit consent is incredibly high and any doubt as to the patient's knowing consent to serve as a gestational surrogate should bar prospective parents from creating a surrogacy agreement.

Under the current opt-in system, federal law bars the sale of human organs with a narrow exception for transferring organs through "human organ paired

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41. Amy Lewis, Angeliki Koukoura, Georgios-Ioannis Tsianos, Athanasios Apostolos Gargavanis, Anne Ahlmann Nielsen, & Efstathios Vassiliadis, *Organ Donation in the US and Europe: The Supply vs. Demand Imbalance*, 35 TRANSPLANTATION REVS. 1, 4 (2021).

42. *Presumed Consent*, DONATE LIFE CAL., https://perma.cc/37SB-FZY4.

43. *Id.* (emphasis in original).

44. Although this latter half of the definition is not included in most criminal definitions of rape, it highlights the close parallel between rape and this medical procedure.

45. Anaiz Zamora & Greta Rico, *'I Felt Raped': Breaking the Silence Around Gynecological Violence*, WOMEN'S MEDIA CTR. (Dec. 21, 2020), https://perma.cc/GC59-XSF2. ("gynecological violence is a form of violence with many varied expressions, from unnecessary procedures, the pathologization of physiological processes, medical misinformation and maltreatment, aggressive practices that provoke harm and injuries, and even inappropriate and violating comments . . . all of which are experienced during gynecological care beyond pregnancy, childbirth, and puerperium.").

46. Canterbury v. Spence, 464 F.2d 772, 783 (D.C. 1972) ("It is the settled rule that therapy not authorized by the patient may amount to a tort—a common law battery—by the physician.").

47. *See* RESTATEMENT CONTRACTS 2D § 69 (explaining that silence operates as acceptance only in explicitly enumerated circumstances); *see also* 1 TIMOTHY MURRAY, CORBIN ON CONTRACTS AT § 3.18 (2024) ("Silence may indicate that the offeree did not hear or receive or understand the offer, or that the offer was still under consideration. It may instead indicate that the offeree preferred to give no thought to the offer and to waste no time and effort in making a reply, whether orally or by a writing.").

48. *Consent and Incapacitation*, WASH. UNIV. ST. LOUIS, https://perma.cc/BYV5-L8EM.

donation."[49] Human organ paired donation occurs in liver and kidney transplants, because the operations may have living-donor transplants.[50] Paired donation allows for a donor who is willing to donate to a friend or family member, but who is not a compatible organ match, to be matched with a similarly situated pair of donor and recipient.[51] This process enables patients who are waiting for a transplant to receive treatment more quickly than waiting for a deceased organ donor match.[52] Even though the organs in WBGD are being taken from a living donor, albeit one who has been declared brain dead, the general prohibition against organ transfer would likely still apply, making WBGD unqualified for the paired donation exception. In a paired donation, the donor must "desire[] to make a living donation of a human organ specifically to a particular patient."[53] Not only can someone who is unconscious not provide consent nor express desire to have a procedure conducted, but they also cannot consent to donate their organ to a particular patient, as required by the paired donation statute.[54] Thus, because of the brain dead patient's inability to consent to use of her uterus by a particular patient, this method of surrogacy would not fit within the current definition of paired donation. Since it would not qualify as an exception, WBGD would fall under the federal bar against the sale of organs, and payment for the use of the brain dead patient's uterus would be illegal.

The National Conference of Commissioners on Uniform State Laws' 2006 draft of the Uniform Anatomical Gift Act ("UAGA") sets guidelines for organ donation laws and provides states with model organ donation laws that they can adopt.[55] The uniform legislation is intended to be "applie[d] to an anatomical gift or amendment to, revocation of, or refusal to make an anatomical gift, whenever made."[56] Application of the UAGA's provisions to WBGD demonstrates further problems as WBGD is currently proposed. The model legislation indicates that

> [t]he two previous anatomical gift acts, as well as this [Act], adhere to an 'opt-in' principle as its default rule. Thus, an individual becomes a donor only if the donor or someone acting on the donor's behalf affirmatively makes an anatomical gift. The system universally adopted in this country is contrary to the system adopted in some countries, primarily in Europe, where an individual is deemed to be a donor unless the individual or another person acting on the individual's behalf 'opts out.' [. . .] the professional consensus appears to be not to replace the present opt-in principle at this time.[57]

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49. *See* 42 U.S.C.S. § 274e(a) (LEXIS through Pub. L. No. 118–46).

50. *Paired Donation*, MAYO CLINIC TRANSPLANT CTR. (May 9, 2023), https://perma.cc/56YD-D2BK.

51. *Id.*

52. *Id.*

53. *See* 42 U.S.C.S. § 274(c)(4)(A).

54. *Id.*

55. ANATOMICAL GIFT ACT 2006, §§ 1, 2 (UNIF. L. COMM'N 2006).

56. *Id.* at § 3.

57. *Id.* History, at 3.

The UAGA limits organ donation to four categories of use:

> [1] transplantation refers to the removal and grafting of one individual's body part into the body of another individual. [2] Research is a process of testing and observing, the goal of which is to obtain generalizable knowledge, while [3] therapy involves the processing and use of a donated part to develop and provide amelioration or treatment for a disease or condition. [4] Education posits the use of the whole body or parts to teach medical professionals and others about human anatomy and its characteristics.[58]

WBGD does not fit within any of those categories because the uterus is not being transplanted into another person, researched, or used for treatment of a condition. Finally, Smajdor does not assert that educational advantages are a benefit of or rationale for implementation of the system.[59]

Further, the 2006 UAGA states that "[s]ince a general statement of intent to be an organ donor does not result in the making of an anatomical gift of the whole body, or any part, for research or education, more specific language is required to make such a gift."[60] Section 11 further limits blanket consent, noting that

> [i]f a donor's gift does not specify the purpose of the gift, as would occur if the driver's license indicated only that the donor was an 'organ donor,' the gift is only of the donor's parts (not the whole body), and the parts may be used only for transplantation or therapy.[61]

Additionally, section 2(18) specifically states that a part is defined as an organ, eye, or tissue of a human being but "does not include the whole body."[62] Thus, the use of a WBGD patient's whole body while the patient remains on somatic support does not fit within the UAGA's existing framework.

Finally, by highlighting the donor's expressed wishes before seeking input from certain third-party decision makers, "the UAGA emphasizes the autonomy interest of the decedent . . . [and promotes] the decedent's expressed wishes regarding organ donation over the wishes of any other party."[63] In a WBGD model, reliance on third-party decisions is necessitated by the patient's brain-dead status, creating a high probability that the autonomy of the WBGD patient will be in some way limited.

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58. *Id.* § 4, cmt.
59. Smajdor, *supra* note 3, at 122–3.
60. ANATOMICAL GIFT ACT 2006, *supra* note 55, History, at 7.
61. *Id.* §11, at 7–8.
62. *Id.* § 2(18), at 11.
63. Gregorian, *supra* note 35, at 408.

B. EXISTING STATE ORGAN DONATION LAWS ALLOW FOR POTENTIAL ABUSE OF BRAIN-DEAD PATIENTS UNDER THE WBGD PROPOSAL

Here, the state laws from the five most populated states:[64] California, Texas, Florida, New York, and Pennsylvania, will be analyzed. Together, these five states account for just over one-third of the United States population, making them a fairly representative sample.[65]

New York law indicates that a hospital administrator could be asked to consent to a patient's organ donation.[66] Texas likewise includes the authority of a hospital administrator to consent if someone from the first nine groups is not "reasonably available."[67] When closer connections are unavailable to make a donation decision, Pennsylvania's catch-all provision allows for the donation decision to be made by any "person authorized or obligated to dispose of the decedent's body."[68] Florida does not grant hospital administrators authority to consent to organ donation.[69]

California law is the narrowest in terms of who can posthumously consent on behalf of the donor because it provides that, "in the absence of an express, contrary indication by the donor, a person other than the donor is barred from making, amending, or revoking an anatomical gift of a donor's body or part."[70] Because of the unique consent implications raised by WBGD, the people who are able to consent on behalf of a patient should be narrow, which will require states to amend existing organ donation laws, at least as applied to WBGD.

C. WBGD WOULD TAKE VALUABLE AND NECESSARY ORGANS OUT OF THE CURRENT ORGAN TRANSPLANT SYSTEM AND CAUSE TRANSPLANT PATIENTS LONGER WAIT TIMES

Donatable organs "include: heart, kidneys, lungs, pancreas, liver, intestines, corneas, skin, tendons, bone, nerve and heart valves."[71] One person's donation could save eight people and improve seventy-five lives.[72] Every day, seventeen people on the organ transplant waiting list die.[73] A new patient is added every eight minutes.[74] Waiting times range from 213 to 370 days.[75]

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64. Josephine Rozzelle, *These are the 10 Most Populated States in the U.S.*, US NEWS (July 17, 2023), https://perma.cc/XQP5-SU2H.

65. *See id.*

66. N.Y. COMP. CODES R. & REGS. tit. 10, § 405.25(c)(3) (2000).

67. TEX. HEALTH & SAFETY CODE ANN. § 692A.009(a)(1)–(11) (West 2009) (listing the first nine groups as including the decedent's agent, spouse, adult children, parents, siblings, adult grandchildren, grandparents, "an adult who exhibited special care and concern for the decedent," and the guardian at the time of death).

68. 20 PA. STAT. AND CONS. STAT. § 8611(b)(10) (West 2019).

69. FLA. STAT. ANN. § 765.512(3) (West 2022).

70. CAL. HEALTH & SAFETY CODE § 7150.35(a) (West 2008).

71. *Facts About Organ Donation*, UNOS, https://perma.cc/98BP-LVPR.

72. *Organ Donation Statistics*, HEALTH RES'S. & SERV'S ADMIN., https://perma.cc/G7VQ-D33A.

73. *Id.*

74. *Id.*

75. Lewis, Koukoura, Tsianos, Apostolos Gargavanis, Ahlmann Nielsen, & Vassiliadi, *supra* note 41, at 2.

Because there is currently a pressing need for organs, the use of bodies to gestate fetuses would cause further unnecessary death of patients waiting for transplants. If a family makes the difficult decision to pull life support from their young mother, daughter, or sister who is a registered organ donor, that woman's organs could immediately be used to save eight people.[76] However, if she is used for her uterus to serve as a gestational surrogate, her other organs will not be able to be used by waiting patients for the forty weeks of gestation. And perhaps after her initial surrogacy experience, her uterus will be used again for a second, third, or fourth surrogacy. If somatic support technology expands to make indefinite ventilation possible, her body could be used for several years, leaving the potential organ recipients waiting, and likely dying, on the transplant list. It is a great irony that this medical procedure has been termed "whole body gestational donation" because this system actually uses less of the woman's whole body to benefit others than the traditional organ donation regime.

Smajdor attempts to rationalize the use of WBGD by arguing that not all organ donation saves lives. She notes "since people can live without eyes, and survive for many years without dialysis, the insistence that organ donation should be 'life saving' seems outdated."[77] However, she fails to address how WBGD can be rationalized when it prevents certain organs that are lifesaving, in particular the heart and lungs, from reaching eligible recipients. Indeed, while eyes do not save a life, neither does the collection of eyes for transplant bar the collection of other vital life-saving organs, as WBGD would.

In addition, Smajdor admits that pregnancy has associated "risks and burdens,"[78] and such risks may ultimately cause harm to the woman's other organs, making those organs less viable for organ donation over time.[79] This causes further unnecessary death of patients waiting on the organ transplant list. Indeed, Smajdor concedes that medical professionals are unsure exactly how long individuals can be kept alive on a ventilator[80] because a person's heart can stop beating even with the ventilator performing other tasks.[81] One medical report indicates that "[m]ost documented cases show that gestation could be prolonged for 14 to 45 days (2–6 weeks)."[82] Thus, aside from the impact of pregnancy upon the woman's body, even prolonged ventilation poses a threat to her ability to donate life-saving organs such as her heart. Indeed, "the longer period of

76. *Organ Donation Statistics*, *supra* note 72.

77. Smajdor, *supra* note 3.

78. *Id.*

79. *See Brain Death & Donation After Circulatory Death*, LIFESOURCE, https://perma.cc/2JRG-DJKW (explaining that for a successful organ retrieval from a brain dead patient "adequate oxygenation and blood pressure must be maintained" so ventilation is continued while preparations are made for the surgery); *see also*, Smajdor, *supra* note 3 ("the longer period of ventilation required for WBGD would give scope for more medical complexities than those involved in conventional organ donation.").

80. The longest recorded gestation on a ventilator is 110 days. *Id.*

81. *Id.*

82. Daniel Sperling, *Should a Patient Who is Pregnant and Brain Dead Receive Life Support, Despite Objection from Her Appointed Surrogate*, 22 AMA J. ETHICS 1004, 1006 (2020).

ventilation required for WBGD would give scope for more medical complexities than those involved in conventional organ donation."[83]

Smajor's suggestion regarding the use of men's livers to gestate fetuses also proves problematic for the vitality of life-saving organs and the ability of recipients to obtain life-saving treatment. While her effort to protect women from being valued solely for their reproductive organs is arguably well-intentioned, the use of men as surrogates would mean that all brain-dead patients were capable of gestating and essentially limit the availability of donated organs to only the very narrow category of individuals who had consented to organ donation but who were unable, either initially or after carrying one or more fetuses to term, to serve as surrogates.

III. THE LEGAL LANDSCAPE AFFECTING WHOLE BODY GESTATIONAL DONATION

A. EXISTING CASE LAW DEMONSTRATES THAT REPRODUCTIVE DECISIONS SUBSEQUENT TO BRAIN-DEATH SHOULD BE MADE BASED UPON THE PATIENT'S WISHES

In *In re A.C.*, the D.C. Circuit Court held that "every person has the right, under the common law and the Constitution, to accept or refuse medical treatment. This right of bodily integrity belongs equally to persons who are competent and persons who are not."[84] That court further stated that "it would be an extraordinary case indeed in which a court might ever be justified in overriding the patient's wishes and authorizing a major surgical procedure such as a caesarean section."[85]

Following, in part, this line of reasoning, the Appellate Court of Illinois, First District, noted in *In re Baby Boy Doe*:

> Courts in Illinois and elsewhere have consistently refused to force one person to undergo medical procedures for the purpose of benefiting another person—even where the two persons share a blood relationship, and even where the risk to the first person is perceived to be minimal and the benefit to the second person may be great.[86]

Under this holding, Smajdor's argument that WBGD could be morally beneficial to society is unsuccessful because despite the mother's inability to improve medically from the brain-death, her body cannot be used, even to provide life to a new baby, absent her explicit consent to the medical procedures at issue. Because WBGD is more closely analogous to a cesarean section than to traditional organ donation, states should implement legislation codifying *In re Baby Boy Doe*'s rule for WBGD patients.

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83. Smajdor, *supra* note 3.
84. In re A.C., 573 A.2d 1235, 1247 (D.C. 1990).
85. *Id.* at 1252.
86. In re Baby Boy Doe, 632 N.E.2d 392, 403 (Ill. App. Ct. 1994).

B. THE SUPREME COURT SHOULD OVERTURN *BUCK V. BELL* TO AVOID EXPANDED APPLICATION OF WBGD BEYOND BRAIN-DEAD PATIENTS TO VULNERABLE POPULATIONS

Buck v. Bell, infamously stated:

> It would be strange if it could not call upon those who already sap the strength of the State for these lesser sacrifices, often not felt to be such by those concerned, in order to prevent our being swamped with incompetence. It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind . . . . Three generations of imbeciles are enough.[87]

While *Buck* as decided is limited to the holding that certain institutionalized individuals could be sterilized because of the supposed genetic conditions causing mental disabilities, it has not been overturned.[88] It is not a mere stretch of dystopian imagination that this precedent could eventually be twisted to argue that WBGD be expanded beyond brain-dead women to include other categories of women seen by some as disposable to the "risks and burdens of gestating a foetus in their own body."[89]

In fact, even in its current state, *Buck* is still being used, albeit not in quite the same manner as it originally was handed down. Between 2006 and 2010, prisons in California sterilized incarcerated women, and in 2017, a Tennessee judge similarly offered time served credit for both men and women if they underwent birth-control and sterilization procedures.[90] Indeed, "[w]hile state sterilization laws have been repealed, there are still gaps in state and federal protections. Currently, sterilization debates continue to emerge most in regard to incarcerated individuals, immigrants, and populations under guardianship or living with a disability."[91]

Because *Buck* is still being used, and it limits certain population's autonomy over their own reproductive decision making, there is a potential that those with ill-will towards these vulnerable groups may seek to test WBGD initially on groups such as these, whose vulnerability often indicates that there are fewer people or less powerful people to speak out about their injustices. While many women who suffer a brain-death may have family members that would deny

87. Buck v. Bell, 274 U.S. 200, 207 (1927).

88. *See* Leita Powers, *Could Forced Sterilization Still Be Legal in the US?*, SYRACUSE L. REV. (Oct. 15, 2020), https://perma.cc/9NQB-LQRL ("there still has not been a sweeping declaration by the Supreme Court ruling eugenics or forced sterilization unconstitutional.").

89. Smajdor, *supra* note 3.

90. Mercedes G. Molina, *The Shadow of* Buck v. Bell*: How Ignoring the United States' History of Forced Sterilization Has Fostered an Environment Ambivalent to Widespread Abuse*, MINN. J.L. & INEQUALITY, https://perma.cc/VU94-UW26.

91. Powers, *supra* note 88.

consent to WBGD, a patient whose mental disability may prevent them from giving their full consent independently of a guardian could potentially be used as a WBGD patient if their guardian consents. Under the precedent of *Buck*, this would be allowed, despite the tremendous harm it would cause to the patient, and even though such a patient who is under a guardianship would likely be rejected as a gestational carrier under existing surrogacy guidelines.[92]

IV. MORAL AND SOCIAL CONCERNS WITH WHOLE BODY GESTATIONAL DONATION

A. WHOLE BODY GESTATIONAL DONATION WOULD DEVALUE WOMEN AS WHOLE PERSONS AND PLACE GREATER VALUE ON THEIR ABILITY TO SERVE AS HUMAN INCUBATORS

Existing surrogacy laws already raise concerns about the valuation of women as whole persons because in surrogacy, "unlike any other medical context, where patients may revoke consent, intended parents expect the surrogate to waive her right to informed consent irrevocably. This decision occurs long before any medical intervention, before becoming pregnant, before hearing of risks and benefits of each intervention."[93] The risk of infringing on women's value is even greater with WBGD which "might lead to the exploitation and commodification of women's bodies, as they could be reduced to mere gestational carriers."[94]

Smajdor seeks to assuage concerns about the devaluation of women's whole persons by suggesting that men who are brain-dead could also potentially serve as gestators. She notes that "this could be risky – even fatal – for the person carrying the pregnancy. But for brain-dead donors, the concept 'fatal' is meaningless."[95] These statements should be alarming for anyone who values human life and autonomy because experimentation on individuals without their consent should not be allowed just because they are terminally ill. Historical experimentation on vulnerable individuals is now recognized for the harm and coercion it entails.[96]

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92. *Recommendations for Practices Using Gestational Carriers: A Committee Opinion*, AM. SOC'Y FOR REPROD. MED., (2022), https://perma.cc/U5TV-UEJF (listing grounds for rejection of a gestational carrier as including "inadequate cognitive functioning to support informed consent").

93. Katherine Drabiak, *Infants Born Through Surrogacy Contracts Cannot Be Canceled or Returned*, BILL OF HEALTH (Feb. 8, 2021), https://perma.cc/9W9Q-6DA3, (citing Katherine Drabiak-Syed, *Currents in Contemporary Bioethics: Waiving Informed Consent to Prenatal Screening and Diagnosis? Problems with Paradoxical Negotiation in Surrogacy Contracts*, 39 J.L. MED. & ETHICS 559 (2011)).

94. Aníbal M. Astobiza & Íñigo de Miguel Beriain, *Why Whole Body Gestational Donation Must Be Rejected: A Response to Smajdor*, 44 THEORETICAL MED. & BIOETHICS 327, 336 (2023).

95. Smajdor, *supra* note 3, at 122.

96. *See* Nina Avramova, *Unethical Experiments' Painful Contributions to Today's Medicine*, CNN HEALTH (Jan. 21, 2019, 8:07 PM), https://perma.cc/78M6-3YP6. ("Historic examples of human experimentation include wartime atrocities by Nazi doctors that tested the limits of human survival . . . . Wendell Johnson, who made several contributions to the field of communication disorders, tried to induce stuttering in normally fluent children. In the 1940s, prisoners in Illinois were infected with malaria to test anti-malaria drugs.").

Further, Smajdor's proposal does not adequately counter the concerns about the valuation of women.[97] Even under her system of gestating fetuses in men's livers, she acknowledges that "male gestators could carry only one pregnancy, rather than many consecutive ones."[98] What has been left unsaid here is that female WBGD donors could be used for many consecutive pregnancies. While even subjecting a brain-dead woman to one pregnancy is alarming, keeping a woman alive solely to serve as a gestational surrogate dehumanizes women by turning them into human incubators.[99] The fact that women could be subjected to this procedure multiple times keeps them in a subordinate and less protected position than similarly situated men.

Additionally, Smajdor does not propose a system for the interim period between the introduction of WBGD and when medicine might be advanced enough for men's livers to be viable gestational tools. In this undefined interim period, "women's bodies will remain the primary source of 'donation' at least until male gestation is viable."[100] This would further cement the male–female inequality created by the WBGD system. At its worst, it is conceivable that this devaluation of women's personhood could also decrease urgency in developing male-based gestational surrogates if society became content letting women serve as the sole gestators because they were seen as less valuable anyways.

B. WHOLE BODY GESTATIONAL DONATION WILL EXACERBATE A GROWING GENETIC GAP BASED ON WEALTH

There is also great risk that this proposal furthers the wealth divide in the United States. Because the cost of paying for assisted reproductive technology generally falls on the party seeking the child, it is likely that "[WBGD] would primarily be available to those who can afford it. Thus, feminist worries about inequities, especially ones about who benefits from whole body gestational donation, cannot be dismissed."[101] One report indicates that the median cost of a single cycle of in vitro fertilization ("IVF") conducted in the United States is approximately $19,200.[102] Given the additional costs that WBGD would implicate,

97. *See* Nicole Fice, *Feminist Responses to Whole Body Gestational Donation*, IMPACT ETHICS (Feb. 17, 2023), https://perma.cc/SY4P-BFE4 ("[T]he author's suggestion that feminist objections can be avoided by including men in the category of people eligible for whole body gestational donation does not sufficiently address the crux of feminist worries.").

98. Smajdor, *supra* note 3, at 122.

99. Said, Amer, Masood, Dirar, & Faris, *supra* note 34, at 222 (". . . with extended somatic support, the pregnant mother will serve as an incubator."); *see also* Sonya Laddon Rahders, *Natural Incubators: Somatic Support as Reproductive Technology, and the Comparative Constitutional Implications on Cases of Maternal Brain Death in the U.S., Canada, and Ireland*, 27 HASTINGS WOMEN'S L.J. 29, 35 (2016) ("If medical providers believe that the technology exists to make a dead body a beneficial 'natural incubator,' regardless of gestational age of the fetus or the family's wishes, we risk losing the ability to draw the line between active reproduction and passive incubation in the female body.").

100. Fice, *supra* note 97.

101. *Id.*

102. The Ethics Comm. of the Am. Soc'y for Reproductive Med., *Disparities in Access to Effective Treatment for Infertility in the United States: An Ethics Committee Opinion*, 116 FERTILITY & STERILITY

particularly the cost of sustaining the surrogate on a ventilator and other life-sustaining measures, the procedure would be largely unavailable to the general population. Indeed, "[s]tudies confirm that compared with their presence in the US population, persons of middle to lower socioeconomic status and persons of African-American or Hispanic ethnicity are underrepresented in the population of treated infertility patients."[103] While WBGD is not motivated by perpetuating racial inequality, it could exacerbate the racial divide.

Additionally, WBGD could exacerbate socioeconomic gaps in assisted reproduction. One existing example is disparity of IVF access in states that mandate insurance coverage for IVF treatments versus those that do not mandate such coverage.[104] However, because "fewer embryos are transferred per cycle in the mandated states, researchers believe that insurance coverage reduces the financial pressure to transfer >1 or 2 embryos in anyone."[105] Thus, rather than using brain-dead women as test incubators to implant large quantities with fetuses in order to maximize the chances of a successful pregnancy, a more safe and ethical solution for prospective parents would be for legislatures to provide greater incentives to insurance companies for covering fertility treatments. This could reduce the financial stress of conceiving couples by allowing parents to implant fewer fetuses in each IVF round without fear of no return on their financial investment in IVF.

Additionally, families who are less wealthy may be more willing to consent to this procedure for their brain-dead relatives to help pay for unexpected medical and funeral expenses. Those making decisions for their brain-dead loved ones

> are under an enormous amount of emotional distress, and when asked to make important medical decisions, such as whether to withdraw a ventilator, [they] often focus on what they want (their loved one alive) and not what the sick loved one would have wanted (for example, not to be hooked up to a ventilator).[106]

54, 55 (2021) [hereinafter *Ethics Committee Opinion*] (citing Alex K. Wu, Anobel Y. Odisho, Samuel L. Washington, Patricia P. Katz & James F. Smith, *Out-of-Pocket Fertility Patient Expense: Data from a Multicenter Prospective Infertility Cohort*, 191 J. UROLOGY, 427, 429 (2014)).

103. *Ethics Committee Opinion*, *supra* note 102, at 56 (citing Anjani Chandra, Casey E. Copen & Elizabeth Hervey Stephen, *Infertility Service Use in the United States: Data from the National Survey of Family Growth, 1982–2010*, NAT'L HEALTH STAT. REP. 7 (2014); Angela S. Kelley, Yongmei Qin, Erica E. Marsh, & James M. Dupree, *Disparities in Accessing Infertility Care in the United States: Results from the National Health and Nutrition Examination Survey, 2013–16*, 112 FERTILITY & STERILITY, 562, 566 (2019)).

104. Tarun Jain, *Racial Disparities and In Vitro Fertilization (IVF) Treatment Outcomes: Time to Close the Gap*, 18 REPROD. BIOLOGY & ENDOCRIN. 112, 112 (2020) ("[T]here was considerably less representation of cycles from black women compared to white women relative to their demographic representation in non-mandated compared to mandated states . . . . This major disparity seems to be further complicated by socioeconomic factors leading to disparate access and care among states with and without an insurance mandate to cover IVF treatment.").

105. *Ethics Committee Opinion*, *supra* note 102, at 56.

106. Kirsten Rabe Smolensky, *Rights of the Dead*, 37 HOFSTRA L. REV. 763, 801 (2009).

If the traumatic event which caused the patient to become brain dead was sudden and unexpected, then these decision makers may be even less likely to desire to terminate life support and they may grasp at the opportunity to gain financial assistance in maintaining such life support by agreeing to a surrogacy contract.[107] In sum, if WBGD is implemented it will allow "the wealthy [to] satisfy their desires with this technocratic solution while using the bodies of the non-wealthy."[108]

C. WHOLE BODY GESTATIONAL DONATION INFRINGES ON THE BRAIN-DEAD PATIENT'S DIGNITY IN DEATH

In whole body gestational donation, Smajdor concedes that "WBGD involves treating the patient's dead body as a means to an end, rather than as an end in itself."[109] Glimmers of this type of devaluation of women can be seen in other methods of ART, such as uterine transplants.[110] With uterine transplants, where a live donor's uterus is implanted into another patient as treatment for a variety of medical conditions, it is anticipated that even when used like other traditional forms of transplantation, there will be uterus shortages;[111] however, at least with live donors for uterine transplants, the woman's life can proceed after donating her uterus.

As proposed, WBGD does not protect brain-dead women to the same extent as non-brain-dead surrogates and poses a potential violation of the Equal Protection Clause, which provides that the government must treat similarly situated individuals equally.[112] Here, the similar situation of both groups is impregnation with a child for another couple to adopt.

Because WBGD patients would be legally alive, they would still have equal protection rights,[113] but their lack of consciousness would make them reliant on others to enforce those rights. In fact, advocacy for all of their interests depends

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107. *See* Cynthia J. Gries, J. Randall Curtis, Richard J. Wall, & Ruth A. Engelberg, *Family Member Satisfaction with End-of-Life Decision-making in the ICU*, 133 CHEST 704, 710 (2008) (summarizing previous studies which indicated that "33% of family members had a high burden of symptoms of Post Traumatic Stress Disorder (PTSD) and that family members had a higher burden of PTSD symptoms if they were involved in end-of-life decision-making.").

108. Astobiza & Beriain, *supra* note 94, at 338.

109. Smajdor, *supra* note 3, at 117.

110. *See* I. Glenn Cohen, *Borrowed Wombs: On Uterus Transplants and the 'Right to Experience Pregnancy*,' 2022 U. CHI. LEGAL F. 127, 133 (2022) ("The consequence of 'injury' (if that term is even appropriate given that the donor is dead) to the structures surrounding the uterus is no longer nearly as significant and this enables faster and more efficient harvesting of the uterus.").

111. Michelle J. Bayefsky & Benjamin E. Berkman, *The Ethics of Allocating Uterine Transplants*, 25 CAMBRIDGE Q. HEALTHCARE ETHICS 350, 353 (2016) ("Given the existence of shortages and waiting lists for every other kind of organ transplantation, it is reasonable to conclude that uteruses will also be in short supply.").

112. *Equal Protection*, LEGAL INFO. INST., https://perma.cc/4FZW-NK68.

113. *See* U.S. CONST. amend. XIV, § 1 ("No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.").

on others, leading to one of the most concerning elements of the proposed WBGD structure: because the surrogate is brain-dead, the surrogacy negotiations will be one-sided, and the donor will be unable to voice abuse or mistreatment that occurs.

Even if they were treated as legally dead, WBGD patients could have vested causes of action depending on the rights that were violated. Indeed, "even though a decedent will never know about any particular harm to his posthumous interests, that does not mean that a harm has not occurred or that such harm should not be protected against."[114] While Smajdor argues that these patients could be treated as means to an end because they are going to die soon,[115] her reasoning ignores their inherent humanity and therefore, courts should step in to ensure that the WBGD patients are not treated as dead prematurely. Courts should seek to preserve the surrogate's human dignity because "[t]he state's interest in a patient's life includes more than preserving her corporeal existence; it extends to a preservation of her humanity."[116] Indeed, "[e]ven if one accepts the notion that a woman's body becomes mere property in the eyes of the law when her brain has died, the state may not use that property without permission from the next of kin."[117] Receiving permission from next of kin leads into the final challenge of using brain-dead patients.

Finally, the use of brain-dead patients risks additional compulsion upon the surviving family members who must make critical decisions as to their loved one in a short period of time. Treatment for brain dead patients and patients in a persistent vegetative state differs: while a "default, recommendation for a brain dead patient might be to remove them from support, . . . the recommendation for a vegetative patient might be to leave them on support."[118] Indeed, "hospital[s] may elect to leave the [brain-dead] patient on support for a matter of days so that the family can say goodbye, though in some cases any further treatment of the patient may constitute interference with a dead body."[119] Faced with these limited options, the family of a brain-dead patient who is presented with the newly introduced opportunity to continue life support by arranging with prospective parents to enter into a surrogacy agreement under WBGD may enter into such agreements under the false hope that their loved one will eventually wake up or the brain damage will reverse itself.[120] Implementation of WBGD would put

114. Smolensky, *supra* note 106, at 771.
115. Smajdor, *supra* note 3, at 117.
116. Jordan, *supra* note 37, at 1155.
117. *Id.* at 1163.
118. Laddon Rahders, *supra* note 99, at 36.
119. *Id.*
120. *Understanding Brain Death*, GIFT OF LIFE DONOR PROGRAM, https://perma.cc/5VXA-5HUX ("A brain dead person being sustained on a ventilator can feel warm to the touch and may look 'alive.' . . . When this happens, families may hope that their loved one's condition will improve."); *see e.g.* Marleen Eijkholt, *Medicine's Collision with False Hope: The False Hope Harms (FHH) Argument*, 34 BIOETHICS 703, 704 (2020) ("[Jahi McMath] was declared brain dead by physicians and court rulings. However, Jahi was kept on artificial nutrition, hydration and a ventilator, while her family hoped that she would

unnecessary pressure on these families, when "[d]ecisions about end-of-life care should be made based on religious and moral beliefs with a view toward protecting the dignity of the human person, not on their utility to gestate."[121] The current decision-making process for family members is already difficult and often exacerbates mental health problems for family members,[122] which the introduction of WBGD would likely only worsen.

V. PROTECTING VULNERABLE GROUPS

WBGD touches on several areas of inequality: gender, wealth, and even status of life. This Note concludes by detailing ways in which states can structure legislation to prevent such inequalities from developing, as well as including suggestions for individuals who care to shape their estates in such a way as to avoid consenting to the proposed system of WBGD.

A. STATES

Because, "the dead are physically incapable of enforcing their posthumous rights and keeping their postmortem affairs in order . . . if the law grants posthumous rights, it must also establish a system for enforcing these rights."[123] If state legislatures choose to accept the inherent risks that come with whole body gestational donation and approve the procedure, they should provide rights for the estates of these donors to ensure that these donors are not abused or taken advantage of because they cannot protect their own rights.

Further, states should establish a separate consent structure for WBGD that is separate from organ donation laws. Because of the sensitive nature of the use of reproductive organs while a patient is on somatic support, this system, if implemented, should be solely on a prior opt-in basis, and not an opt-out basis. Further, unlike the UAGA which allows close family members who are statutorily categorized to make the decision in the absence of clarity regarding the patient's wishes, WBGD should not be implemented unless consent was clearly given directly by the patient before the brain-death occurred. This would protect the woman's right to refuse medical treatment, as reasoned in *Cruzan v. Missouri Department of Health*, which found that "there is no automatic assurance that the view of close family members will necessarily be the same as the patient's would have been

recover from brain death."); *see also* Laddon Rahders, *supra* note 99, at 36 (explaining that "[t]here is confusion and controversy about differentiation of brain death and vegetative state even in the medical community.").

121. Matt Lamb, *Using "Brain Stem Dead" Women to Incubate Babies is Objectification at its Worst*, WASH. EXAMINER (Feb. 14, 2023, 11:58 AM), https://perma.cc/2RKN-V8N4.

122. Gries, Curtis, Wall, & Engelber, *supra* note 107 (reviewing previous studies that showed "73% of surrogate decision makers experienced anxiety and 35% experienced depression during their loved one's ICU stay.").

123. Smolensky, *supra* note 106, at 799.

had she been confronted with the prospect of her situation while competent."[124] Additionally, this limitation on consent would prevent even the appearance of impropriety raised by a hospital administrator's statutory ability to consent in some states[125] given that, unlike the ability to consent to an organ transfer, the costs associated with sustaining somatic support and providing fertility services could prove incredibly lucrative for a hospital.

State legislatures should limit the number of surrogacy attempts that WBGD patients are subjected to so that brain-dead women do not turn into human incubators. Furthermore, WBGD patients should be afforded the same protections as to the number of fetuses transferred at a time to ensure they receive the same safety protections as conscious surrogates would receive. While Smajdor argues that the health risks are different between the two groups,[126] the complete death of the brain-dead patients should not be accelerated by unnecessarily transferring more fetuses than would be transferred into a conscious surrogate.

States may also wish to consider funding appointed counsel to represent donors so that negotiations are not solely one-sided demands by the prospective parents seeking a surrogate. Alternatively, some states, such as New York, have enacted statutory provisions regarding the surrogate's right to representation at the expense of the prospective parents.[127] Implementation of this payment structure could be difficult in WBGD because the brain-dead patient would be unable to communicate with the lawyer paid by the prospective parents and therefore it would likely that the lawyer's primary source of information would be the prospective parents. While the lawyer would be duty bound to zealously advocate[128] for the client they're hired to represent,[129] the attorney would likely use a substituted judgment model based on information obtained from the hiring prospective parents.[130] However, this payment scheme could serve to limit the number of

124. Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 286 (1990); *see also,* In re A.C., 573 A.2d 1235, 1250 (D.C. 1990) ("sometimes family members will rely on their own judgments or predilections rather than serving as conduits for expressing the patient's wishes.").

125. *See* N.Y. COMP. CODES R. & REGS. tit. 10 § 405.25 (2000); TEX. HEALTH & SAFETY CODE ANN. § 692A.009 (West 2023).

126. *See* Smajdor, *supra* note 3, at 120 ("The WBG donor *has* no everyday life: her function is solely to gestate. We dare not transfer too many embryos into living women, because selective reduction is traumatic and harmful to the pregnant woman. There are no such problems in relation to the WBG donor.").

127. N.Y. FAMILY COURT ACT § 581–603 (Consol., 2024) ("A person acting as surrogate has the right to be represented throughout the contractual process and the duration of the surrogacy agreement and its execution by independent legal counsel of their own choosing who is licensed to practice law in the state of New York, to be paid for by the intended parent or parents.").

128. MODEL RULES OF PRO. CONDUCT 1.3, cmt. 1 (AM. BAR ASS'N 2024) ("A lawyer must also act with commitment and dedication to the interests of the client and with zeal in advocacy upon the client's behalf.").

129. MODEL RULES OF PRO. CONDUCT 1.8(f) (AM. BAR ASS'N 2024) (outlining the conditions which must be satisfied for a third party to pay for an attorney's representation of an individual).

130. *See* Andrea Khoury, *ABA Adopts Model Act on Child Representation*, ABA (Sept. 1, 2011), https://perma.cc/5YRQ-SQML (defining substituted judgment as "the lawyer attempts to determine what the child would decide if the child was capable of making an adequately considered decision.").

prospective parents by creating an additional financial hurdle for prospective parents to pass.

Regulations of WBGD should also take into consideration the potential custody of the child in the event that the prospective parents either die before the child is born or divorce while the fetus is gestating. In New York, prospective parents must agree to have a will naming a guardian for the child before embryo transfer begins.[131]

New York surrogacy agreements also require that "the intended parent or parents agree to accept custody of all resulting children immediately upon birth regardless of number, gender, or mental or physical condition."[132] Because the brain-dead gestator would not be in a condition capable of caring for the child, it would be particularly important for states to require prospective parents to agree to take custody of the child after it is born without regard for sex or possible genetic conditions that arise.

Finally, states will need to decide whether minors can be used for WBGD. Minors have independent rights to consent to certain reproductive health treatments without parental approval.[133] However, the 2006 UAGA indicates that a minor's consent to serve as an organ donor can be revoked by a parent upon an event which makes donation an imminent possibility.[134] While WBGD is uniquely situated in the middle of these two laws, states should seek to err on the side of restricting the consent of minors from this invasive and experimental procedure.

B. INDIVIDUALS

The very first step that individuals who wish to refuse WBGD treatment should take in preparing their estate in case of sudden brain death is to discuss their wishes with trusted loved ones who will be responsible for making decisions regarding care. A study found that "decision-makers, whether spouses, children or other family members, correctly predict the patient's wishes only sixty-six percent of the time."[135] By conveying one's wishes to trusted decision-makers before a decision triggering event occurs, this percentage could hopefully be raised to more accurately reflect the overall wishes of patients who are unable to make their own medical decisions.

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131. N.Y. FAMILY COURT ACT § 581–403(2)(v) (Consol., 2024) ("the intended parent or parents agree to execute a will, prior to the embryo transfer, designating a guardian for all resulting children and authorizing their executor to perform the intended parent's or parents' obligations pursuant to the surrogacy agreement.").

132. *Id*. at (2)(i).

133. *Minors' Rights*, NYCLU, https://perma.cc/3CUH-KFZ3 ("New York law allows [minors] to consent to confidential sexual and reproductive health care without involving parents or guardians in the process.").

134. ANATOMICAL GIFT ACT 2006, *supra* note 55, at § 8(g) ("If a donor who is an unemancipated minor dies, a parent of the donor who is reasonably available may revoke or amend the anatomical gift of the donor's body or part.").

135. Smolensky, *supra* note 106, at 800.

Individuals seeking to avoid use as a whole body gestational donor should also sign an organ donation refusal as described in Section 7 of the 2006 UAGA which

> permits an individual to sign a refusal that bars all other persons from making an anatomical gift of the individual's body or parts. A refusal generally can be made by a signed record, a will, or, under limited circumstances, orally. By permitting refusals, this [Act] recognizes the autonomy interest of an individual either to be or not to be a donor. The section also recognizes that a refusal can be revoked.[136]

Signing a refusal before circumstances present themselves is vital because the UAGA is a one-way street in that

> [a]n anatomical gift by an agent, parent, or guardian remains in effect until such time as amended or revoked by an agent, parent, or guardian, or by the donor on whose behalf the gift was made. [. . .] While agents, parents, and guardians can make an anatomical gift, they cannot sign a refusal under Section 7 on their principal's or ward's behalf. A refusal can only be made by that individual whose part or body might otherwise have been the subject of an anatomical gift.[137]

Women who are actively growing their own families but do not wish to serve as surrogates for unknown recipient parents should clearly indicate their wishes to their partner, as well as in an advanced directive. They may also seek to research their state's laws regarding pregnancy clauses in advanced directives, and in this way their advanced directive may be read to maintain an existing pregnancy's viability while expressly indicating their lack of consent to WBGD which would transfer a fetus to their uterus post-brain death.

It's recommended that individuals review their advanced directives and other health care forms with each new diagnosis, change in marital status, or passage of ten years.[138] This repetition returns to the conversations with loved ones who will be charged with making medical decisions. Regularly conversing about a patient's wishes will ensure her desires are clear and able to be followed if traumatic injury occurs.

CONCLUSION

Insomuch as Smajdor asserts that the system of whole-body gestational donation should lead us to reconsider the existing structure of our organ donation system, she is correct that improvements could be made. But beyond the concerns

136. ANATOMICAL GIFT ACT 2006, *supra* note 55, at 6.

137. *Id.* § 4, cmt.

138. Mayo Clinic Staff, *Living Wills and Advance Directives for Medical Decisions*, MAYO CLINIC, https://perma.cc/8EAV-NCTE.

that currently are posed by the organ donation structure, whole body gestational donation clearly would cause harm to the women who by misfortune became the initial brain-dead patients to carry the babies of prospective parents. The human cost in this proposal would be astoundingly high, and the societal cost of treating women merely as a means to an end would take generations to repair.

While technology to implement WBGD does not currently exist, lawmakers should begin to consider passage of policies that establish opt-in organ donation consent that would protect brain-dead patients from being used as human incubators. Legislators should also review existing laws on surrogacy and put limits on the number of implantations to protect current surrogates and also any future WBGD patients. Additionally, individuals who desire to avoid use as a WBGD patient should create an advanced care directive, establish an estate plan with an attorney, and have clear conversations with their loved ones and surrogate decision makers as to their wishes if they suffer a brain-death trauma or are otherwise unable to make their own decisions. Together, these steps can create an environment limiting some of the harms that WBGD poses and maintaining the dignity and worth of women as whole persons.