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LIVE ORGAN DONATIONS BETWEEN SIBLINGS AND THE BEST INTEREST STANDARD: TIME FOR STRICTER JUDICIAL INTERVENTION

INTRODUCTION

As medical technology has advanced, becoming progressively more sophisticated, the associated legal, medical, and ethical aspects have shown a corresponding increase in complexity. Within this context, issues of patient autonomy and who should decide whether treatment is beneficial have become particularly prominent.\(^1\) This is especially true with respect to live organ donations between minor siblings. It has long been accepted that competent adults have the right to exercise control over their bodies.\(^2\) The situation is different, however, for children. Parents have generally been allowed to determine what medical treatment their children are to receive based on the theory that parents will act in the best interest of their children.\(^3\) This presumption may not always be valid. The possibility of organ transplants from a living donor adds numerous complicating factors. With respect to the donor, live organ transplantation is a procedure not entirely consistent with traditional medical practice, straining the normal obligation of physicians to respect the health of their patients.\(^4\) In some instances, a healthy sibling is the only suitable donor for a child in need of a kidney or bone marrow transplant.\(^5\) This places the parents in a position of having to balance the interests of their critically ill child with those of their healthy child.\(^6\)

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1. Stewart G. Pollock, *Life and Death Decisions: Who Makes Them and by What Standards*, 41 RUTGERS L. REV. 505 (1989). These issues of autonomy and benefit have been raised in a number of contexts including procreation and death and dying, including the right to refuse treatment. *Id.* at 507, 513.
6. Charles H. Baron et al., *Live Organ and Tissue Transplants from Minor Donors*
In several instances, courts have been called to intervene in these controversies to protect hospitals and physicians from liability by ensuring valid consent to the procedure.7 However, the greatest concern for the court has been to ensure that the best interest of the donor are recognized and respected.8 Several standards have been employed to determine the interests of the donor child in pediatric organ transplantation, generally resulting in the court granting permission for the transplant to proceed.

This Note examines the various standards that have been utilized and the emergence of one of these standards as the accepted means of guarding the interests of all parties involved. It includes a critique of the prevailing standard, arguing that it has given improper consideration to factors such as recipient benefit and parental desires. It concludes with recommendations to modify the criteria under which the standard is applicable to ensure that the needs of the donor are satisfied. These recommendations adopt the proposition that, absent a duty for an adult to submit to an invasion of bodily integrity, there can be no justification for subjecting a healthy child to a similar invasion, in order to benefit another, without a definitive, non-speculative benefit for the donor. This argument applies not only to children but also to adults who have never been competent.

I. STANDARDS

Two standards for organ transplantation from legally incompetent donors have emerged from case law: the substituted judgment doctrine and the best interest doctrine. The substituted judgment doctrine originated in nineteenth century English law, dealing with property of the mentally incompetent.9 It allows a court of equity to make decisions for an incompetent, entering that person's mind and reaching conclusions based on what it

9. Louise Harmon, Falling Off the Vine: Legal Fictions and the Doctrine of Substituted Judgment, 100 YALE L.J. 1, 16 (1990). English common law during this period distinguished between lunatics, who had once possessed a sound mind, and idiots, who had never been of sound mind. Id.
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believes the incompetent would do if competent. The doctrine emerged in the United States in 1844, conferring authority on a court of equity to deal with the property of a mental incompetent as it believed the incompetent would have acted if competent. The doctrine of substituted judgment, in its original form, was a means of making allowances from the income of a person who had once been mentally sound but was now incompetent by utilizing a subjective test of prior conduct and intent. The judgment substituted for the current incompetent is what the person would have done if competent, not what the court would objectively substitute.

In contrast, the best interest test is objective, focusing on the benefit to be gained by the incompetent. This benefit is not restricted to property but may include psychological or emotional benefits. Under this theory, a surrogate decision-maker, either parents or a court, determines the best interest for the incompetent.

II. HISTORICAL PERSPECTIVE

The case law dealing with live organ transplants between siblings is limited but illustrates variation in the application of these legal standards.

The seminal reported case involving a transplant between siblings is Strunk v. Strunk. The prospective donor was a twenty-seven-year-old with a mental age of approximately six years. The prospective recipient was his twenty-eight-year-old mentally competent brother, suffering from end-stage kidney failure. Tissue compatibility testing of the family, including several collateral relatives, revealed that the sibling was the only acceptable donor. The parents sought permission from the

10. Id. at 22-23. The seminal case cited is Ex parte Whitbread, 35 Eng. Rep. 878 (Ch. 1816), involving the estate of an elderly lunatic. Id. at 19. While the court purported to enter the mind of the incompetent, there was no apparent effort to discover the intent of the lunatic prior to his current state. Id. at 23.
11. Id. at 28 (citing In re Willeoughby, 11 Paige Ch. 257 (N.Y. Ch. 1844)).
12. Id. at 35.
13. Korins, supra note 8, at 506.
14. Id.
15. Id.
17. Id. at 146.
18. Id. at 145.
19. Id. at 146.
court to authorize the procedure.\textsuperscript{20} Citing the substituted judgment doctrine, the court held that it had the authority to allow the operation and, based on the expert testimony of a psychiatrist, found that the survival of his brother was psychologically in the incompetent's best interest.\textsuperscript{21} Ironically, the comments of the expert medical witnesses were limited to renal transplants because they found the possibility of any organ transplant from a live donor, other than a kidney, inconceivable.\textsuperscript{22}

Permission for a kidney transplant between seven-year-old twins was requested by the parents in \textit{Hart v. Brown}.\textsuperscript{23} The court recognized that the decision involved the balancing of rights between the natural parents and the donor child but found that the parents had the right to consent to the operation.\textsuperscript{24} In reaching its decision, the court considered the side effects of immunosuppressive drugs on the recipient should a donor other than the twin sibling be used.\textsuperscript{25} The court cited the doctrine of substituted judgment, recognizing it as sufficient to cover the well-being of a legally incompetent person.\textsuperscript{26}

A different result was reached in \textit{In re Richardson}.\textsuperscript{27} The parents of a seventeen-year-old incompetent sought the court's authorization to allow the transplantation of a kidney to his thirty-two-year-old sister.\textsuperscript{28} The court denied permission based on property law.\textsuperscript{29} Because Louisiana state law provides unqualified protection from intrusion into a property right, "it is inconceivable . . . that it affords less protection to a minor's right to be free in his person from bodily intrusion to the extent of loss

\begin{flushleft}
\textsuperscript{20} \textit{Id.}
\textsuperscript{21} \textit{Id.} at 148-49. The dissenting opinion questioned the validity of the purported psychological benefits to be gained by the incompetent donor, viewing the psychological trauma that a six-year-old child would suffer as the result of the loss of a close relative or friend as minimal. \textit{Id.} at 150. While the dissent rejected the donation as being of significant benefit to justify the transplant in this case, it did not reject the doctrine in general. \textit{Id.} Instead, it simply demanded conclusive demonstration that the organ transplant would be of significant benefit to the donor. \textit{Id.} at 151.
\textsuperscript{22} \textit{Id.} at 148.
\textsuperscript{24} \textit{Id.} at 391.
\textsuperscript{25} \textit{Id.}
\textsuperscript{26} \textit{Id.} at 387.
\textsuperscript{27} \textit{In re Richardson}, 284 So. 2d 185 (La. Ct. App. 1973).
\textsuperscript{28} \textit{Id.} at 186.
\textsuperscript{29} \textit{Id.} at 187.
\end{flushleft}
of an organ unless such loss be in the best interest of the minor.\textsuperscript{30} The court found the asserted psychological benefit to be gained by the donor to be highly speculative and, in this case, unlikely.\textsuperscript{31} The court concluded "that neither [the] parents nor the courts can authorize surgical intrusion \ldots{} for the purpose of donating one of his kidneys . . . \textsuperscript{32}

The court in \textit{In re Pescinski}\textsuperscript{33} reached a similar conclusion. The guardian of a thirty-nine-year-old catatonic schizophrenic sought permission for the incompetent to donate a kidney to his thirty-eight-year-old sister.\textsuperscript{34} The court found that it lacked the statutory authority to authorize the transplant from a living person.\textsuperscript{35} The court specifically rejected the substituted judgment doctrine, finding that the interests of an incompetent should be particularly protected.\textsuperscript{36} "In the absence of real consent on his part, and in a situation where no benefit to him has been established, we fail to find any authority for the county court, or this court, to approve this operation."\textsuperscript{37}

In \textit{Little v. Little},\textsuperscript{38} the court was presented with a request to allow a kidney to be transplanted from a fourteen-year-old with Down's Syndrome to her younger brother.\textsuperscript{39} The court recognized the parents' right to authorize medical treatment for their children, but rejected the claim that donation of a kidney

\textsuperscript{30} \textit{Id.}
\textsuperscript{31} \textit{Id.}
\textsuperscript{32} \textit{Id.} A concurring opinion found that the court holds the authority to approve the transplant from the minor but only when the best interest of the minor are served. \textit{Id.} Before the best interest of the donor child can be considered, the court must first clearly establish that the surgery is urgently required, no reasonable alternatives exist, and that there are minimal contingencies. \textit{Id.} at 188. These threshold criteria were not satisfied in this case. \textit{Id.}
\textsuperscript{33} \textit{In re Pescinski}, 228 N.W.2d 180 (Wis. 1976).
\textsuperscript{34} \textit{Id.}
\textsuperscript{35} \textit{Id.} at 181.
\textsuperscript{36} \textit{Id.} at 182.
\textsuperscript{37} \textit{Id.} The fact that no benefit to the donor has been established raises the possibility that authority to proceed may be granted if a benefit is satisfactorily established. \textit{Id.} In a dissenting opinion, authorization to proceed would be granted if certain guidelines were met. \textit{Id.} These criteria include: a showing that the recipient stands to suffer death in the absence of the transplant; reasonable steps have been taken to find another source for the organ; the incompetent is closely related by blood to the recipient; a showing that the donor would most likely donate due to normal family ties, if he were competent; the donor must be in good health; and the operation must pose little threat to the donor. \textit{Id.} at 183.
\textsuperscript{38} \textit{Little v. Little}, 576 S.W.2d 493 (Tex. Ct. App. 1979).
\textsuperscript{39} \textit{Id.} at 494.
constitutes medical treatment for the donor. The court ultimately concluded that the donor would receive a benefit from the donation of a kidney and authorized the procedure. In reaching this conclusion, the court noted that the Strunk decision, while purportedly grounded on the substituted judgment doctrine, was actually based on the benefits that the donor would derive from the procedure.

The court addressed the issue of bone marrow rather than renal transplantation in In re Doe. The court was requested to authorize a transplant from a severely retarded forty-three-year-old to his thirty-six-year-old brother suffering from leukemia. The decision to proceed with the transplant was based on the best interest test with specific rejection of the substituted judgment doctrine. The various risks and benefits were analyzed, including the risk to the donor and alternatives for the recipient. The determining factor ultimately found to confer the required benefit on the donor, however, was that the potential recipient had been the sole family member involved in the care and placement of the donor in the past.

The most recent case to address this issue is Curran v. Bosze. While the factual circumstances involved in this case vary from the previous cases, the decision was ultimately reached using the best interest test, providing additional guidelines on how the test should be applied. Here, the father of a twelve-year-old boy with leukemia sought to compel compatibility testing for bone marrow transplantation from three-year-old half-sibling twins, the product of a non-marital relationship. The mother of the twins had sole care and custody under a parentage order, signed by the father, and refused to submit them to compatibility testing. The relationship, therefore, differed from the previous cases in that the donor and recipient were not full siblings, had no established social relationship, and the parents of the

40. Id. at 495.
41. Id. at 499.
42. Id. at 498.
44. Id.
45. Id. at 933.
46. Id.
47. Id.
49. Id. at 1320-21.
50. Id.
prospective donors disagreed over whether to allow the half-
siblings to serve as donors.\footnote{51}

The court specifically rejected the substituted judgment
doctrine, finding it an irrelevant exercise to try to discover that
which does not exist, specifically, whether children would consent
to bone marrow harvesting if they were competent.\footnote{52} The court
instead relied on the best interest test, holding that a parent may
consent on behalf of a minor child for bone marrow donation only
when it would be in the minor's best interest.\footnote{53} Three critical
factors were found as determining whether the best interest of
the child are being met: (1) the parent who consents must be
informed of the benefits and risks; (2) the child's caretaker must
be able to provide emotional support to the child; and (3) "there
must be an existing, close relationship between the donor and
recipient."\footnote{54} While the court could have based its decision on
the lack of consent by the custodial parent\footnote{55} or on the resulting
impairment to the provision of emotional support inferred from
the absence of this consent,\footnote{56} it proceeded to address the third
criterion, the requirement for an existing, close relationship
between donor and recipient.\footnote{57} The court concluded that there
was no physical benefit to the donor, only a potential
psychological benefit based on the fact that the donor and
recipient are known to each other as family.\footnote{58} "Only where
there is an existing relationship between a healthy child and his
or her ill sister or brother may a psychological benefit to the
child . . . realistically be found to exist."\footnote{59} The request for
compatibility testing was refused because there was no indication
that the donor knew the recipient as family.\footnote{60}

\begin{footnotes}
\item[51] Jeanna Hunter, Consent for the Legally Incompetent Organ Donor: Application of a Best-Interests Test, 12 J. LEGAL MED. 535, 551 (1991); Korins, supra note 8, at 625. These differences have prompted one commentator to observe that the decision was relatively easy to reach. Korins, supra note 8, at 527.
\item[53] Id. at 1331.
\item[54] Id. at 1343.
\item[55] Korins, supra note 8, at 525.
\item[56] Id. at 527.
\item[57] Curran v. Bosze, 566 N.E.2d 1319, 1344 (Ill. 1990).
\item[58] Id. at 1344-45
\item[59] Id.
\item[60] Id.
\end{footnotes}
III. ANALYSIS

A. Summary of the Standards

1. Pre-Curran Criticisms of Standards

The decision in each of these cases was based either on the best interest standard or the substituted judgment doctrine. However, the name appended on a particular standard does not necessarily mean that it was the actual standard applied. For example, the Strunk court stated that it was applying a substituted judgment standard but used language referring to the best interest of the incompetent donor. The court in Hart v. Brown also referred to the benefits that the donor would gain by the operation, but still claimed to be using the substituted judgment doctrine. One of the major differences between these two standards is the reliance of the best interest standard on objective information and the reliance of the substituted judgment standard on subjective information. However, objective information has been relied upon when subjective information is unavailable and subjective factors have been relied upon within the context of an objective analysis. Before the decision in Curran, certain objective factors formed the basis for the decision regardless of the standard espoused: critical need of the recipient, minimal risk to the donor, absence of acceptable alternative sources, and psychological benefit to be gained by the donor. The psychological benefit to be derived by the donor in many cases seems contrived, especially when the donor is

61. Pollock, supra note 1, at 511.
62. Korins, supra note 8, at 506; Pollock, supra note 1, at 511.
65. Korins, supra note 8, at 506.
66. Id.; Pollock, supra note 1, at 513. In Strunk, the court specifically invoked the substituted judgment doctrine as the basis for allowing the transplant to proceed, but then cited psychological benefits to be gained by the donor as serving his best interest. Strunk, 445 S.W.2d at 146-49. The court in Hart also based its authority to allow the parents to proceed with the transplant on the substituted judgment doctrine, but cited the benefits to be conferred upon the donor. Hart, 289 A.2d at 337, 391. The court in Little specifically recognized that the previous decisions were based on the benefit to be gained by the donor regardless of whether the substituted judgment doctrine was invoked. Little v. Little, 576 S.W.2d 493, 498 (Tex. Ct. App. 1979).
67. Pollock, supra note 1, at 513.
extremely young. Psychiatrist testimony has conceded that this psychological benefit is highly speculative.

Even more fundamental, however, is the criticism of the substituted judgment standard. Until the decision in *Strunk*, this standard had been used only for making allowances from the income of the incompetent, not for all events impacting on the incompetent's interests. Additionally, the doctrine dealt with those who had been competent at some previous time, not with those who had never been of sound mind. This application of the substituted judgment doctrine has been criticized as an improper expansion to cover any matter concerned with the well-being of the incompetent.

2. The Curran Standard

The *Curran* decision is an important development for several reasons. It has been praised as a thoughtful consideration of the issues and as a needed evolution toward a clear standard for tissue transplantation between siblings. Its primary importance lies in its rejection of the substituted judgment doctrine based on the impossibility of determining what a competent three- and one-half-year-old minor would do. The emergence of the best interest test as the applicable standard also marks the establishment of an objective analysis that firmly removes any decision-making from the donor, even under the fiction that the donor would consent if competent, and places it exclusively with a surrogate decision-maker, either the parents or

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68. Baron et al., *supra* note 6, at 171.
70. Harmon, *supra* note 9, at 35.
71. Id.
72. Id. at 34. Because factors that courts had relied on in their previous applications of the substituted judgment doctrine, specifically, prior capacity to make gifts and evidence of gift-giving to support an inference of potential intent, were absent in *Strunk*, the judge effectively assumed unrestrained discretion in substituting judgment for the donor. Id. at 35.
74. Curran v. Bosze, 566 N.E.2d 1319, 1326 (ILL. 1990). This criticism appears to be a more consistent interpretation of the original application of the doctrine that distinguished between lunatics and idiots. See Harmon, *supra* note 9, at 16.
the court. The holding in particular gives great deference to parental discretion in reaching a decision. Upon satisfaction of the requirements of informing the consenting parent of risks and benefits and ensuring that emotional support is available to the donor child, psychological benefits to the donor may then be assessed. The existing and future sibling relationships are examined to determine whether the donor's best interest is served by the procedure. The decision was narrowly restricted to transplants between siblings with no extension to other immediate or collateral family members.

B. Determination of Donor Rights

The right to be determined is not the right of the minor to serve as a donor; rather, it is the right of the minor not to serve as an organ donor. Should a minor be forced to serve as an organ donor without the same express consent required of an adult? The answer to this question is in the positive but only under very narrow circumstances established by clear and convincing evidence.

1. Rights of Adults

Preservation of bodily integrity is a protected right with "no right . . . held more sacred, or . . . more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person . . . ." All adults of sound mind have the right of bodily determination. This right to bodily integrity has been premised on the penumbral right to privacy found under the Ninth and Fourteenth Amendments.

75. Korins, supra note 8, at 500-01.
76. Id.
77. Curran, 566 N.E.2d at 1344.
78. Id.
79. Id.; Hunter, supra note 51, at 553-54.
81. Schloendorff v. Society of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914). The central holding of Schloendorff, dealing with liability of a charitable hospital for injuries to patients through the negligence of their employees, was overruled in Bing v. Thunig, 143 N.E.2d 3 (N.Y. 1957).
82. In re A.C., 533 A.2d 611, 615 (D.C. 1987). This case involved the refusal of a terminally ill woman at the twenty-sixth week of her pregnancy to submit to a Caesarean section. Id. at 612-13. The court allowed the Caesarean section to proceed against the wishes of the mother, citing four countervailing interests that the state may have in sustaining a person's life: "preserving life; preventing suicide;
The right of an adult to refuse medical treatment includes the right to refuse to become an organ donor. There is no affirmative duty to come to the rescue of a stranger. However, a special relationship, such as a family relationship, may impose a duty to rescue. The courts have not imposed this duty on collateral family members when the need for an organ transplant has arisen. In McFall v. Shimp, the plaintiff, in critical need of a bone marrow transplant, sought to force his cousin to undergo compatibility testing. The court refused to order the testing, citing societal respect for individual autonomy. While the court registered moral condemnation for the refusal to submit to compatibility testing, coercing the cousin to submit to the intrusion would result in defeating the sanctity of the individual and "impos[ing] a rule which would know no limits . . . ."

There is also precedent supporting the refusal to impose a duty on a parent to become a tissue donor. In In re George, a thirty-three-year-old adoptee with leukemia was in critical need of a bone marrow transplant. When no suitable donors were found, an attempt was made to contact the plaintiff's alleged biological

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83. W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 56, at 376 (6th ed. 1984); see also Head v. Colloton, 331 N.W.2d 870, 872, 873 (Iowa 1983) (involving the attempt by a terminal leukemia patient to force a hospital to reveal the name of an unrelated potential bone marrow donor). The court refused to reveal the name of the potential donor, based on the donor's right to privacy. Id. at 876. This decision has been inferred to support the view that a stranger cannot be forced to donate tissue. Nancy K. Rhoden, The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans, 74 CAL. L. REV. 1951, 1978 (1986).

84. KEETON ET AL., supra note 83, at 377.

85. While the court refused permission for the requested transplant, it did note that a brother of the potential recipient declined to be tested for suitability as a donor. In re Pescinski, 226 N.W.2d 180, 181 (Wis. 1975). Claiming a duty to his own family, he simply stated that he did not care to be a donor. Id. The court expressed no condemnation of this decision. Harmon, supra note 9, at 36.


87. Id.

88. Id. at 91.

89. Id.


91. Id. at 152-53.
father.\textsuperscript{92} The alleged natural father denied paternity and refused to undergo the desired testing.\textsuperscript{93} The court refused to violate the confidentiality of the natural parents.\textsuperscript{94} This decision supports the view that parents cannot be forced to serve as organ donors for their children.\textsuperscript{95} There is also general recognition that a court would not coerce organ donation from a parent for the benefit of a child.\textsuperscript{96}

2. Rights of Children

Children, as incompetents, fall within the protective power of the state, requiring state recognition of their dignity and worth and affording them the same range of rights and choices that it recognizes in competent persons.\textsuperscript{97} Minors are protected by the Constitution and possess constitutional rights, rights that do not mature and materialize only upon attainment of the state-defined age of majority.\textsuperscript{98} Minority alone does not place a child beyond the protection of the Constitution;\textsuperscript{99} neither the Fourteenth Amendment nor the Bill of Rights is reserved solely for adults.\textsuperscript{100} A child should not be required to come to the rescue by providing a critically needed organ since there is no general obligation to rescue.\textsuperscript{101} It would seem unfair indeed to impose this burden on children when the same burden is not imposed on adults. While there may be a special duty to rescue as a result of a family relationship, the relationship that imposes the special duty is usually defined as a parent-child or husband-wife relationship, not a sibling or child-parent relationship.\textsuperscript{102}

\begin{footnotes}
\item[92] Id. at 152.
\item[93] In re George, 630 S.W.2d 614, 618 (Mo. Ct. App. 1982).
\item[94] Id. at 623.
\item[95] Korins, supra note 8, at 504.
\item[96] Id. at 505. Other commentators have also recognized that mandatory organ donation violates principles of privacy, autonomy, and bodily integrity. Rhoden, supra note 83, at 1978. "[C]urrent law nowhere forces men to sacrifice their bodies and restructure their lives even in those tragic situations (of needed organ transplants, for example) where nothing less will permit their children to survive . . . ." Laurence H. Tribe, CONSTITUTIONAL CHOICES 243 (1985) (emphasis in original).
\item[98] Planned Parenthood of Mo. v. Danforth, 428 U.S. 52, 74 (1976).
\item[100] In re Gault, 387 U.S. 1, 13 (1966).
\item[101] KEETON et al., supra note 83, at 375.
\item[102] Id. at 377.
\end{footnotes}
3. Comparison of the Rights of Children and Adults

The constitutional rights of adults and children are the same in many areas. With respect to many claims by minors regarding constitutional protection against loss of liberty or property interests, the child's constitutional rights have been virtually identical with those of an adult. The Supreme Court has generally supported the doctrine that children are protected by the same constitutional guarantees that protect adults against government deprivations. However, there are basic reasons why the constitutional rights of children cannot be compared with the rights of adults: "the peculiar vulnerability of children; their inability to make critical decisions in an informed, mature manner; and the importance of the parental role in child rearing." The state has the authority to adjust its legal system to consider the particular vulnerabilities of children.

Last, the freedoms of minors may be limited by the guiding role of parents. The Supreme Court in Prince v. Massachusetts declared, "[i]t is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder." The Court proceeded to state, however, that the rights of parenthood are not unlimited. The state retains a wide range of power that limits parental control over actions affecting the child's welfare. These limitations are expressed as follows: "Parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves." There is, therefore, no parental right that allows parents to exert life and

103. Id. Many of these decisions have addressed due process in juvenile court proceedings. See In re Winship, 397 U.S. 358, 368 (1970); see also Goss v. Lopez, 419 U.S. 565, 576 (1974) (holding that children cannot be deprived of their property interest in education without due process).
104. Bellotti, 443 U.S. at 639.
105. Id. at 634.
106. Id. at 635.
107. Id. at 637.
109. Id. at 167.
110. Id. at 170.
death control over their children. The welfare of the child is the first and paramount duty, not the rights of the parents. If it appears that the health or safety of the child will be jeopardized by parental decisions, parental control may be subject to the Prince limitations. The privacy rights of children cannot be asserted by the parents on their own behalf. Rather, full recognition is granted to the child's own rights of privacy and bodily integrity.

All of these decisions indicate that while a child may not have the same protection from the state, because of the greater vulnerability of a child, the law will intercede to provide greater protection where it would otherwise allow adults to proceed under their own discretion. The trend is for greater protection of children rather than less.

4. Conflict of Interest of Parents

The best interest test, in theory, should only consider the interests of the donor child, not the prospective recipient. In practice, however, especially for parents, the standard has essentially become a balancing test, balancing the extreme need of one child and the benefits to be granted, against the relatively limited intrusion and risk on the healthy donor sibling. The problem, however, is that the balancing conflicts with the traditional respect for the individual observed by our society. Balancing plays no role in the determination of whether an individual is to provide an organ to benefit another person; that determination should be based only on consent. There is also an unavoidable conflict of interest for the parents who, no matter how much one may protest to the contrary, cannot divorce the extreme need of one child from the interests of the healthy

112. Purinton v. Jamrock, 80 N.E. 802, 805 (Mass. 1907); see Custody of a Minor, 379 N.E.2d at 1063.
115. Id. (citing Custody of a Minor, 393 N.E.2d 1053 (Mass. 1978) and Superintendent of Belchertown v. Saikewicz, 370 N.E.2d 417 (Mass. 1977)).
116. John A. Robertson, Organ Donations by Incompetents and the Substituted Judgment Doctrine, 76 Colum. L. Rev. 48, 50-51 (1976); see also Baron et al., supra note 6, at 167.
117. Robertson, supra note 116, at 51.
118. Id.
child.\textsuperscript{119} A tendency to place the entire situation within the
general context of the family fails to recognize that there are
different relationships within the family, with different
obligations and interests. The parent-child relationship is not the
same as a sibling relationship. While a parent may feel obligated
to donate an organ to a child, a sibling may not necessarily feel
the same compulsion. This is especially true when the siblings
are very young and may only be able to appreciate the familial
relationship in its most rudimentary aspects.\textsuperscript{120} The balancing
test then becomes a matter of imposing the parent's view of
familial obligation on the child who may have a different set of
priorities and responsibilities.

There is also evidence indicating different treatment of
donors depending on mental status. In \textit{Strunk},\textsuperscript{121} \textit{In re
Richardson},\textsuperscript{122} \textit{In re Pescinski},\textsuperscript{123} \textit{Little},\textsuperscript{124} and \textit{In re
Doe},\textsuperscript{125} the prospective donor in each case was mentally
incompetent. There are no reported cases in which permission
was sought to transplant tissue from the mentally competent
sibling to a mentally incompetent sibling. There is also a report
of a family choosing a thirteen-year-old retarded child for
compatibility testing for bone marrow donation, while refusing to
consider an eleven-year-old mentally sound sister as a possible
donor.\textsuperscript{126} This manner of donor selection, exercised under the
guise of the best interest test, is discriminatory, based more on
mental status of the donor rather than the benefit to be gained
by the donor within the context of saving a family member or
preserving the family unit.

The potential conflict of interest is further complicated,
ironically, by technological advances. At the time of the \textit{Strunk}
decision, the expert medical witnesses were unable to foresee any
organs other than kidneys as capable of being transplanted from
a live donor.\textsuperscript{127} Subsequent developments allow transplantation

\begin{thebibliography}{9}
\bibitem{note119} Korins, \textit{supra} note 8, at 503.
\bibitem{note120} Baron et al., \textit{supra} note 6, at 171.
\bibitem{note122} \textit{In re Richardson}, 284 So. 2d 185, 185-86 (La. Ct. App. 1973).
\bibitem{note123} \textit{In re Pescinski}, 226 N.W.2d 180, 180-81 (Wis. 1975).
\bibitem{note126} Melvin D. Levine et al., \textit{The Medical Ethics of Bone Marrow Transplantation in
Childhood}, 86 J. PEDIATRICS 145, 147 (1975).
\bibitem{note127} \textit{Strunk}, 445 S.W.2d at 148.
\end{thebibliography}
of bone marrow and, more recently, even partial liver transplants.\textsuperscript{128} The ethical issues raised are more profound in this area because of the greater complexity of the liver, its existence as a single rather than a paired organ, and the greater technical risks in the transplant procedure.\textsuperscript{129} While the current protocols for partial liver transplants allow only adult donors,\textsuperscript{130} the consent of the donor is recognized as problematic, questioning the credibility of consent when the parents are balancing personal risk against saving the life of their child. It is recognized that most parents are willing to risk their own lives in order to save that of their child.\textsuperscript{131} More to the point, if parents are allowed to serve as donors, should other family members, including siblings, also be able to serve as donors?\textsuperscript{132} Even though the current protocols for live liver transplants bar minors as donors,\textsuperscript{133} there is no assurance that this policy will be perpetuated as experience with the procedure increases and complications are reduced. The tremendous pressure placed on parents to donate, where there is an acceptable tissue match, could easily be transferred to children in cases where the sibling is the only available match.

Perhaps the most extreme example of the potential conflict of interest is when, after being unable to find a suitable donor, the parents conceive in the hope that the infant produced will be a tissue match. This course of action has been termed purity for donation.\textsuperscript{134} The most publicized example of this type of transplant is of a California family.\textsuperscript{135} When no bone marrow

\textsuperscript{128} Peter A. Singer et al., Occasional Notes: Ethics of Liver Transplantation with Living Donors, 321 NEW ENG. J. MED. 620 (1989); Michael Specter, Transplant Uses Liver of Live Donor: Mom Provides Tissue in Pioneering Effort, WASH. POST, Nov. 28, 1989, § A, at a03.


\textsuperscript{130} Singer, supra note 128, at 621.

\textsuperscript{131} Boonman, supra note 129, at Z10 (quoting Arthur Caplan of the Center for Biomedical Ethics at the University of Minnesota). Professor George Annas, professor of health law at Boston University School of Medicine, is also quoted as recognizing that the choice to donate an organ is not a purely rational decision. Id.

\textsuperscript{132} Id.

\textsuperscript{133} Singer, supra note 128, at 621; Boonman, supra note 129, at Z10.

\textsuperscript{134} Warren Kearney & Arthur Caplan, Parity for the Donation of Bone Marrow: Ethical and Policy Considerations, in 1 EMERGING ISSUES IN BIOMEDICAL POLICY: AN ANNUAL REVIEW 262, 262-63 (Robert H. Blank & Andrea L. Bonnickson eds., 1992).

\textsuperscript{135} Abigail Trafford, Brave New Reasons for Mothering: Having a Baby to Produce
donor could be found for their seventeen-year-old leukemic daughter, the father underwent a vasectomy reversal, and the parents conceived another child to serve as a potential marrow donor. Prenatal testing indicated that the fetal tissue was a suitable match for their leukemic daughter. When the infant reached the age of thirteen months, a successful bone marrow transplant was performed.

It may be misleading to view this as an isolated event. While no registry keeps records of this practice, a reported phone survey indicates at least forty attempted cases of parity for donation between 1984 and 1989. In eight of these cases, the infant subsequently served as a donor. Donor safety becomes a significant factor when an infant serves as a bone marrow donor for an adolescent or an adult. Because of the disparity in physical size, a proportionately greater amount of marrow must be harvested from the infant. Repeat or multiple harvests, necessary to obtain a sufficient amount of marrow, will subject the infant to multiple anesthetic procedures and, potentially, a larger number of replacement transfusions.

While conceiving to produce a potential donor does not necessarily preclude a family from loving a child, it does present problems with respect to rationalizing consent for a procedure

136. Id.
137. Id.
138. Child Born to be Donor Gives Sister Her Marrow: Conception for Transplant Just One of Many, DET. FREE PRESS, June 5, 1991, at A1 [hereinafter Child Born to be Donor]. This decision to subject the infant to bone marrow donation was apparently made with no judicial intervention, with the concurrence of both parents. The decision was reached prior to conception when the eventual donor could not, at least in the conventional sense, be recognized as "family." The inherent conflict of interest emerges in a statement by the mother that "when you're faced with the possibility that your child is going to die . . . whatever you need to do, you do it." Trafford, supra note 135, at Z6.
139. Kearney & Caplan, supra note 134, at 269.
140. Id. at 270.
141. Id. Because parents may be hesitant to inform transplant teams that an infant was conceived to serve as a donor, figures are believed to be underestimated. Id. Anecdotal information emerging from the survey includes a family having three children in the hope of finding a compatible donor. Id. Two centers reported adult recipients who had located unrelated donors and delayed transplantation pending delivery and tissue typing of an infant. Id.
142. Id. at 271.
143. Id. at 275.
144. Id.
that confers no physiologic value on the donor. The issue arises whether simply being born into a family immediately confers a fully developed familial relationship or whether the relationship requires time to develop and mature.\footnote{Id. at 278.} An infant, especially a newborn, is arguably a stranger to the family and community.\footnote{Id.} At a minimum, however, the basic time sequence with respect to decision-making seems reversed. Earlier cases depended upon an established relationship, usually sibling, to confer the benefit that justifies the decision to donate. Under the circumstances of parity for donation, the decision to donate precedes establishment of the relationship upon which the conferring benefit is premised.\footnote{Id. at 273.} Even under the best interest standard, the reasoning seems skewed and attenuated. Because events do not conform to the standard, the best interest test should be inapplicable under these circumstances.\footnote{This should not be interpreted as an attack on reproductive freedom. Defenders of the right to conceive for donation have based their conclusion on the right to privacy of reproductive choice, suggesting that it is ethically improper to question the reasons parents have for deciding upon pregnancy. \textit{Id.} at 272 (citing Alan Dershowitz, \textit{Don't Rush to Judge These Parents}, \textit{Boston Herald}, Feb. 26, 1990, at 23). There is a vast difference between controlling the decision to become pregnant and controlling the subjection of an infant to a surgical procedure. \textit{Id.}}

5. \textit{Judicial Effectiveness in Applying the Standard}

Because of the parental conflict of interest and the occasional discriminatory selection of which sibling is to serve as donor, judicial intervention may be necessary to ensure that decisions consider the healthy donor child’s best interest. However, when faced with a critically ill person, the ability of the courts to be more objective is seriously in doubt. It has been conceded that the benefit to be conferred on the donor is not a physiologic benefit.\footnote{Curran v. Bosze, 566 N.E.2d 1319, 1337 (Ill. 1990); Little v. Little, 576 S.W.2d 493, 495 (Tex. Ct. App. 1979); Baron et al., \textit{supra} note 6, at 170; Korins, \textit{supra} note 8, at 502. \textit{Id.}} The decisions to allow a transplant to proceed, then, have been based on the psychological benefits to the donor\footnote{Korins, \textit{supra} note 8, at 502. \textit{Id.}} even when the donor is severely mentally impaired.\footnote{Strunk v. Strunk, 445 S.W.2d 145, 146 (Ky. 1969).} These putative psychological benefits have been the subject of criticism,
commonly cited as too speculative,\textsuperscript{152} illusory,\textsuperscript{153} or contrived, especially when the donor is very young.\textsuperscript{154} Courts have generally shown great deference to the decision of parents, at times loosely applying standards and allowing parties to structure proceedings that do not adequately represent the donor's interests.\textsuperscript{155}

The Curran decision itself has been cited as showing considerable deference to parental discretion, moving beyond prior case law and its emphasis on consent of the donor.\textsuperscript{156} The benefits test "contains no criteria . . . for determining what constitutes a benefit, or the amount of benefit that must be shown in a particular case."\textsuperscript{157} The courts have further strayed from their duty to protect the donor child by improperly focusing on the interests of both children,\textsuperscript{158} including the recipient's need for the tissue and lack of acceptable alternative sources.\textsuperscript{159}

The recipient's need for the organ transplant is not entirely irrelevant, serving primarily as an initiating event in the search for a suitable donor. While the requirements used by the Curran court in order to authorize donation, informing the consenting parent of the risks and benefits, provision of emotional support, and an existing close familial relationship,\textsuperscript{160} do not consider the interests of the recipient, this holding does not necessarily preclude the consideration of the interests of the recipient when a more conventional family relationship exists.\textsuperscript{161}

There have also been attempts to justify the transplant on the basis of degree of risk and degree of bodily intrusion to the donor.\textsuperscript{162} These factors are especially applicable in cases involving bone marrow transplantation rather than kidney

\textsuperscript{152} Baron et al., \textit{supra} note 6, at 171.
\textsuperscript{153} Pollock, \textit{supra} note 1, at 512.
\textsuperscript{154} Baron et al., \textit{supra} note 6, at 171.
\textsuperscript{155} \textit{Id.} at 168.
\textsuperscript{156} Korins, \textit{supra} note 8, at 500-01.
\textsuperscript{157} Robertson, \textit{supra} note 116, at 56.
\textsuperscript{158} Baron et al., \textit{supra} note 6, at 172 (citing Nathan v. Farinelli, Eq. No. 74-87 (Mass. July 3, 1974)).
\textsuperscript{159} Pollock, \textit{supra} note 1, at 513.
\textsuperscript{160} Curran v. Bosze, 566 N.E.2d 1319, 1343 (Ill. 1990).
\textsuperscript{161} Korins, \textit{supra} note 8, at 529.
\textsuperscript{162} Strunk v. Strunk, 445 S.W.2d 145, 148 (Ky. 1969). The proposed renal transplant was characterized as posing only minimal danger to both the donor and recipient. \textit{Id.} These same surgical risks were viewed as negligible in Hart v. Brown, 289 A.2d 386, 381 (Conn. Super. Ct. 1972) and Little v. Little, 576 S.W.2d 493, 499 (Tex. Ct. App. 1979).
transplants. The rationale is based on the recognition that a bone marrow transplant is less invasive, removes tissue that will not compromise hematopoietic function, and is regenerated rapidly, in contrast with a kidney transplant where the degree of invasion is greater and the tissue removed will never regenerate. The possibility of damage to the remaining kidney, perhaps years later, is recognized as a legitimate but statistically low risk that could endanger the health of the one time donor. The greater risks of one procedure do not of themselves affect or minimize the risks of another procedure. These justifications will only become more confusing with advancing technology. The rationale that low risk and minimal bodily invasion justify the donation is flawed because it is not the degree of bodily invasion but the bodily invasion itself that produces the problem. The right to maintenance of bodily integrity is a matter of a right to privacy that is not subject to degrees of invasion. The least intrusion is a violation of that privacy. This invasion is not allowed for adults in the absence of their consent, and it should not be allowed for children. It is recognized that children may have different rights under the Constitution, but these differences are to protect children and their particular vulnerabilities, not to make them more vulnerable. Children within this context are entitled to greater consideration and protection.

C. Solutions

The issue of forcing healthy children to submit to a procedure that confers no physiologic benefit, when adults are not subject to the same demands, is problematic. Society should not be able to demand more of children than of competent adults.

163. Levine et al., supra note 126, at 149.
164. Id. at 146.
165. Baron et al., supra note 6, at 164 (citing personal communication from David Nathan, M.D.).
166. Korins, supra note 8, at 518; Pratts, supra note 4, at 446.
167. Korins, supra note 8, at 518.
171. HOLDER, supra note 7, at 172; Tribe, supra note 96, at 243; Baron et al., supra note 6, at 174.
172. Korins, supra note 8, at 503.
Considering the conflict of interest confronting parents and the previous inability of courts to properly address the issues, focusing on speculative psychological benefits to the donor, and considering the need of the recipient, an outright ban on organ donations from children may initially appear to be the best solution. This option would, at least superficially, protect childrens’ right to privacy and freedom from bodily intrusion that adults enjoy. This position has been recommended but rejected.\textsuperscript{173} The basis for this rejection appears to lie largely in the desperate need of the recipient, whether admitted or not.\textsuperscript{174}

As a general rule, however, there should be a presumption that a minor cannot serve as a live organ donor. The law still maintains an interest in protecting those who are not capable of protecting themselves.\textsuperscript{175} This presumption may be rebutted under narrow circumstances, subject to the best interest standard. However, rather than advance criteria to reduce judicial interference, which increases deference to parents when custodial parents agree on treatment,\textsuperscript{176} the goal should be to increase judicial scrutiny.

1. \textit{Role of Parents}

First, parental consent alone should not serve as a basis for allowing a child or incompetent adult to serve as a tissue donor.\textsuperscript{177} This principle is based on the conflict of interest parents face. Parents, in their desperation, should not be subjected to criticism for their decision, but this does not mean that courts should grant such a degree of deference to parents that their decisions go effectively unchallenged. Parental consent should simply serve as a procedural requirement that allows the issue to proceed to judicial examination.\textsuperscript{178}

\textsuperscript{173} Baron et al., \textit{supra} note 6, at 160; Korins, \textit{supra} note 8, at 508; Robertson, \textit{supra} note 116, at 50, 68.
\textsuperscript{174} Pollock, \textit{supra} note 1, at 513.
\textsuperscript{175} Angela Roddey Holder, \textit{Organ Donation by Incompetent}, 213 JAMA 513, 514 (1970).
\textsuperscript{176} Korins, \textit{supra} note 8, at 537, 538.
\textsuperscript{177} Baron et al., \textit{supra} note 6, at 167.
\textsuperscript{178} The \textit{Curran} court also viewed parental consent as a preliminary issue, suggesting that parental consent, while necessary, is not a sufficient ground for granting permission for the transplantation to proceed. Korins, \textit{supra} note 8, at 525. Parental consent may present numerous problems, considering the divorce rate and incidence of children arising from non-marital relationships. \textit{Id.} The parentage order and attenuated relationship between half-siblings in \textit{Curran} point out the difficulty of
2. Role of Courts

- When the threshold procedural requirement of parental consent is satisfied, judicial scrutiny should be invoked in all cases to determine if the procedure is to be allowed. The determination should occur in an adversarial setting with an appointed guardian ad litem for the prospective donor. However, the appointment of a guardian ad litem, as previously employed, does not necessarily mean that the donor's interest will adequately be represented or accepted by the court. Courts must overcome an aversion to subjecting families in such tragic circumstances to less than a full adversarial inquiry. The benefit to be conferred on the donor, establishing the tissue donation as being in the donor's best interest, should be shown by clear and convincing evidence. A putative psychological benefit to the donor is generally not sufficient, especially when the donor is very young. Exceptions may exist, for example with twins,

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179. Baron et al., supra note 6, at 186. Appointment of guardians ad litem have been inconsistent, even within the same states, in some instances providing such representation for potential bone marrow donors but not for kidney donors. Id. at 181.


181. Baron et al., supra note 6, at 186.

182. Id. at 171. Altruism is one of the cited benefits to be received by the donor, Curran v. Bosse, 586 N.E.2d 1319, 1335 (Ill. 1990), even though there may be reluctance to accept it as a legitimate motive. Korins, supra note 8, at 520. Even under optimal circumstances, viewing altruism as a benefit rather than a motive, studies finding great psychological benefits conferred upon the donor have involved adults. Baron et al., supra note 6, at 178. These benefits have been extrapolated from adults to children and consider future as well as contemporaneous benefits when applied to children. Id. at 178. Psychiatrists in Massachusetts cases have admitted that evidence regarding future psychological benefits or detriments would be speculative. Id. at 171. There is also no psychological evidence to support the conclusion that all children would benefit from serving as donors. Id. at 178. Expert psychiatric testimony in Curran indicated that no psychological benefits could be predicted for the donor ten to twenty years in the future when the age at donation was three and a half years. 566 N.E.2d at 1335. The child's future view of events will be determined by how the parents will present them. Id. A variety of life experiences that cannot be anticipated also plays a role in determining whether a benefit will be conferred on the donor. Id. at 1336. It is highly doubtful that very young donors, including those as young as thirteen months, are capable of altruistic motivation or recognition that their donation benefitted a family member. Id. The contemporaneous benefit of altruism therefore appears to be lacking. Id. The relevance of any future benefit based on altruism is also extremely suspect in light of
but the psychological benefit is too speculative and subject to manipulation to justify organ donation. Excluding the psychological benefit, the basis for essentially all the cited cases, substantially restricts the conditions upon which a court may grant permission for donation. A compelling argument could possibly be made where the recipient is financially responsible for the support of the donor, as in In re Doe. This would obviously allow parents to be beneficiaries of donations and restrict siblings, who would generally not be in a position to provide this support, from serving as recipients. While this may seem discriminatory, the standard is invoked to determine the benefit to the donor, not to consider the need or benefit to the recipient.

Attempts to ameliorate the harshness of this rule could perhaps be accomplished by using the mature minor rule. Early application of a similar standard permitted the court to consider the consent of the minor donor in determining whether to allow a transplant to proceed. This leads to whether the mature minor rule should be applicable where consent of the minor donor does have legally binding force. The major objection concerns doubts that consent within this context may be voluntary.

the speculative nature of the psychological benefit. Id. Altruism should be present at the time of the act, as a motivating factor, not used at some future point to retrospectively justify an action. Id. Motivation and intent cannot be supplied after the act. Id.


184. William J. Curran, A Problem of Consent: Kidney Transplantation in Minors, 34 N.Y.U. L. REV. 891, 893 (1959). This review includes three unreported cases from Massachusetts in the 1950s. Id. In each case, the siblings were twins, aged nineteen, fourteen, and fourteen. Id. The court relied on psychiatric tests that indicated the donor twin was informed of the nature of the operation, understood and consented. Id. Rather than simply finding that the minor donor had the authority to make the decision, the court acted as the final decision-maker, partially relying on the consent of the donor as one of the factors on which it based its decision. Korins, supra note 8, at 510.

185. Bellotti v. Baird, 443 U.S. 622, 643 (1979) (holding that a pregnant minor is entitled to a judicial hearing to determine if she is sufficiently mature to make an abortion decision independently of her parents); Planned Parenthood of Mo. v. Danforth, 428 U.S. 52, 74, 75 (1976) (rejecting a blanket requirement for parental consent before an unmarried minor could obtain an abortion); Jennifer Fouts Skels, In re E.G.: The Right of Mature Minors in Illinois to Refuse Lifesaving Medical Treatment, 21 LOY. U. CHI. L.J. 1199, 1210 (1990) (recognizing that some minors are sufficiently mature to make constitutionally protected decisions).

Even for adults, pressures within the family to donate may be so extraordinary that there is no actual free choice.\(^{187}\) Psychological and psychiatric evaluation may be required of a prospective adult donor\(^{188}\) as well as a waiting period\(^{189}\) in an effort to ensure a voluntary decision. These precautions, arguably effective for adults, may not necessarily extend to minors. Children and adolescents have been found to be particularly susceptible to parental pressure within the context of choosing medical treatment.\(^{190}\) While there is no conclusive evidence indicating that adolescents are incapable of voluntary consent, there is evidence demonstrating that adolescents may not have sufficient resources to execute their intentions in the face of parental pressure.\(^{191}\) As a result of this documented submission to parental pressure, one option would be simply to reject the mature minor rule in this context. At the very least, however, all minors should be entitled to the same psychiatric and psychological evaluations as adults in order to determine the legitimacy of their consent.\(^{192}\)

Ultimately, the root of the problem is that technology has created the demand for a product that exceeds the supply. The scarcity of tissue and organs, from both live and cadaveric donors, under existing procurement procedures simply cannot meet the need, with tragic and fatal consequences.\(^{193}\) This

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187. Id.
188. Id. at 315; Singer et al., supra note 128, at 621.
189. Singer et al., supra note 128, at 621.
191. Id. at 446.
192. Some states have passed legislation conferring legal force to the consent of a minor. See, e.g., Ala. CODE § 22-8-9 (1981). In Alabama, minors fourteen years of age and older may give effective consent with respect to donations of bone marrow for transplantation. Id. The requirements for psychological evaluation are not statutorily imposed but are simply criteria proposed and used in particular transplantation centers for particular organ transplantations. Singer et al., supra note 128, at 621. Allowing minors to consent to bone marrow donations by statute with no accompanying requirements to determine if consent is actually voluntary exposes the minor to all the pressures that a family may mount with no effective means of protection. Id. Michigan had a statute allowing a person fourteen years of age or older to donate a kidney to an immediate family member when authorized by probate court. Mich. COMP. LAWS § 701.19(a)(b) (1970). Authorization of the probate court depended on the ability of the donor to understand the needs and consequences of the donation. Id. This statute was subsequently repealed in 1978. 1978 Mich. Pub. Acts 543.
193. Prottas, supra note 4, at 463; see also Kearney & Caplan, supra note 134, at
desperate demand, however, does not justify the bodily invasion of children in the absence of a corresponding obligation on adults.194

CONCLUSION

Using siblings or mental incompetents as live organ or tissue donors subjects children or mental incompetents to bodily invasions that are prohibited in adults, absent proper consent. Allowing parents to provide consent for their children to serve as organ donors poses enormous problems with respect to conflict of interest, precluding parental consent alone as providing acceptable consent. Courts should be required to evaluate each individual case, using a much stricter application of the best interest standard, under narrow circumstances.

Robert W. Griner

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194. Baron et al., supra note 6, at 181.