

Ethical Issues Surrounding Surrogate Health Care Decisions

I. Introduction: Consent and Competency

It is well understood by the public that a person has the right to consent to a medical treatment. The doctrine of consent stems from our concept of battery. “At common law, even the touching of one person by another without consent and without legal justification was a battery.”¹ “This notion of bodily integrity has been embodied in the requirement that informed consent is generally required for medical treatment.”² “Every human being of *adult years and sound mind* has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault, for which he is liable in damages.”³ “The logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment.”⁴ In practice, a competent person will be asked to consent to medical treatment.

While it is clear that a competent person may consent to treatment, most state statutes provide that a person who is incompetent cannot consent to medical treatment.^{5, 6} While every state’s definition may differ, a good working definition of competent might be:

the ability to understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of and alternative to any proposed health care, and to reach an informed decision.⁷

A person may be incompetent due to a variety of reasons and circumstances. For example, the person may be under the age of 18, unable to understand the health care decision, or unable to communicate a health care decision. For whatever reason, if a person is incompetent, he or she cannot consent to medical treatment.

If a person is incompetent and not able to consent for him or herself, then the only way for the person to consent to medical treatment is through a surrogate. A surrogate is a person who speaks for the incompetent and could be a family member, friend, spouse or health care provider.

Although a surrogate is the only way for an incompetent person to consent, there are limits to the surrogate’s decision-making authority. Due to advances in science and medicine, the range of health care decisions which might have to be made by a surrogate far exceed the legal guidance available, which brings the surrogate to the threshold of ethics.

II. The Law Regarding Surrogate Decision-Making: *What We Know*

Surrogate decision makers can look to the law for guidance regarding their authority, the standard that they base their decisions on, and the limits to their authority.

A. By What Authority?

Surrogate health care decision makers may derive their authority from statutes that create a health care proxy or from other sources when a proxy is not available.

1. Health Care Proxy Statutes. At this time, all 50 states have a statute which creates a durable power of attorney for health care or a health care proxy.⁸ Such statutes outline the requirements for the creation of a surrogate's authority, the execution formalities and other details. Due to space constraints, this presentation will focus on the proxy statutes of Massachusetts, New York, California and Florida.⁹

Although it is common for estate planning professionals to draft a health care proxy for a client, less common is the circumstance when the proxy is actually used and there is conflict with other family members, or a health care professional or institution. In this situation, the professional may find himself or herself in an interesting ethical predicament illustrated by the following hypothetical:

An attorney drafts estate planning documents, including a proxy, for his client, A. The proxy names A's son, B, as the surrogate decision maker. A becomes incapacitated, and B comes to the attorney with the proxy in hand and asks the attorney for assistance and representation. Can the attorney, who represented A, now represent B as he exercises the authority given in the proxy?

According to the American Bar Association's Model Rules for Professional Conduct, an attorney who has formerly represented a client cannot thereafter represent another person in the same or a substantially related matter in which that person's interests are materially adverse to the interests of the former client unless the former client gives informed consent, in writing.¹⁰ Here, the attorney's former client, A, is not competent to give the written consent waiving the conflict. But is this representation materially adverse? The attorney may simply be carrying out the express wishes of his client, A, by assisting B in exercising the proxy power that A gave to him. This situation may be more analogous to representing a principal and then an agent in a business endeavor than it is to representing a ward and then the guardian in a proceeding to establish the guardianship.

2. Absence of a Health Care Proxy. In many circumstances, a health care proxy was never executed or could never have been executed. For example, the person in need of a surrogate may never have had the capacity to execute a proxy because that person has always been a child or has always been unable to understand health care decisions. When a proxy is not available to authorize a surrogate to act, the surrogate must look to other sources for authority.

One source of a surrogate's authority other than a proxy could be a statutory provision allowing a family member to make health care decisions for the incompetent person. For example, the Massachusetts statutes provide that if no health care proxy has been executed, the health care provider may rely on the informed consent given by responsible parties on behalf of the incompetent patient to the extent permitted by law.¹¹ In other states, a parent may have authority as a health care surrogate without statutory authority.

Another source of a surrogate's authority other than a proxy could be a formal guardianship. In the well-known Cruzan case, the patient did not execute a proxy while competent and her parents became the co-guardians of her person with the authority to make health care decisions, although with some limitations.¹²

In New York, a parent of a child may have authority to make decisions. In the Matter of AB involved a child who was in a persistent vegetative state.¹³ The child never had the capacity to execute a health care proxy. The child's mother as parent and natural guardian petitioned the court to remove life support. The Supreme Court of New York held that, as parent and natural guardian, the mother had the authority to consent to the removal of life support.

B. By What Standard?

In general there are two standards by which a surrogate decision maker may make health care decisions: substituted judgment and best interest.

Substituted judgment focuses on the patient's viewpoint:

"If a patient, while competent, expressed clear wishes regarding treatment, the standard for surrogate decision-making is substituted judgment (i.e., what the patient would have wanted, if competent.) In other words, if the patient's wishes are known or knowable, they are to be respected. The surrogate decision maker must endeavor to faithfully reflect the patient's wishes in making health care decisions."¹⁴

Some of the factors that a court might consider include the patient's expressed preferences, the patient's religious convictions and their relation to refusal of treatment, the impact on the patient's family, the probability of adverse side effects and the prognosis with and without treatment.¹⁵

Best interest focuses on the decision maker's viewpoint:

"If an incompetent patient's prior wishes are not known or knowable, the standard for surrogate decision-making is best interest (i.e., what is best for the patient). The surrogate decision maker must carefully assess the benefits and harm of various treatment options (including the option of no treatment) and determine which of these options has the most favorable benefit-harm ratio."¹⁶

Some of the factors that a surrogate could consider include the patient's present levels of physical, sensory, emotional and cognitive functioning, the quality of life, life expectancy and the prognosis for recovery with and without treatment, the various treatment options, the degree of humiliation, dependence and loss of dignity resulting from the condition and treatment, the opinions of the family, the reasons behind those opinions and the motivations of the family in advocating a particular course of treatment.¹⁷

Many of the state's statutes require that surrogates make decisions based on a combination of the standards. For example, under the Massachusetts proxy statute, the agent makes health care decisions "(i) in accordance with the agent's assessment of the principal's wishes, including the principal's religious and moral beliefs, or (ii) if the principal's wishes are unknown, in accordance with the agent's assessment of the principal's best interests."¹⁸ The laws of Florida and California similarly require the surrogate to first consider the patient's wishes before considering the patient's best interests.¹⁹ Under New York's health care proxy statute, the surrogate must first consult with a licensed physician, registered nurse, licensed psychologist, licensed master social worker or a licensed clinical social worker.²⁰ Then, the surrogate must make health care decisions in accordance with the patient's wishes, including the patient's religious and moral beliefs or, if the patient's wishes are not reasonably known and cannot with reasonable diligence be ascertained, in accordance with the patient's best interests.²¹

C. What Limits?

Although it seems that a health care surrogate has broad powers, he or she may not have unlimited power and authority to make decisions regarding the patient's health. Generally, if a surrogate has authority based on a health care proxy statute, then the authority is quite broad. For example, the Massachusetts statute states that "an agent shall have the authority to make **any and all health care decisions** on the principal's behalf that the principal could make, including decisions about life-sustaining treatment, subject, however to any express limitations in the health care proxy."²² The term, "all decisions" has been interpreted broadly, and includes decisions regarding mental health care and involuntary confinement, as well as the authority to consent to treatment and refuse treatment, and the related issue of pain management.²³

Although health care proxy statutes seem to provide broad powers, many proxy statutes expressly limit the authority of the agent to "health care decisions." For example, under the Massachusetts statute, "health care" means "any treatment, service or procedure **to diagnose or treat** the physical or mental condition **of a patient**."²⁴ The New York statute specifically states that a surrogate acting by proxy has no authority to make end-of-life decisions, absent evidence of a patient's wishes.²⁵ Therefore, some health decisions that a surrogate could be called on to make (discussed below) may not come within the definition of "health care decisions," and the surrogate may lack the authority to speak for the patient.

When the surrogate's authority is based on qualification as a guardian, the surrogate may still encounter limits to his or her authority to make health care decisions. For example, in the Cruzan case, the patient was in a persistent vegetative state and her parents became co-guardians.²⁶ The guardians decided to refuse treatment (or decided not to consent to treatment) on the patient's behalf. The guardians found that their authority to refuse to consent as a

surrogate was limited by a Missouri law, upheld by the Supreme Court, which required the guardians to produce clear and convincing evidence of the patient's wishes regarding end-of-life decisions. Absent that evidence, the guardians were not able to make a surrogate health care decision.

III. Ethical Considerations Regarding Surrogate Decision Making: *What We Don't Know*

Given the limits on the scope of a surrogate's authority, there are many situations in which a surrogate finds that existing law provides insufficient guidance. Until the law catches up to scientific advances, resolving new and previously untested questions in these cases requires interpretation and extrapolation of existing law, with guidance from the ethical principles that helped shape existing law.

A. What Happens if a Patient Objects?

In some cases, a patient might object to the decision made by his or her surrogate health care decision maker. In the case of Health Care Proxies, the authority of the surrogate decision maker is limited to circumstances when the principal either cannot make, or unable to communicate, medical decisions for him or herself. Many proxy statutes address the conflict between the surrogate decision maker and the patient. In Massachusetts and New York, if the patient objects to a decision made by a surrogate pursuant to a health care proxy, then the patient's decision will prevail unless there is a court order regarding incapacity.²⁷ Similarly, in California, an agent is not authorized to make a health care decision if the principal objects to the decision.²⁸

In Cohen, the patient gave her surrogate a health care power of attorney.²⁹ The surrogate made a decision under that authority that the patient should be confined to a mental health facility. The patient objected to the confinement, revoked the proxy and filed a motion to dismiss the hospital's petition for involuntary commitment. The Massachusetts court held that although the broad language of the proxy includes mental health decisions, if the patient objects to a decision, then the decision is invalid unless a court determines that the patient is incapacitated. The patient's objection functioned as a revocation of the proxy. Without authority under the proxy, the surrogate was forced to seek authority from the courts to make any health care decisions.

In some cases, if the patient objects but is found to be incompetent, then the court will use the best interest standard when making a decision regarding health care. In In re Storar, the patient was an adult who had never had the mental competency to express his health care preferences and who suffered from terminal bladder cancer.³⁰ The health care facility determined that the patient needed regular blood transfusions; however, after several transfusions had already taken place, the patient expressed discomfort and emotional stress. The patient's guardian decided to refuse to consent to further transfusions. The health care facility petitioned the court to override the patient's objection and the guardian's decision. The court held under the best interest standard that the treatments could continue because, although they were

disagreeable to the patient, they allowed him to maintain his usual mental and physical activities such as feeding himself and taking walks.

In the case of a patient whose incompetence is solely due to age, there remains a question as to whether his or her objection would be more persuasive to the court. Parents are the legal decision makers with respect to health matters for their children, although their authority is not unlimited, and the State may challenge decisions made by the parent if not in the best interests of the child. Consider also, if the child were seventeen years old, just on the cusp of being competent to consent to treatment, and she objected to her parent's consent to a particular treatment, such as a certain medication. Would the court take into consideration that she is near competency, and consider her wishes? Would the court apply the same standards as if the parent had petitioned to be appointed the guardian of her person after reached age 18?

B. What Happens if the Decision Benefits Someone Other than the Patient?

A health care surrogate may be asked to make a health-related decision that benefits someone other than the patient. For example, the spouse of a patient in a persistent vegetative state might desire to have children with that person, which would require the surrogate health care decision maker to consent to the harvesting of gametic material from the patient, or consent to the use of previously stored gametic material. Arguably, this process would not benefit the patient's health (although, if the patient had previously expressly the wish and desire to procreate, there may be "benefit" to the patient, albeit not directly related to the patient's health); rather, in this example, it benefits the patient's partner). In another example, the surrogate may request experimental, aggressive treatment for the patient in lieu of conventional treatment, and the experimental treatment may have potentially severely debilitating side effects, or an increased likelihood of fatality. The surrogate decision maker may wish to include the patient in an experimental study for research purposes in which some of the participants may receive placebos instead of treatment, and may require the disclosure of medical information unrelated to the particular illness. Participation in the experimental study may not benefit, and may actually harm, the patient, but may benefit society at large. In other situations, the surrogate may be asked to consent to the patient donating an organ, such as a kidney, or bone marrow, to a family member, or, in a more extreme case, to consent to the storage of tissue or cells that may possibly be used to treat a child in the future, but for which there is no current need. This decision may not benefit the patient's health at all, but most certainly will expose the patient to unnecessary medical risk. The question remains whether a surrogate decision maker has the authority to make a decision which the patient may have made if competent, but that does not benefit the patient.

Decisions that benefit someone other than the patient are not decisions that a surrogate can make under the authority of a health care proxy. Under the language of most health care proxy statutes, a surrogate may make "health care decisions", defined as decisions for the diagnosis or treatment of the patient.³¹ Under the Uniform Anatomical Gift Act, adopted with variations in all states, there are designated individuals who may consent to organ donation, provided the purpose of the donation is for transplantation, therapy, education or research.³² It is not clear whether the health care surrogate may consent to organ donation, particularly if he or she is not a decision maker under the state statute. Even if such a decision will benefit the patient in some way as well as another person, the surrogate may not have the authority to

consent to a procedure which does not diagnose or treat the patient, much less one that may result in harm to the patient, as in the case of an experimental study.³³

Perhaps the most interesting ethical question in this area is the situation where parents deliberately conceive another child in order to create a match for organ donation for an ill child. There are a number of ethical questions raised. First, was the decision to conceive a child deliberately with the intention of donating an organ ethical, and second, whether the parents are the appropriate persons to consent to the procedure when and if it is determined that the two children are an appropriate match for organ donation.

Even if the surrogate has authority as a court-appointed guardian, the surrogate may still be restricted in his or her ability to consent to a medical procedure which benefits someone other than the patient. In the Strunk case, the patient was an incompetent adult who had never had the capability to sign a health care proxy.³⁴ The patient's brother suffered from kidney disease and required a transplant, and the only family member who matched was the incompetent patient. The patient's guardians, his parents, thought it best to consent to the patient having one of his kidneys removed and donated to his brother and petitioned the court for authority to force the health care facility to comply. The Kentucky Court of Appeals held that it was in the best interest of the patient to donate a kidney to his brother because the patient was close to his brother, emotionally and psychologically dependent on him, and because his well-being would suffer more from the loss of his only brother than from the loss of one of his kidneys.

In contrast to the holding in the Strunk case, the Wisconsin Supreme Court found that guardians could not consent to the removal of a kidney for the benefit of a sibling. In In re Guardianship of Pescinski, the patient was an incompetent adult who existed in a catatonic state.³⁵ The patient was the only family member who provided an appropriate match for donating a kidney to another family member who would die without it. The court held that it was not in the best interest of the patient for the guardian to consent to such a procedure, noting that the patient was without understanding or ability to acknowledge the emotional and psychological benefits of having that family member continue to live. Therefore, the patient gained nothing from the donation and the procedure was not in his best interest.

While the subject of consent to organ donation during the patient's life is still a matter of debate, once the patient dies, the state statute, and the priority of decision makers thereunder, should apply. Under common law, the patient's next of kin has the right to make decisions concerning burial or cremation, organ donation and autopsy, subject to the overriding authority of the state to regulate those matters for the public safety.³⁶

Once impossible, science has progressed to the point where it is possible for an incompetent person in a persistent vegetative state to have children, and the question becomes who has the right to consent to the removal of gametic material on behalf of the incompetent person? In many cases, no express consent to the removal was provided by the patient, nor was direction given as to the permissible use of the sperm or ova. A surrogate acting under a health care proxy likely would not have the authority to consent because the removal of sperm or ova is not a procedure to diagnose or treat the patient,³⁷ but such retrieval is occurring with increasing frequency, particularly if the treating physician is presented with some evidence of the patient's

wishes, as is sometimes available in the case of an expected decline in health. The Uniform Anatomical Gift Act, although applicable to bodily fluids, does arguably also does not apply, unless specific provisions are included in the particular state statute. For example, the New York statute specifically includes ova. In fact, many institutions are working to create guidelines for evaluating such requests for patients in a persistent vegetative state or post death.³⁸ If the courts have the authority to consent, which standard would they use: substituted judgment or best interest? And, even if the retrieval is accomplished successfully, it is not clear who has the authority to store the gametic material, nor is it clear who has permission to authorize its use, during the patient's life or following his or her death.³⁹ The scant case law that exists does not address postmortem procurement of gametic material.

C. What Happens if Someone Other than the Principal/Patient Objects?

If a person other than the patient objects to the health care decision made by the surrogate, some state statutes allow for a proceeding to challenge the surrogate's decision. For example, in Massachusetts and New York, the health care proxy statutes provide that a health care provider, guardian family member, or friend has the right to commence a special suit in court to override the surrogate's decision.⁴⁰ The petitioner must show that the surrogate's decision was made in bad faith or was not made in accordance with the standard set by law.⁴¹ This type of proceeding is not as extensive as a guardianship proceeding and would likely only override a particular decision of the surrogate; the burden would be extremely heavy in any action to remove the surrogate.

In other cases, a person who objects to a surrogate's decision could institute a temporary or permanent guardianship proceeding to completely supersede the surrogate's authority to make any health care decision. For example, in the Guardianship of Elma Mason, the surrogate with authority under a health care proxy (the patient's son) and the temporary guardian (the health care facility) disagreed as to whether to enter a "do not resuscitate" order on the patient's chart.⁴² The Massachusetts Court of Appeals held that the surrogate's authority to make health care decisions was terminated when the temporary guardian was appointed, because the petition of the temporary guardian qualified as a proceeding under the Massachusetts statute described above.

In New York, the health care proxy statute specifically states that the guardian can override a decision made by a surrogate health care decision maker. "Every adult shall be presumed competent to appoint a health care agent unless ... a committee or guardian of the person has been appointed for the adult..."⁴³ The appointment of a guardian prevents the patient from executing a valid health care proxy and prevents any already-appointed surrogate from making any health care decisions.

In contrast, the Florida statute provides that the surrogate continue to make all health care decisions even after a guardian of the person has been appointed, unless the court has modified or revoked the power of the surrogate.⁴⁴

For these reasons, many Health Care Powers of Attorney documents include a guardian nomination provision to name the designated agent to serve as guardian of the person of the principal, in the event a guardianship proceeding is required. However, even if the surrogate decision maker is the guardian of the incompetent person, if there is conflict among family members, then the authority of the guardian may be limited and the courts may get involved. For example, in the well-publicized Schiavo case, a woman in a persistent vegetative state had not executed a proxy while capable of doing so.⁴⁵ Her husband and legal guardian made the decision to remove her artificial life support; however, her parents, and eventually the State of Florida, objected to the decision. When the guardian prevailed in the courts, the Florida legislature passed a law giving Governor Bush the authority to issue a stay.⁴⁶ In theory, a validly executed health care proxy and a court-appointed guardian should eliminate uncertainty and the need to use judicial resources; however, in reality, if there is conflict among family members, and especially if the government becomes involved, the courts may make the final decision.

D. What Happens if the Surrogate and the Person Financially Responsible do Not Agree on the Health Care Decision?

In some circumstances, the surrogate decision maker and the person financially responsible for payment for the health care treatment may not be the same person, and the surrogate responsible for financial decisions may believe that a particular experimental treatment which is not covered by insurance is not a wise use of the patient's resources. The financially responsible person could be a conservator or guardian of the property, the heirs or spouse of the patient, or the health care facility. The bifurcation of decision making can make an already difficult decision even more so.

In a case arising in New York prior to the adoption of the health care proxy statute, the spouse of a patient consented to the removal of the patient's feeding tube to be removed.⁴⁷ The health care facility refused to honor the consent, and petitioned the court to determine whether the life support should be removed. The court initially held that the spouse had not shown clear and convincing evidence of the patient's wishes to be free from life support, which was the appropriate standard at that time. Therefore, the patient remained on life support with the feeding tube. After the patient's death, the health care facility sued the spouse for payment of services relating to the time after the spouse had consented to the removal of life support. The New York Court of Appeals held that the facility rightfully refused to discontinue treatment because the burden to show the patient's wishes was on the spouse. The spouse had not met the burden, the treatment was appropriate, and the spouse was not excused from payment. Had the patient remained alive, it is not clear that she (or indeed anyone else with financial decision making authority) could have argued that the financial resources were inadequate to support the treatment. On the other hand, if the particular treatment were elective, the outcome might be different.

IV. Conclusion

Health care proxy statutes and other sources of authority give a surrogate health care decision maker the power to make decisions, but statutes and case law precedents have not kept

pace with the advances in medicine and science, and new application of existing science that blurs the line between treatment of the patient and procedures that benefit others. Clients, surrogates, and the attorneys who advise them, must consider ethics, as well as the law, to resolve the tough questions that science presents.

2550851_v3

¹ Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261, 269 (1990).

² Id.

³ Id. (emphasis added).

⁴ Id. at 270.

⁵ Mass. Gen. Laws ch. 201D, § 1; N.Y. Pub. Health Law § 2980.

⁶ Incompetent persons are referred to in this paper as either "patients" or "principals." Health care agents and/or proxies are referred to as either a "surrogate" or "decision maker."

⁷ Mass. Gen. Laws ch. 201D § 1.

⁸ For a list of the state statutes and further discussion, see T.P. Gallanis, Write and Wrong: Rethinking the Way We Communicate Health-Care Decisions, 31 Conn. L. Rev. 1015, n.113 (1999).

⁹ See Mass. Gen. Laws ch. 201D, § 1; N.Y. Pub. Health Law § 2980; Cal. Prob. Code § 4701; Fla. Stat. ch. 765.201.

¹⁰ Model Rules of Prof'l Conduct R. 1.9(a).

¹¹ Mass. Gen. Laws ch. 201D, §16.

¹² Cruzan, 497 U.S. at 265.

¹³ In the Matter of AB, 768 N.Y.S.2d 256 (N.Y. App. Div. 2003).

¹⁴ Francoise Baylis, Expert Testimony By Persons Trained in Ethical Reasoning: The Case of Andrew Sawatzky. Journal of Law, Medicine & Ethics 224 v.28 i3 (Fall 2000); Superintendent of Belchertown State School v. Saikewicz, 370 N.E.2d 417, 423 (Mass. 1977) (refusal of treatment by parent-guardian).

¹⁵ Woods v. Commw. of Kentucky, 142 S.W.3d 24, 34 (Ky. 2004) (internal quotations omitted).

¹⁶ Baylis, *supra*.

¹⁷ Woods, 142 S.W.3d at 35.

¹⁸ Mass. Gen. Laws ch. 201D, § 5.

¹⁹ Fla. Stat. ch. 765.205(1)(b); Cal. Prob. Code § 4714.

²⁰ N.Y. Pub. Health Law § 2982(2).

²¹ Id. Interestingly, the New York statute specifically states that the surrogate has no authority to decide to remove nutrition and hydration if the patient's wishes are not known. Id. In other words, an end-of-life decision may not be made based on the best interests standard.

-
- ²² Mass. Gen. Laws ch. 201D, § 5 (emphasis added).
- ²³ See Cohen v. Bolduc, 760 N.E.2d 714 (Mass. 2002).
- ²⁴ Mass. Gen. Laws ch. 201D, § 1 (emphasis added); see also N.Y. Pub. Health Law §§ 2980, 2982; but see Cal. Prob. Code § 4617 which does not limit by definition.
- ²⁵ N.Y. Pub. Health Law § 2982(2).
- ²⁶ Cruzan, 497 U.S. 261 (1990).
- ²⁷ Mass. Gen. Laws ch. 201D, §6; N.Y. Pub. Health Law § 2983.
- ²⁸ Cal. Prob. Code § 4689.
- ²⁹ Cohen v. Bolduc, 760 N.E.2d 714 (Mass. 2002).
- ³⁰ In the Matter of Storar, 52 N.Y.2d 363 (N.Y. 1981).
- ³¹ See the above discussion, with the exception of California.
- ³² Uniform Anatomical Gift Act, 8A U.L.A. 4 (Supp. 1991). See also, for example, Mass. Gen. Laws ch. 113, §8; Ronald Chester, Double Trouble: Legal Solutions to the Medical Problems of Unconsented Sperm Harvesting and Drug-Induced Multiple Pregnancies, 44 St. Louis U. L.J. 451, 459, n.52 (Spring 2000).
- ³³ Sandra Carnahan, Promoting Medical Research Without Sacrificing Patient Autonomy: Legal and Ethical Issues Raised by the Waiver of Informed Consent for Emergency Research, 52 Okla. L. Rev. 565, 582 (Winter 1999); see also Michael J. Morley, Proxy Consent to Organ Donation by Incompetents, 111 Yale L.J. 1215, 1245 (March 2002) (in which the author opines that parent-guardians have both the constitutional right and moral duty to consider the best interest of the entire family).
- ³⁴ Strunk v. Strunk, 445 S.W.2d 145 (Ky. Ct. App. 1969).
- ³⁵ In re Guardianship of Pescinski, 67 Wis.2d 4 (1975).
- ³⁶ Carson Strong, Ethical and Legal Aspects of Sperm Retrieval After Death or Persistent Vegetative State, Journal of Law, Medicine & Ethics 347, v.27, i4 (Winter 1999).
- ³⁷ Id.; Carson Strong, Jeffrey R. Gingrich and William H. Kutteh, Ethics of Postmortem Sperm Retrieval, Human Reproduction 739-745 v.15, no.4 (2000).
- ³⁸ See New York Hospital Guidelines for Consideration of Request for Post-mortem Sperm Retrieval, reproduced on the Cornell University Department of Urology website at <http://cornellurology.com/uro/cornell/guidelines.html>.
- ³⁹ Hecht v. Superior Court, 16 Cal. App. 4th 836 (Ct. App. 1993), Davis v. Davis, 842 S.W.2d 588 (Tenn. 1992); see also Cheri L. Riedel, The Impact of Modern Reproductive Technology on the Law of Probate: "Frozen Pops" and Inheritance, American College of Trust and Estate Counsel (2003).
- ⁴⁰ Mass. Gen. Laws ch. 201D, § 17; Cal. Prob. Code § 2992.
- ⁴¹ Id.
- ⁴² Gardianship of Elma Mason, 669 N.E.2d 1081 (Mass. App. Ct. 1996).

⁴³ N.Y. Pub. Health Law § 2982(b)(1).

⁴⁴ Fla. Stat. ch. 765.205(3).

⁴⁵ Schiavo v. Schindler, 780 So.2d. 176 (Fl. Ct. App. 2001).

⁴⁶ Ultimately, this law was determined to be unconstitutional. See Bush v. Schiavo, 885 So.2d 321 (Fl. 2004), writ denied January 24, 2005.

⁴⁷ Grace Plaza of Great Neck, Inc. v. Elbaum, 82 N.Y.2d 10 (N.Y. 1993).