CURRAN v. BOSZE: TOWARD A CLEAR STANDARD FOR AUTHORIZING KIDNEY AND BONE MARROW TRANSPLANTS BETWEEN MINOR SIBLINGS

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INTRODUCTION

Jean Pierre Bosze was the subject of "a tangled courtroom drama involving love, desperation and spite."[1] The twelve-year-old boy desperately needed a bone marrow transplant, but neither his father nor his brothers were compatible donors. Jean Pierre's father, Tamas Bosze, turned to Nancy Curran, the mother and custodial parent of James and Allison Curran, children of Mr. Bosze and half siblings of Jean Pierre. He requested that the three-year-old twins be tested to determine if they were compatible bone marrow donors for their half brother. Nancy Curran refused to consent to this invasive and risky procedure for her children.

Desperate to save his son, Mr. Bosze petitioned a circuit court to order that the twins be tested for compatibility. The circuit court refused to grant the petition. The Illinois Supreme Court affirmed the circuit court's decision in *Curran v. Bosze*.[2] The court was aware that without the transplant operation Jean Pierre would "almost certainly die."[3] Yet, the Illinois Supreme Court stated:

> The sympathy felt by this court, the circuit court, and all those who have learned of Jean Pierre's tragic situation cannot . . . obscure the fact that, under the circumstances presented in the case at bar, it neither would be proper under existing law nor in the best interests of the 3½-year-old twins for the twins to participate in the bone marrow harvesting procedure.[4]

This case was not the first in which a court struggled with the

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1. Bob Secter, *Boy in Transplant Legal Battle Dies of Leukemia*, L.A. TIMES, Nov. 20, 1990, at A22.

2. Curran v. Bosze, 566 N.E.2d 1319 (Ill. 1990).

3. *Id.* at 1345.

4. *Id.*

issues posed by organ and bone marrow transplants between minor siblings.[5] The approaches adopted by courts in this context parallel those adopted in cases involving organ or bone marrow transplants from adult donors who have never been competent to consent for themselves. In both contexts, because the donor has never been competent to make fully informed medical decisions, the decision maker lacks a reliable indication of what the donor would choose. Faced with these difficulties, courts must nevertheless decide whether these transplants may be performed and, if so, who should be authorized to give consent and by what standards.

This article explores the issue of consent to nontherapeutic medical treatment of minors for the benefit of their siblings.[6] In *Curran*, the court refused to authorize the testing of the twins in light of maternal objection. The court indicated that nontherapeutic treatment for minor children would be authorized where the donor's custodial parent consents and where a close relationship exists between the donor and recipient. The *Curran* approach moved beyond prior cases by giving considerable freedom to parents to determine whether nontherapeutic procedures are in the best interest of the donor and by recognizing that, where a close relationship exists between siblings, it may be in a child's best interest to be a donor.

Section I of this article examines the haphazard development of the law prior to the *Curran* decision. Section II outlines several factors which influence the standards for authorizing transplants between minor siblings. The various approaches adopted by courts and commentators are evaluated in light of these factors.

Section III analyzes the test in *Curran* and highlights questions which the court's approach does not resolve. The *Curran* test differs from prior approaches because it gives considerable deference to parental discretion. This presumption in favor of parents

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5. Because there is only a handful of reported cases in this area, it is difficult to determine how often these cases arise. There are also several unreported cases of transplants from children or mentally disabled adults to members of their families. In addition, transplants can occur without litigation if the procedure is unchallenged. "Challenges" to transplants in this context often arise because hospitals and doctors want judicial authorization to protect them from subsequent lawsuits. Interview with Professor Robert Mnookin, Adelbert H. Sweet Professor, Director of the Stanford Center on Conflict and Negotiation, Stanford Law School, while a visiting professor at Harvard University Law School, in Cambridge, Mass. (Mar. 19, 1991).

6. A "nontherapeutic" medical procedure is one that does not provide any direct medical benefit to the patient.

contrasts with the emphasis in many prior cases on the consent or assent of the donor. Illinois moved beyond prior case law by not considering donor consent or assent and by giving great weight to parental consent.

Section IV outlines principles suggesting three possible ways to resolve this legal issue. The first principle is that of parental autonomy, based on the presumption that parents rather than the courts are most able to determine the best interest of their children. This principle suggests a legal rule in which courts defer to parental decisions regarding organ or bone marrow donations where the parent and child have a close relationship. This approach takes the premise of parental autonomy underlying the court's decision in *Curran* to its logical conclusion. The second principle is that of respect for the individual autonomy of the donor. This principle of individualism suggests a legal rule in which the court focuses on the consent or assent of the individual donor, allowing transplants only if the donor understands and expresses a desire to participate in these invasive procedures. Combining these two approaches suggests a rule that defers to custodial parents, yet ensures that the donor's best interest is protected with minimal judicial intervention.[7]

Any approach to the issue of transplants from minors to siblings must be justified by and understood in light of a particular vision of the family. Two competing conceptions of the family underlie the arguments in this article. The family might be viewed as a network of relationships where individuals are bound by ties of love, interdependence, and a sense of obligation. This view of the family favors the principle of parental autonomy because the family members are in a better position to make decisions affecting children than are courts. In contrast, the family may be seen as an institution in which individuals need the protection of the state to secure their rights. This view of the family supports the principle of individual autonomy. The approaches suggested in this article will facilitate the consistent application of the tests articulated by *Curran* and previous decisions by making explicit their premises about the family.

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7. *See infra* section IV.C.

I. BACKGROUND TO *CURRAN V. BOSZE*

A. The Risks and Benefits of Transplants

Transplants from incompetents for the benefit of their siblings have emerged as an alternative only recently, due to technological advances in the medical field. Siblings, and particularly twins, are far more likely than unrelated persons to be medically viable donors. In addition, siblings frequently are available and willing to serve as donors. Because transplants from siblings can make the difference between life and death, the cases discussed in this article involve emotionally charged, often tragic situations.

When asked to authorize a transplant from an incompetent donor for the benefit of a sibling, a court must evaluate the risks and benefits of the procedure. The primary risk to a donor of bone marrow or a kidney is that associated with anesthesia. In a bone marrow transplant, the donor must undergo a painful procedure in which needles are inserted into the pelvic bone. Donors also face a slight risk of bone fractures, infections, ruptured arteries, and scarring.[8] Kidney donors face even greater risks, both from the more complex nature of the operation itself and from the possibility that the remaining kidney will fail subsequently. Either type of donor may also suffer psychological trauma from the procedure.[9]

There are no physiological benefits to donors from transplants. According to courts, the primary benefits to donors are psychological. These benefits derive from the fact that donors may be able to prevent the death of siblings. Even if the siblings do not survive, the donors may benefit from the knowledge that they did all that was possible to try to save their siblings.[10] Empirical studies indicate that the vast majority of kidney donors made their decisions freely and described donation as a deeply rewarding act.[11]

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8. Charles H. Baron et al., *Live Organ and Tissue Transplants from Minor Donors in Massachusetts*, 55 B.U. L. REV. 159, 163-64 n.20 (1975).

9. *Id.* For example, the donor might fear operations or, in the case of a kidney donor, worry about damage to his or her remaining kidney.

10. On the other hand, if a bone marrow transplant fails, the patient may suffer a particularly agonizing death, causing increased psychological trauma to the donor. *Id.* at 163-64 nn.19-20.

11. Jane B. Baron, *Gifts, Bargains and Form*, IND. L.J. 155, 173-75 (1988-89) [hereinafter *Gifts*].

B. The Requirement of Consent

Competent individuals are not compelled to donate organs or risk their health to benefit another, even if the beneficiary is a family member. Doctors must always secure consent before treating competent individuals. In the case of the therapeutic treatment of a minor, parental consent is a sufficient proxy.[12] This rule rests on the presumption that parents act in their child's best interest.

Proxy consent for a transplant, which is a nontherapeutic procedure for the donor, is more problematic. The donor will receive no physiological benefit and may be exposed to serious risks. In addition, parents face an inherent conflict of interest. A parent must decide whether to risk the health of one child in order to save the life of another. Courts have rejected their traditional reliance on parental consent because the questions raised in this context undermine the presumption that parents will act in a child's best interest.

Adults generally have not been compelled to undergo organ or bone marrow transplants for the benefit of relatives. The rule for incompetents should be consistent with this principle—more should not be demanded of incompetents than is required of competent adults. Two cases demonstrate the general view courts take on the issue of compelled treatment between relatives.

In *McFall v. Shimp*,[13] a Pennsylvania county court refused to compel an adult to submit to a bone marrow transplant for the benefit of his cousin. The court dismissed authority from other countries that suggested support for a duty to aid, stating: "[O]ur society, contrary to many others, has as its first principle, the respect for the individual, and that society and government exist to protect the individual from being invaded and hurt by another."[14] Coerced medical treatment for the benefit of another is generally perceived as contrary to the premise of individual autonomy which pervades American law.[15] As one commentator stated, coerced do-

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12. W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS 115 (5th ed. 1984) (indicating that parental consent is sufficient to bar recovery in a battery action against a doctor).

13. McFall v. Shimp, 10 Pa. D. & C.3d 90 (1978).

14. *Id.* at 91.

15. The failure of American common law to recognize a more general duty to aid has been sharply criticized by many commentators. *See, e.g.*, THE GOOD SAMARITAN AND THE LAW (James M. Ratcliffe ed., 1966); Francis H. Bohlen, *The Moral Duty to Aid Others as a*

nation is "a practice clearly beyond the pale."[16]

Although *McFall* involved cousins, several commentators have cited it to support the idea that parents do not have a duty to undergo similar treatment for a child.[17] Commentators also point to *In re George*[18] in support of the rule against coerced donations.[19] In that case, an adoptee in need of a bone marrow transplant petitioned a court to open his adoption records so that he could ask his natural parents and siblings to donate. The trial court contacted the natural mother, and she was tested but found to be incompatible. When the court contacted the father, however, he refused to be tested. The trial court would not provide the father's name to his son, and the court of appeals affirmed the trial court's ruling.[20]

George supports the view that a parent cannot be compelled to donate bone marrow for the benefit of a child. *George*, however, does not present the strongest case conceivable for a compelled donation. The lack of an existing emotional relationship, as well as

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Basis for Tort Liability, 56 U. PA. L. REV. 217, 316 (1908). For a criticism of *McFall* in particular, see Fordham E. Huffman, Comment, *Coerced Donation of Body Tissue: Can We Live with* McFall v. Shimp?, 40 OHIO ST. L.J. 409 (1979).

16. Donald H. Regan, *Rewriting* Roe v. Wade, 77 MICH. L. REV. 1569, 1585 (1979).

17. For example, Lawrence J. Nelson et al., pose the hypothetical case of a four-year-old girl in need of a kidney transplant from her mother. Based on *McFall* and the apparent disfavor of coerced organ donation, they conclude that "[i]n all likelihood" the daughter would fail in a legal action to compel the transplant. Lawrence J. Nelson et al., *Forced Medical Treatment of Pregnant Women: 'Compelling Each to Live as Seems Good to the Rest,'* 37 HASTINGS L.J. 703, 754 & n.250 (1986).

See also Joan Mahoney, *Death with Dignity: Is There an Exception for Pregnant Women?*, 57 UMKC L. REV. 221, 230-31 (1989). Mahoney poses the hypothetical case of a father who is the only possible bone marrow donor for his son. Before he can make a decision whether to undergo a transplant, the father suffers a cerebral hemorrhage. His living will indicates his choice to refuse life-sustaining treatment. Mahoney relies on two cases, *Strunk* and *Pescinski* to argue that the donor himself would receive no benefit from a transplant. *See infra* notes 46-61, 77-79 and accompanying text. On this basis, Mahoney concludes that "[i]t would seem unlikely" that a court would order that the father be kept alive, contrary to his express wishes, in order to preserve his bone marrow to donate to his son when he reached the proper stage for treatment. *Id.*

It should be noted that courts might be more willing to impose a duty if the transplant procedure were not so intrusive. For example, if an individual were the only available donor for a blood transfusion or a skin graft operation, courts might impose a duty to aid even though they would not require a bone marrow or kidney donation.

18. *In re* George, 625 S.W.2d 151 (Mo. Ct. App. 1981), *appeal after remand*, 630 S.W.2d 614 (Mo. Ct. App. 1982).

19. *See, e.g.*, Nancy K. Rhoden, *The Judge in the Delivery Room: The Emergency of Court-Ordered Caesareans*, 74 CAL. L. REV. 1951, 1978 (1986).

20. *In re* George, 630 S.W.2d 614 (Mo. Ct. App. 1982).

the lack of a legal relationship, between the adopted child and his father distinguishes *George* from cases of compelled donations between individuals in family contexts. Despite these distinctions, however, there is almost universal agreement that a court would not force a parent to undergo an organ or bone marrow transplant for the benefit of his or her child.[21]

In contrast, in the context of pregnancy, there is authority to support compelling a mother to undergo invasive medical treatment for the benefit of her fetus.[22] Such a conception of a woman's duty to aid her fetus arguably could be extended to compel parents to undergo transplants for their child's benefit.[23] This duty would likely be premised on the idea that since parents created the child, they have a responsibility to it. The same could not be said, however, of a child's sibling.

Where a minor child is a potential donor, consent is a hurdle that courts must address before authorizing a transplant. Because neither children nor their parents can provide consent, parents look to the courts to provide legal sanction for the necessary procedures. In deciding whether to permit such procedures, courts have employed two basic approaches: the best interest standard and the substituted judgment standard.

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21. *See Developments in the Law—Medical Technologies and the Law*, 103 HARV. L. REV. 1519, 1570-71 (1990). *But see* John A. Robertson, *Procreative Liberty and the Control of Conception, Pregnancy and Childbirth*, 69 VA. L. REV. 405, 456 n.166 (1983) [hereinafter *Procreative Liberty*] (relying on fetal therapy cases to argue generally in favor of physical intrusions on parents to benefit children as long as the therapy does not pose a serious risk to the parent); Deborah Mathieu, *Respecting Liberty and Preventing Harm: Limits of State Intervention in Prenatal Choice*, 8 HARV. J.L. & PUB. POL'Y 19, 43-44 (1985) (arguing that *Strunk v. Strunk*, discussed *infra* notes 46-61 and accompanying text, suggests a sweeping duty on the part of family members to come to each other's aid).

22. *See, e.g.*, *In re* A.C., 533 A.2d 611 (D.C. 1987), *reh'g granted, vacated*, 539 A.2d 203 (D.C. 1988), *reheard*, 573 A.2d 1235 (D.C. 1990) (authorizing doctors to perform a caesarean on a woman against her will, for the benefit of the fetus). Many commentators have criticized such decisions as imposing a duty on pregnant women to come to the aid of the fetus that is not similarly required of fathers or of parents in any other context. *See, e.g.*, Regan *supra* note 16, at 1623.

23. *See Procreative Liberty*, *supra* note 21, at 456 n.166 (1983). Professor Robertson argues in favor of both compulsory fetal therapy for pregnant women and compelled bodily intrusions on parents when the life or health of the child requires it. He argues that state statutes authorizing courts to order blood, marrow, or tissue donations, but not major organ donations, from parent to child would probably be constitutional. He does not specify whether a kidney donation would be barred as a "major organ donation" under his analysis. *Id.*

C. *Judicial Standards: Best Interest of the Donor and Substituted Judgment*

Courts have relied on one of two doctrines to authorize nontherapeutic procedures for incompetents. Under the doctrine of best interest of the donor, courts authorize a procedure where they believe that it is in the donor's objective best interest. Generally, the benefit is psychological or emotional. Under the doctrine of substituted judgment, the court will authorize the procedure if it believes that the donor would consent if he or she were competent. Though the doctrines appear to set out a simple dichotomy based on whether the decision will be made according to subjective or objective information, application of these doctrines is extremely problematic. Where the subjective information needed for the substituted judgment approach is lacking, courts often turn, without acknowledgment, to objective information. Likewise, in cases that turn on psychological benefit, the purely objective analysis of the best interest standard frequently breaks down due to the inherent subjectivity of all but the most rudimentary psychological evaluations. Therefore, the label given to the rule of law that a court applies in these cases often has little meaning.[24]

In theory, the best interest of the donor test provides a stricter approach because it focuses purely on the objective benefit to the individual donor. But with the introduction of psychiatric testimony the standard can be transformed from a limited, purely individualistic approach into a more expansive one that encompasses an individual's relationships with family members.[25] A broadly applied best interest test, which includes psychological benefit to the donor, is effectively identical to a substituted judgment test. In addition, the best interest test has been criticized for being manipu-

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24. *See infra* note 55 and accompanying text (court affirming best interest test but applying doctrine of substituted judgment).

25. The use of psychiatric and sociological testimony in this context has been compared to the reliance on social science in *Brown v. Board of Education*. *See, e.g.*, Madsen v. Harrison, No. 68651 Eq., slip op. at 4 (Mass. June 12, 1957) (citing *Brown* to support the court's reliance on psychiatric testimony).

Commentators have questioned the use of such testimony to support premises that most people would accept as a matter of common sense. As Professor Curran observed, "[i]t hardly seems that psychiatric evidence is necessary to convince anyone that a healthy identical twin would suffer a grave emotional impact on the death of his twin brother." William J. Curran, *A Problem of Consent: Kidney Transplantation in Minors*, 34 N.Y.U. L. REV. 891, 894 (1959) [hereinafter *Kidney Transplantation*]. Professor Curran suggests that such expert testimony encroaches on areas traditionally handled by fact finders. *Id.* at 894-95.

lable because it relies on psychological testimony about the donor that is often contrived.[26]

The substituted judgment test was originally used by courts of equity to authorize gifts from the estates of incompetent persons.[27] In determining whether a gift would be made courts generally looked first at the individual's intent to give, then to the relationship between the incompetent and the proposed recipient, and finally, absent such evidence, to a reasonable person standard.[28] The purpose was to determine what the individual would have done had he or she been competent. Some courts adopt the same approach when confronted with the question of whether an incompetent's body, as opposed to his or her property, can be invaded for the benefit of another.[29] Courts applying the substituted judgment test attempt to determine whether the donor would consent to the procedure if he or she were competent and fully informed. But in the case of a minor, there may be little, if any, way to determine what the minor would do if competent.[30] Even where children can express their views and understand the procedure, their views are legally insufficient to provide a basis for consent.[31] Perhaps all a court is capable of doing is maximizing the child's flexibility and

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26. *See, e.g.*, Baron et al., *supra* note 8, at 171.

27. John A. Robertson, *Organ Donations by Incompetents and the Substituted Judgment Doctrine*, 76 COLUM. L. REV. 48, 57 (1976) [hereinafter *Organ Donations*].

28. *Id.* at 59-62.

29. *See* Hart v. Brown, 289 A.2d 386 (Conn. Super. Ct. 1972); *In re* Richardson, 284 So. 2d 185 (La. Ct. App. 1973). The doctrine of substituted judgment, as originally applied to property, permitted courts to give away only the excess from an incompetent's estate. A transplant of blood or bone marrow, which the body regenerates, arguably can be termed "excess," justifying reliance on the substituted judgment doctrine. The same, however, cannot necessarily be said of organs, such as kidneys, that are not regenerated. Therefore, the substituted judgment doctrine in this context arguably should be limited to donation of tissue which may be defined as "excess." In fact, some commentators argue that the application of the substituted judgment doctrine in the biomedical context is inappropriate unless applied to allow only nonharmful interventions. *See* Alexander M. Capron, *The Authority of Others to Decide about Biomedical Interventions with Incompetents*, *in* WHO SPEAKS FOR THE CHILD: THE PROBLEMS OF PROXY CONSENT 115, 122-23 (Willard Gaylin & Ruth Macklin eds., 1982).

30. If we believe that children will adopt the values of their parents, however, then we can predict minors' decisions based on discussions with their parents. In *Curran v. Bosze*, an expert articulated this analysis: "[Y]ou don't really have to talk to the kids. You just have to talk to their parents. . . . [M]ost children adopt the views of their parents." *Curran*, 566 N.E.2d at 1334-35 (alteration in original). If this argument is valid, then parental consent might be sufficient to authorize nontherapeutic treatment under the substituted judgment approach.

31. Baron et al., *supra* note 8, at 170 n.54.

freedom to make choices in the future.[32]

One final approach to donations by minors to siblings—one that has not been adopted by courts—would be to bar these transplants as a matter of law. Transplants pose serious risks, but provide no direct physiological gain, to the donor. A minor is incapable of giving informed consent; and a parent's consent may not reliably reflect the donor's best interest because of the conflict of interest that arises when a transplant will benefit another of the parent's children. Arguably, neither a parent nor a court should be permitted to submit a child to a risky medical procedure which provides no therapeutic benefit, simply to help a member of the family.[33] As the United States Supreme Court explained in *Prince v. Massachusetts*, "[p]arents may be free to become martyrs themselves. But it does not follow that 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."[34]

D. *Cases Prior to* Curran v. Bosze

Curran v. Bosze was decided in the wake of a series of judicial decisions which considered the propriety of transplants from incompetents to their siblings. The decisions in these cases, individu-

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32. Several commentators have based their criticism of the substituted judgment doctrine on principles developed by John Rawls. JOHN RAWLS, A THEORY OF JUSTICE (1971). *See, e.g.*, Gerald Dworkin, *Consent, Representation and Proxy Consent*, *in* WHO SPEAKS FOR THE CHILD: THE PROBLEMS OF PROXY CONSENT 191, 205 (Willard Gaylin & Ruth Macklin eds., 1982). Dworkin argues that choices for those who have not attained competence should be made

> not as they might want, but in terms of maximizing those interests that will make it possible for them to develop life plans of their own . . . [by preserving] their share of what Rawls calls "primary goods"; that is, such goods as liberty, health and opportunity, which any rational person would want to pursue whatever particular life plan he chooses.

Id. Under Dworkin's Rawlsian analysis, an individual's health should not be jeopardized for purely altruistic reasons. *Cf. Organ Donations supra* note 27, at 62-68 (concluding that, in the case of a child or a person who might attain competency in the future, the substituted judgment doctrine should preserve maximum flexibility to pursue the tastes and preferences he or she develops in the future). *But see* Anthony D. D'Amato, *The "Bad Samaritan" Paradigm*, 70 NW. U. L. REV. 798, 806 & n.32 (1975) (arguing under a Rawlsian analysis that individuals under the veil of ignorance would agree to a good samaritan rule where the risks were small and the benefits were high).

33. *See supra* note 32 (Rawlsian analysis of the duty to aid).

34. Prince v. Massachusetts, 321 U.S. 158, 170 (1944), *reh'g denied*, 321 U.S. 804 (1944).

ally or as a group, did not offer a coherent or consistent resolution of the transplant issue. Nevertheless, they provided basic principles upon which the *Curran* court drew to resolve the issues presented in that case.

The problem presently under consideration arose quickly after 1954, the year of the first successful kidney transplant between adult identical twins.[35] In 1956, the same hospital that performed the original procedure received three requests to perform transplants on identical minor twins. Although the parents consented to the transplants, the hospital sought sanction in the form of declaratory judgments in all three cases. Each case was heard by a single justice of the Massachusetts Supreme Judicial Court, and all three justices authorized the procedures.

In *Madsen v. Harrison*,[36] a transplant between nineteen-year-old twins was authorized.[37] The donor and his mother were fully informed about, and consented to, the procedure.[38] In addition, the justice heard evidence from a psychiatrist that the donor would suffer "a grave emotional impact" if his brother died.[39] In reaching his decision, Justice Counihan emphasized both the nineteen-year-old donor's consent and the potential emotional harm to him if the recipient died.

The other two cases decided that year by single justices of the court involved twins who were fourteen years old.[40] In each case, the justice made a special finding that the donor fully understood the procedure and consented to it.[41] In *Huskey v. Harrison*, Justice Whittemore found that the fact that both the donor and parent had consented was a sufficient basis upon which to authorize the transplant.[42] In *Foster v. Harrison*, Justice Cutter found that the donor was of "good understanding and intelligence. . . . [The donor was also] fully informed of . . . the nature of the operation and its possible risks and consequences. . . . [The donor's consent] is the result of his own decision, free from pressure or coercion, made

35. *Kidney Transplantation*, *supra* note 25, at 892.

36. Madsen v. Harrison, No. 68651 Eq. (Mass. June 12, 1957).

37. The age of maturity in Massachusetts was 21 at this time.

38. The court noted that the father had deserted the family and was, therefore, unavailable to give his consent. *Madsen*, No. 68651 Eq., slip op. at 1.

39. *Id.* at 2.

40. Foster v. Harrison, No. 68674 Eq. (Mass. Nov. 20, 1957); Huskey v. Harrison, No. 68666 Eq. (Mass. Aug. 30, 1957).

41. *Kidney Transplantation*, *supra* note 25, at 895.

42. *Huskey*, No. 68666 Eq., slip op. at 2.

with admirable courage, generosity, and appreciation of the factors involved."[43] Thus, although the donors in all three cases were minors, the court placed special emphasis on their informed consent.[44]

The court adopted a test in these three cases that has been restated as requiring: (1) parental consent, as required for any medical procedure; (2) informed consent of the minor donor, even though by itself this consent has no legal validity; and (3) benefit to the donor, presumably psychological benefit.[45] With the second and third prongs of this test, the Massachusetts court effectively imposed an age and maturity requirement for potential donors. The donor had to be mature enough to consent to the procedure and to experience the psychological benefit presumed to accrue if the sibling were saved.

In *Strunk v. Strunk*,[46] the Kentucky Court of Appeals first addressed the problem of a donor incompetent to consent. The court affirmed an order authorizing a kidney transplant from an incompetent donor to his brother. The donor, Jerry, was a twenty-seven-year-old, severely retarded man living in a state institution.[47] The trial court heard evidence describing the close relationship between Jerry and his brother Tommy.[48] A psychiatrist testified that Tommy's death would have an "extremely traumatic effect" upon

43. *Foster*, No. 68674 Eq., slip op. at 2-3.

44. At the time of these decisions, the question of whether a donor was too young to express his or her consent had not yet arisen. Professor Curran, writing in 1959, noted that "[i]n the case of very young children, the query [whether the donor is too young to understand the situation] may be purely academic." *Kidney Transplantation*, *supra* note 25, at 895 n.15. Curran nevertheless suggests that parental consent would be sufficient in those circumstances to authorize the operation, since parental consent is generally decisive in medical treatment for minors. *Id.* at 896.

45. *See* Joe C. Savage, *Organ Transplantation with an Incompetent Donor: Kentucky Resolves the Dilemma of* Strunk v. Strunk, 58 Ky. L.J. 129, 136 (1970). *But see* Baron, et al., *supra* note 8, at 169 (describing these cases as applications of the best interest test, where the court authorized the transplants because it found net benefits to the donors).

46. Strunk v. Strunk, 445 S.W.2d 145 (Ky. 1969).

47. *Id.* at 146.

48. According to one commentator, Mrs. Strunk testified:

> You have to be there in the home to have known of the devotion between these two boys and the love that Tommy has for Jerry and Jerry has for Tommy. Jerry looks up to Tommy; Tommy has been so good to him. Jerry needs Tommy. . . . After we [his parents] are gone, the only living person who will be there will be Tommy to go to the school and see about Jerry and take him out and let him live a half-normal life and let him know what it is outside of cold institution walls.

Savage, *supra* note 45, at 144 (quoting trial transcript).

Jerry.[49] The psychiatrist also testified that Jerry understood that his brother was sick and that he could undergo an operation to "'give kidney' to help Tommy."[50] Although the psychiatrist felt that Jerry understood he was being asked to help his brother, he did not believe that Jerry was capable of providing informed consent to the procedure.[51]

All of the members of the family supported the proposed transplant.[52] The donor's guardian ad litem, however, questioned the authority of the court to authorize the removal of an incompetent adult's organ because the donor was a ward of the state. Despite the objections of the guardian ad litem, the lower court found that the operation would be beneficial to the donor because he "was greatly dependent upon [his brother], emotionally and psychologically, and . . . his well-being would be jeopardized more severely by the loss of his brother than by the removal of a kidney."[53] The court of appeals affirmed the lower court's ruling that the doctrine of substituted judgment was broad enough to cover bodily invasions as well as invasions of property.[54] But, while the decision explicitly referred to the doctrine of substituted judgment, the court reviewed the evidence and affirmed the lower court's conclusion that the procedure was in the donor's best interest.[55]

The issue in *Strunk* is analogous to that involved with minors because that case involved an organ transplant by an adult who was never able to give informed consent. The court had no expressions of the donor's values or views on medical issues upon which to base its decision. Although the court heard evidence that the donor was aware of the nature of the operation, it also heard evidence that the donor was not able to comprehend fully the issues involved. The lack of actual consent by the donor sharply contrasts with the consent provided by the donors in the Massachusetts cases. *Strunk* has been criticized for reducing the protection available to the mentally disabled from bodily intrusions for the benefit of family members.[56] The *Strunk* analysis, if applied to minor do-

49. *Strunk*, 445 S.W.2d at 146.
50. Savage, *supra* note 45, at 147.
51. *Id.*
52. *Strunk*, 445 S.W.2d at 146.
53. *Id.*
54. *Id.* at 148.
55. *Id.* at 149.
56. *See, e.g.*, Mathieu *supra* note 21, at 42-45; Charles J. Cronan, IV, *Spare Parts from Incompetents: A Problem of Consent*, 9 J. FAM. L. 309 (1969); Robert A. Koory, *Eq-*

nation cases, would reduce the protection afforded them as well.

In addition, *Strunk* is significant because it applied a psychological benefit concept to a donor with a mental age of six. Use of the psychological benefit concept for young donors has been challenged on the ground that these donors lack the maturity to appreciate the loss of a sibling.[57] The dissent in *Strunk* pointed out that evidence of psychiatric trauma to six-year-olds upon the loss of a close friend or relative is "at best most nebulous."[58] One commentator has argued that "[i]t is fairly clear that in this case the best interests of the donor were not really the primary concern."[59]

The attorney for the Strunk family acknowledged the important and potentially broad implications of the court's decision. At the very minimum, he wrote, *Strunk* holds that a person incompetent to consent can donate an organ. This holding alone is significant because it is the first reported case in the United States to stand for this proposition.[60] If *Strunk* were interpreted more broadly, the decision could give courts great authority to sanction actions they deem beneficial to those incompetent to act for themselves.[61]

Three years after *Strunk* a Connecticut superior court authorized a kidney transplant between seven-year-old twins.[62] In *Hart v. Brown*, as in *Strunk*, the court relied explicitly on the doctrine of substituted judgment in support of its decision. The court held that parents may consent to nontherapeutic procedures for their children after a "close, independent and objective investigation of their motivation and reasoning."[63] They may give consent "when their motivation and reasoning are favorably reviewed by a community representation which includes a court of equity."[64]

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uity—Transplants—Power of Court to Authorize Removal of Kidney from Mental Incompetent for Transplantation into Brother, 16 WAYNE L. REV. 1460 (1970).

57. *See, e.g.*, Cronan, *supra* note 56, at 313.

58. *Strunk*, 445 S.W.2d at 150 (Steinfeld, J., dissenting).

59. Mathieu, *supra* note 21, at 42.

60. Savage, *supra* note 45, at 155.

61. *Id. Strunk* has also been interpreted in an extremely expansive way to suggest "a rather stringent duty to prevent or remove harm, or both, to a member of one's immediate family, a duty that involves significant risk to oneself and is shared even by members of the family who are incompetent to shoulder other types of obligations." Mathieu, *supra* note 21, at 43-44.

62. Hart v. Brown, 289 A.2d 386 (Conn. Super. Ct. 1972).

63. *Id.* at 390.

64. *Id.* at 391.

In *Hart*, the substituted judgment doctrine was interpreted to mean that parents, not the court, may substitute their consent for that of the child.[65] Reviewing the parent's consent to the procedure, the court considered evidence from the family's clergy, from the child's guardian ad litem who approved of the procedure, and from a psychiatrist who examined the child and found that she strongly identified with her sister. The psychiatrist also testified that the child would be worse off in a family traumatized by the death of her sister.[66]

In addition, the court noted that the seven-year-old donor assented to the procedure. She was "informed of the operation and insofar as she may be capable of understanding she desires to donate her kidney so that her sister may return to her."[67] The court's focus on the donor's wishes is consistent with the three early Massachusetts decisions. It reflects respect for the donor's autonomy—a desire to ensure that the transplant is authorized only if the decision to undergo the procedure is made by the donor, rather than by the donor's parents, guardian ad litem, or clergy.

Hart is not the first case to authorize nontherapeutic treatment to benefit a sibling where the donor was very young.[68] By considering the child's assent in its decision to authorize the procedure, however, the court suggested that in the future judges should inquire into the donor's qualitative understanding of the procedure. If they do so, they will eventually be called upon to evaluate the "assent" of children of increasingly young ages. If a child's assent is necessary to ratify a parent's consent to the nontherapeutic procedures, very young children found to be incapable of assenting will be ineligible to donate.

Hart did not clarify the proper roles of the donor, the parents, and the courts in deciding whether transplants from donors should proceed. The holding places the decision in the hands of the parents, but dicta suggests that the assent of the donor is also important to the test. Additionally, the requirement of judicial or "community" review of the parents' decision has been criticized as an

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65. *Id.* at 390-91.

66. *Id.* at 389.

67. *Id.*

68. Savage, *supra* note 45, at 136-37 & n.25 (discussing McMahon v. McMahon, Civ. No. 607074 (King County Ct., Wash. Aug. 20, 1963) (authorizing a skin transplant from a three-year-old twin to his badly burned brother)).

unwarranted intrusion into family autonomy.[69]

In apparent contrast to *Hart*, the court in *Nathan v. Farinelli*[70] reviewed the sufficiency of the consent given by the parents of a six-year-old to donate bone marrow to her sibling, but did not consider the donor's desires because of her young age. The court authorized the procedure after it favorably reviewed the parents' evaluation of the costs and benefits to the children. The court approved the transplant despite rejecting the best interest test and stating that the transplant would produce no real benefit to the donor.[71] The case has been criticized for failing to protect adequately the interests of the donor.[72]

In re Richardson[73] is one of at least two cases where courts refused to authorize transplants from adult incompetents to their siblings on the grounds that the medical procedures were not in the donor's best interest. In that case, a Louisiana court of appeals rejected the doctrine of substituted judgment. Under Louisiana law an incompetent's property is unqualifiedly protected from invasion for the benefit of family members. The court held that Roy, a young man with a mental age of three or four years, was entitled to equal, if not greater, protection from intrusion into his body as he was from intrusion into his property. The court concluded that only an objective best interest test was appropriate in such cases.

Although Roy was the best possible donor for his sister, the court noted that "neither a kidney transplant, nor particularly a transplanted kidney from Roy, [was] an absolute immediate necessity in order to preserve [his sister's] life."[74] The court suggested that the operation might have been in Roy's best interest if there had been more evidence that Roy would benefit from his sister's

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69. *See, e.g.*, Joseph Goldstein, *Medical Care for the Child at Risk: On State Supervention of Parental Autonomy, in* WHO SPEAKS FOR THE CHILD: THE PROBLEMS OF PROXY CONSENT, 153, 186-87 (Willard Gaylin & Ruth Macklin eds., 1982).

70. Nathan v. Farinelli, No. 74-87 Eq. (Mass. July 3, 1974). Neither the author nor the Massachusetts court was able to locate the *Farinelli* opinion, although the citation here noted is correct according to the court. Information regarding the opinion was derived from Savage, *supra* note 45.

71. *See* Baron et al., *supra* note 8, at 171-73; James G. Nolan, *Anatomical Transplants between Family Members—The Problems Facing Court and Counsel,* 1 FAM. L. REP. 4035, 4036 (1975).

72. Baron et al., *supra* note 8, at 174-75. Baron's article also contains a more comprehensive discussion and critique of all the Massachusetts cases and procedures for live organ transplants from minors.

73. *In re* Richardson, 284 So. 2d 185 (La. Ct. App. 1973).

74. *Id.* at 187.

survival.[75] Absent such evidence, the court refused to find that the best interest test had been met and held that neither his parents nor the court could authorize the organ transplant.[76]

In *Lausier v. Pescinski*,[77] the Supreme Court of Wisconsin adopted an approach similar to the court in *Richardson*. It rejected the substituted judgment test in favor of a best interest test.[78] The court held that it did not have the power to approve an operation on the schizophrenic, institutionalized adult absent evidence that the donor or the guardian ad litem had consented or that the donor would benefit.[79] The court did not state whether the consent of the donor, who had a mental age of twelve, would have been a sufficient basis for the court to authorize the procedure.

In contrast to these two cases, *Little v. Little*[80] adopted the substituted judgment test in deciding whether to authorize a kidney transplant from a girl suffering from Down's syndrome to her brother. In *Little*, unlike *Hart*, the court held that the substituted judgment doctrine authorized the court, rather than the parents, to substitute its judgment for the child's and consent to the operation. The court reasoned that parents have the authority to consent only to "treatment."[81] Therefore, parental consent was decisive for the treatment of the donor's brother, but more was required before the proposed procedure could be performed on the donor.[82]

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75. The court in *Richardson* dismissed the argument that the operation was in the donor's best interest because his sister, if she survived him, would be able to care for him after his parent's death. Such an outcome was deemed "not only speculative, but, in view of all the facts, highly unlikely." *Richardson*, 284 So. 2d at 187. This sort of evidence was relied upon in *Strunk* to conclude that it was in Tommy's best interest to donate a kidney to Jerry. *See Strunk*, 445 S.W.2d at 146-47. *See also*, Savage, *supra* note 45.

76. *Richardson*, 284 So. 2d at 187. The court recognized that both parents consented to the transplant procedure, even though the action was brought by the husband to compel the wife to consent to the operation. "The suit was filed against the child's mother as a procedural vehicle for placing the matter before the court . . . ." *Id.* at 186.

77. Lausier v. Pescinski, 226 N.W.2d 180 (Wis. 1975).

78. *Id.* at 181.

79. *Id.* at 181-82. A subsequent case, *In re Guardianship of Eberhardy*, emphasized that *Pescinski* was an instance of judicial restraint rather than a holding that the court lacked jurisdiction to authorize the procedure. *In re* Guardianship of Eberhardy, 294 N.W.2d 540, 544 (Wis. Ct. App. 1980), *aff'd*, 307 N.W.2d 881 (Wis. 1981).

80. Little v. Little, 576 S.W.2d 493 (Tex. Civ. App. 1979).

81. *Id.* at 495. The court relied on the language of the Texas family and probate codes for its emphasis on the word "treatment." *Id.*

82. *Id.* The court referred to *Black's Law Dictionary* to illustrate that even a most expansive definition of "treatment" could not include a procedure that did not aim to "cure" an ailment of the patient. *Id.*

The court authorized the procedure based on evidence that the donor would suffer psychological harm if her brother died.[83] Explicitly limiting its holding to transplants where the recipient is a sibling or a parent of the donor,[84] the court recognized the psychological benefits stemming from close relationships within the family.[85] Its holding was dependent on, among other things, the fact that there was a full judicial proceeding in which the donor's guardian ad litem assumed a vigorous adversarial stance. The development of a full record with arguments presented on both sides assured the court that the decision complied with due process.[86]

Finally, in *In re Doe*,[87] the appellate division affirmed an order of a New York Supreme Court authorizing a bone marrow transplant from a severely retarded adult to his brother. This case differs from the other cases discussed because a bone marrow transplant poses fewer risks to the donor than a kidney transplant.[88] The court in *Doe* adopted the best interest approach, defining it as a balancing test. The trial court had found "that the transplant would be in the incompetent's best interest because the benefits to him of his brother's future company and advocacy outweigh any physical and psychological risks."[89] The appellate division did not dispute this analysis, nor did it decide what standard of review would be applied in such cases. Because the trial court had found that the higher standard of proof had been met, the appellate court affirmed the decision authorizing the transplant.

The preceding discussion highlights the major decisions prior to *Curran v. Bosze* on the issue of transplants to siblings from those who were not and had never been competent to consent. One basic tension in the cases is the extent to which the courts focused on the consent of the donor rather than the consent of the parents or an independent review by the court of the donor's best interest.

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83. *Id.* at 498.

84. *Id.* at 500.

85. *Id.* at 498.

86. *Id.* at 499-500. In contrast, the donors in *Madsen*, *Foster* and *Huskey* (the Massachusetts cases) did not have their own advocates, raising the question of whether their interests were actually advocated. For an argument that courts should appoint guardians for minor organ donors and instruct them to adopt an adversary role, see Baron et al., *supra* note 8, at 182-88. *See also* Martin Guggenheim, *The Right To Be Represented but Not Heard: Reflections on Legal Representation for Children*, 59 N.Y.U. L. REV. 76, 147-54 (1984).

87. *In re* Doe, 481 N.Y.S.2d 932 (N.Y. App. Div. 1984).

88. *See supra* notes 8-11 and accompanying text.

89. *Doe*, 481 N.Y.S.2d at 932.

They struggled with the application of both the substituted judgment and the best interest of the donor doctrines. Courts differed on whether substituted judgment involved the consent of one parent, both parents, or the authorization of the court. The similarity of the two approaches seemed most apparent when each involved speculation as to the psychological impact on the donor if his or her sibling died. The inherent difficulty of determining the preferences or views of a young child or incompetent adult further complicated judicial attempts to respect the autonomy of the individual.

II. Factors to Consider

This section outlines six factors that affect the articulation and evaluation of judicial approaches to transplants between minor siblings. These factors often shape judges' decisions and, therefore, should be considered in evaluating the issues.

A. *Evaluation of the Risks and Benefits of Transplants*

The risks and benefits of a bone marrow or kidney transplant between siblings are difficult for a court to quantify and evaluate. For example, a court might weigh the benefits to the recipient against the risks to the donor and conclude that the operation should proceed if the risks are slight and potential benefits great.[90] More often, a court will focus exclusively on the donor and determine whether the psychological benefit of saving a sibling outweighs the risk of the transplant procedure. If a court considers psychological benefit, it must decide how to evaluate this benefit and compare it with the risks of an invasive medical procedure. To evaluate the benefit to the donor, the court might consider whether the source of the benefit is an existing relationship between the donor and the recipient, and if it is, whether the donor is too young to appreciate the loss of the sibling and to benefit psychologically from saving the sibling. In determining the nature of the relationship, the court could look to objective criteria such as whether the siblings live together. It could also make its determination based on subjective criteria such as the siblings' and others' testimony about their relationship.

The court also must compare the psychological benefit with

90. *See supra* notes 87-89 and accompanying text (discussing *Doe*).

the physiological risks. One option would be to distinguish between various transplant procedures based on the physical risks to the donors. For example, kidney donations might be barred as a rule, but less risky procedures such as bone marrow transplants could be subjected to a balancing test. Alternatively, highly invasive and risky procedures might be permitted only if the benefit to the recipient is especially large.[91]

Courts have not distinguished explicitly between these different procedures.[92] Increased attention to the level of physical risk could encourage procedure-specific rules that doctors and patients could rely upon when making decisions about transplants from minor donors.[93]

B. *Importance of Donor Consent*

Because coerced transplants are disfavored in American law, courts that authorize nontherapeutic procedures use language indicating respect for the donor's autonomy. In particular, courts often emphasize the consent or assent of donors who are not legally capable of consenting to medical procedures. Frequently, however, it is unclear whether this assent was necessary for the courts' holdings.

If courts require a showing that the donor understands and consents to the procedure, they in effect prohibit transplants from donors too immature to understand the risks. By focusing on the individual donor's choice, this consent requirement protects donors from exploitation, but also deprives some donors of making choices

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91. The riskiness of the procedure would also depend on the donor's suitability for a transplant, since the remaining kidney could fail. For example, in *Strunk*, the guardian ad litem testified that the risk to a mentally disabled kidney donor was increased because, if the donor had kidney problems in the future, he might not be selected as a candidate for a transplant because of his disability. *See* Savage, *supra* note 45, at 146.

92. One commentator has noted that attention to these distinctions might help to reconcile the cases on this point. Nolan, *supra* note 71, at 4037 (reconciling *Farinelli* with *Richardson* based on the theory that a kidney donation is more intrusive than a bone marrow transplant).

93. *See* Charles H. Baron, *Medicine and Human Rights: Emerging Substantive Standards and Procedural Protections for Medical Decision Making within the American Family*, 17 FAM. L.Q. 1, 30-31 (1983) (proposing that courts "gradually carve out classes of cases for which advance court approval is not required"). Procedure-specific rules have also been suggested in the context of coerced donations. *See* Huffman, *supra* note 15, at 419 (arguing against compelled donations of lungs and kidneys, and in favor of compelled skin graft operations and bone marrow transplants with certain restrictions and if certain requirements are met).

they clearly would have made if competent. On the other hand, attempts to justify transplants by reference to the easily manipulable tests of substituted judgment or best interest of the donor deny an individual the right to choose whether to donate. Courts have disagreed about what role donor consent or assent should play in their decisions. It is also not clear how courts will evaluate the assent of increasingly young donors. Any standard for the authorization of transplants from minors to their siblings must reflect a view about the importance of individual choice.

C. Parental Consent

Courts are often suspicious of parental consent because of the conflict of interest inherent in parents consenting to transplants between their children. It is unclear, however, who should consent on behalf of children, if not parents. There is no basis to conclude that courts are more capable of determining a child's best interest. Thus, despite the conflict of interest, some courts might prefer to leave the decision in the hands of the parents.

Courts that have addressed the issue of nontherapeutic treatment for the benefit of siblings have not analyzed adequately the role of parental consent. In two early cases, courts suggested that doctors must always secure parental consent before proceeding with the nontherapeutic treatment of a minor.[94] Consent or assent by the minor donor was insufficient to shield doctors from liability.[95] In the Massachusetts cases, however, the court focused on the consent of the donors to support their decisions to authorize the procedures.[96] In those cases, the court's emphasis on the wishes of the minors suggested that their consent was necessary, though perhaps not sufficient.

Courts have yet to consider cases where a parent's decision conflicts with a minor child's decision. Because courts have refused to articulate the relative weight of a parent's consent compared with a child's consent, it is unclear how they would resolve such a case. Ultimately, courts must clarify the roles of parental and child consent and establish whether either is sufficient, or necessary, to

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94. Zaman v. Schultz, 19 Pa. D. & C. 309 (1933); Bonner v. Moran, 126 F.2d 121 (D.C. Cir. 1941) (finding doctors liable for failing to secure parental consent prior to taking blood from a minor to be used in a transfusion for the benefit of another).

95. *Bonner*, 126 F.2d at 123.

96. *See supra* notes 36-44 and accompanying text.

authorize nontherapeutic procedures.

D. Altruism as a Motive within the Family

Another factor underlying the suspicion of parental consent to nontherapeutic treatment for children is a reluctance to accept altruism as a bona fide motive. Yet some individuals genuinely may want to come to the aid of a family member, despite risks to themselves. Within a family, an individual's actions may be guided by feelings of interdependence and altruism, rather than individualism and self-interest. If an individual would choose to donate an organ or bone marrow, an overly strict legal standard may prevent him or her from doing so.

Unless a donor's consent to a transplant is fully informed, the donor may be deprived of his or her right to choose. Courts, therefore, have been reluctant to authorize transplants on the basis of an assumption that the donor would choose to be altruistic. Instead, they have emphasized the benefit to the donor and based their decisions on self-interest.

E. Judicial Review of Family Decisions

Judicial supervision is designed to ensure that decisions made by parents and doctors are consistent with a child's best interest. The process of judicial review, however, involves significant time, expense, and emotional costs. This intrusion into the family is inconsistent with the traditional deference to parents in matters of a child's upbringing. Courts should take care not to impose unnecessary burdens on families that face the emotional and financial burdens of caring for seriously ill children.

Judicial review also questions the judgment of parents who, in consultation with their doctors, make decisions to benefit the family and its members. Because no process can guarantee complete accuracy, parents may be the most likely parties to understand what is best for a child and to act on this knowledge. Judicial review in such circumstances may not provide benefits sufficient to justify its costs.

On the other hand, if a judicial or administrative proceeding increases the accuracy of determining a child's best interest, the intrusion might be justified. For example, if a formal judicial setting helps parents to better understand and appreciate the serious-

ness of their decision and more carefully reflect on the issues, then all parties would benefit from judicial review.[97] This process would encourage parents and doctors to consider carefully the question of donor benefit. In addition, if doctors were aware that their recommendations could be subjected to judicial review, their institutional biases in favor of treatment would be offset.[98] These arguments presume that judicial review is a benign and corrective intervention into family decisions.

F. Choice between a Flexible Standard and a Clear Legal Rule

Courts applying a flexible standard will probably refer to and rely upon concepts of parenthood, families, and relationships. These concepts help to identify the adult who is most qualified to decide a child's best interest. To ensure that the appropriate adult is identified in each particular case, these concepts should be interpreted and applied based on particular facts. This sort of flexible standard, however, requires increased judicial supervision and monitoring.[99]

A bright line rule would be easier to apply and would require less judicial monitoring. For example, if a court adopted a rule that doctors were shielded from liability if both parents consented to the transplant, then parents could make decisions without the prospect of judicial intervention. Such a "clear" rule, however, can become "muddied" when a court is faced with divorce, stepparents, foster parents, children raised by relatives other than parents, cohabitation, and other nontraditional family contexts.[100]

The resolution of the issue of transplants between minor sib-

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97. Baron et al., *supra* note 8, at 168 & nn.45-46.

98. *See id.* at 167 (supporting official intervention in the decision because doctors cannot be relied on to further the best interest of the child). *Cf.* Nolan, *supra* note 71, at 4038 (recommending that courts protect against biased medical testimony by relying on experts who are uninvolved and disinterested physicians, rather than physicians who are deeply involved in the donor's case and in research in the field); Baron, *supra* note 93, at 20-21 (favoring a judicial resolution of these issues as opposed to leaving the decisions in the hands of doctors, because the judicial process encourages *public, principled, impartial* decision making in an adversary process).

99. For a more extensive discussion of the opposition between legal rules and standards, see Duncan Kennedy, *Form and Substance in Private Law Adjudication*, 89 HARV. L. REV. 1685 (1976) (examining the opposition between individualistic, formal rules and altruistic legal standards).

100. *Cf.* Carol M. Rose, *Crystals and Mud in Property Law*, 40 STAN. L. REV. 577, 601-04 (1988) (explaining that a "crystalline" rule becomes "muddy" when judges make post hoc adjustments to it).

lings involves a careful balancing of many conflicting concerns. Courts must evaluate and compare psychological and physiological risks and benefits, determine the relative importance of donor and parental consent, judge the reliability of altruism as a motive within the family, determine the proper extent of judicial review of family decisions, and choose between a clear or flexible legal standard. These factors will often point to conflicting results in any particular case. In recent years, little has been written to clarify or develop the issue of transplants from incompetents for the benefit of siblings, with the exception of some treatment of the issue of a woman's duty to aid her fetus. The Illinois Supreme Court faced the issue of transplants from incompetents for the benefit of siblings, with all of its unresolved questions, in the case of *Curran v. Bosze*.

III. The Case of *Curran v. Bosze*

Curran v. Bosze is significant because it differs from prior cases in many important ways: the potential donors were only three years old and, therefore, not capable of assenting; the potential donors did not have a relationship with the proposed recipient; the parents of the potential donors did not agree about whether the procedure should be undertaken; the potential donors lived with their mother, but not with their father; the parents of the potential donors were never married; the potential donors did not have a close relationship with their father; and the donors' mother was not related to the proposed recipient. These unusual factual circumstances presented the Illinois Supreme Court with an opportunity to develop significantly the law of transplants between minor children.

A. *Facts in* Curran v. Bosze

Tamas Bosze and Nancy Curran began living together in Mr. Bosze's home when they became engaged in April of 1988.[101] Mr. Bosze was separated from his wife at the time. When Ms. Curran was eight months pregnant with their twin children, Mr. Bosze ended the relationship and returned to his wife.[102] Ms. Curran gave

101. Andrew Fegelman, *Bone Marrow Case Goes to High Court*, Chi. Trib., Sept. 5, 1990, § 2, at 3; Sesyer & Shryer, *Judge Asked to Order Twins' Blood Tests*, L.A. Times, July 13, 1990, at 4.

102. *Court Told to Give Kids a Voice in Marrow Case*, UPI, Aug. 10, 1990, *available in*

birth to Allison and James Curran shortly thereafter. Mr. Bosze refused to acknowledge that he was the twins' father. Ms. Curran was forced to rely on public assistance while seeking to establish his paternity in court.[103] Her fight to win child support from Mr. Bosze, ultimately successful, lasted for eighteen months.[104] Mr. Bosze made his first child support payment more than two years after the twins were born.[105] Under the parentage order, Ms. Curran received sole legal and physical custody of the children, subject to consultation with Mr. Bosze on important health, education, and welfare issues.

Allison and James Curran had lived with their mother and their maternal grandmother for their entire lives. Mr. Bosze was permitted to visit the twins weekly; in the fifty-two weeks prior to bringing the petition, he visited them fifteen times.[106] On two of these visits, he brought along one of his other children, Jean Pierre, who was the twins' half brother. These visits, which lasted for a total of four hours, were the only occasions on which the twins and Jean Pierre had met.[107] The twins did not know that Jean Pierre was their half brother because Ms. Curran had requested that Mr. Bosze not confuse them with this information.[108]

Jean Pierre was suffering from a rare form of leukemia and needed a bone marrow transplant. Doctors decided that only a transplant from a relative would be successful.[109] Neither Mr. Bosze nor his other children were compatible donors for Jean Pierre. Mr. Bosze, therefore, asked Ms. Curran to consent to the twins' blood being tested for donor compatibility. He also requested her consent to a bone marrow harvesting procedure for the benefit of Jean Pierre in the event that they were compatible. Ms. Curran refused to consent to either procedure.

On June 28, 1990, Mr. Bosze filed an emergency petition in the Cook County Circuit Court, requesting that the court order Ms. Curran to produce the twins for testing. At the hearing on the peti-

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LEXIS, Nexis Library, Wires File; Joan Beck, *For Court to Compel Marrow 'Gift' Turns Donor into a Victim*, CHI. TRIB., Sept. 17, 1990, at 17.

103. Sesyer & Shryer, *supra* note 101.

104. Secter, *supra* note 1.

105. *Bodily Intrusions*, N.Y. TIMES, Aug. 29, 1990, at A20.

106. Curran v. Bosze, 566 N.E.2d 1319, 1321 (Ill. 1990).

107. *Id.*

108. *Id.*

109. Secter, *supra* note 1.

tion, Mr. Bosze was portrayed as a less than ideal father who had fought Ms. Curran's attempts to prove paternity and who was five months in arrears on his support payments until "shortly before he asked for help" for Jean Pierre.[110] Mr. Bosze's attorney criticized Ms. Curran as "a woman who is perfectly willing to bring those children forward for a blood test to get money [in a paternity suit] . . . but . . . [who] will not bring the twins forward to take the same test to save the life of a sibling."[111] Judge Reynolds ruled that the court did not have the authority to grant the petition because compulsory tissue donation would interfere with the twins' constitutional rights to privacy.[112]

Mr. Bosze appealed to the Illinois Supreme Court. News reports indicated that "[w]hat was already an unusual case became stranger."[113] Apparently, life-sized photographs of the twins, mounted on cardboard, were submitted into evidence to show the justices what the twins looked like.[114] The court heard oral arguments and remanded the case to the circuit court. It instructed that the twins and Jean Pierre be made parties to the case and ordered the circuit court to appoint a guardian ad litem for the twins.[115]

The circuit court again denied Mr. Bosze's petition after hearing additional testimony. Once again Mr. Bosze appealed to the Illinois Supreme Court, but it affirmed the circuit court's decision. The supreme court's opinion, written by Justice Calvo, is the latest contribution to the legal debate surrounding organ transplants from minors for the benefit of their siblings.

B. *The Court's Analysis in* Curran v. Bosze

The Illinois Supreme Court refused to apply the substituted judgment test to a minor child. Illinois courts apply the substituted judgment test by examining an individual's explicit intent and his or her personal value system to determine a preference for or against medical treatment.[116] Because the twins were three years

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110. Sesyer & Shryer, *supra* note 101, at 4.
111. *Id.*
112. *Curran*, 566 N.E.2d at 1321.
113. Fegelman, *supra* note 101, at 3.
114. *Id.*
115. *Curran*, 566 N.E.2d at 1322.
116. *Id.* at 1323.

old, the court found that it was not possible to examine their personal values to determine their preference about whether to donate bone marrow. Therefore, it held that the doctrine of substituted judgment was "not relevant and may not be applied."[117]

Instead, the court adopted the best interest of the donor standard. The court examined the decisions of other jurisdictions[118] and stated:

> In each of the foregoing cases where consent to the kidney transplant was authorized, regardless [of] whether the authority to consent was to be exercised by the court, a parent or a guardian, the key inquiry was the presence or absence of a benefit to the potential donor. Notwithstanding the language used by the courts in reaching their determination . . . , the standard by which the determination was made was whether the transplant would be in the best interest of the child or incompetent person.[119]

Because it concluded that these prior decisions all focused on the best interest of the donor regardless of whether they used the language of substituted judgment, the Illinois court also adopted the best interest approach. It held that "a parent or guardian may give consent on behalf of a minor daughter or son for the child to donate bone marrow to a sibling, only when to do so would be in the minor's best interest."[120] With this statement, the court emphasized two basic inquiries: parental consent and the best interest of the donor.

The court treated the question of parental consent as a preliminary issue, separate from the question of the best interest of the donor. This treatment suggests that parental consent is necessary, but not sufficient, for a transplant operation to proceed. If the parents consent to the procedure, their decision must then be reviewed to determine whether it is consistent with the donor's best interest.

Yet, although Ms. Curran did not consent to the procedure, the court nevertheless addressed the issue of the twins' best interest. If the holding was premised on her lack of consent, then the

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117. *Id.* at 1326.

118. *Id.* at 1326-31. The court mentioned *Strunk, Hart, Bonner, Little, Pescinski,* and *Richardson* in its survey of the issue. *Id.*

119. *Id.* at 1331.

120. *Id.*

best interest analysis may be viewed as dicta. If that was not the premise, then Mr. Bosze's consent may have sufficed had the court found the procedure to be in the twins' best interests. The court, however, did imply that the procedure must not occur over the objections of the "primary caretaker," perhaps recognizing the potential link between the issues of parental consent and the donor's best interest. The court seemed to imply that, to the extent that parents will be the primary caretakers, a procedure cannot be in a child's best interest without parental consent. Therefore, the court's test may not treat parental consent and the donor's best interest as distinctly as first appears, especially where the parent that consents is not a primary caretaker.

The court cited the parentage order to support giving substantial weight to Ms. Curran's decision to withhold consent. Under the order, Ms. Curran, as sole custodian of the twins, had full power to make decisions regarding the health and medical care of her children, unless a court found, after a hearing, that "the absence of a specific limitation of the custodian's authority would clearly be contrary to the best interests of the child[ren]."[121] Under these terms, Mr. Bosze had the burden of proving that the withholding of consent to the transplant was "clearly contrary" to the best interests of the twins. Although not expressly discussed, the court's inquiry into the twins' best interests suggests that Mr. Bosze's consent might have been sufficient if he had fulfilled this burden.

The court's application of the best interest test revealed additional ambiguity. The best interest element turned on three questions: Is the parent who consents informed of the risks and benefits?[122] Will the donor have emotional support from the primary caretaker? Is there an existing close relationship between the donor and the recipient? With respect to the first question, the court found that both parents were informed of the risks of the bone marrow harvesting procedure.[123] Though the rule suggests that the

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121. *Id.* The parentage order mirrored the language of the Illinois statutory provisions for judicial supervision of custody arrangements where alternative standards agreed upon by the parties are absent. ILL. REV. STAT. ch. 40, ¶ 608(a) (1989).

122. *Curran*, 556 N.E.2d at 1343. The court categorizes this element as one of the "three critical factors" necessary to determine whether a transplant is in the donor's best interest. *Id.* However, this element seems more relevant to the issue of parental consent than it is to the question of the donor's best interest. If parental consent is not fully informed, it should not qualify as valid consent.

123. *Id.* at 1344.

court would concern itself with the knowledge of the consenting parent (i.e., Mr. Bosze), the court focused its attention on Ms. Curran. It is not clear whether the court did so because of her objection to the procedure or because she was the primary caregiver.

The second question is whether adequate emotional support is available to the donor. The court concluded that, as primary caregiver, Ms. Curran's refusal to consent brought into question whether the twins would have the appropriate emotional support. The court found that it would not be in the twins' best interest to undergo "all that is involved" in bone marrow harvesting "without the constant reassurance and support by a familiar adult known and trusted by the child."[124] Ms. Curran was "not only . . . the twins' primary caretaker . . . [but also] the only caretaker the twins have ever known."[125] Because Mr. Bosze's involvement in their lives had been "limited,"[126] the court concluded that he was unable to provide the necessary support to the twins.[127]

The third question is whether there is an existing close relationship between the donor and the recipient. The court failed to find such a relationship between the twins and Jean Pierre. The twins were not aware that he was their half brother[128] and there was no evidence that the twins and Jean Pierre were "known to each other as a family."[129] Because the court found that the transplant would not be in the twins' best interest, it refused to order them to be tested as potential bone marrow donors for their half brother.

C. *Questions Left Unresolved by* Curran v. Bosze

The test adopted in *Curran v. Bosze* has broad implications. *Curran* was an easy case in many ways—there was no close existing relationship between potential donor and recipient, and the parent with sole legal and physical custody objected to the procedure. Courts in other cases may be more willing to limit parental autonomy, particularly when a custodial parent consents, rather than objects, to a transplant. If the *Curran* test is applied in all

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124. *Id.*
125. *Id.*
126. *Id.*
127. *Id.*
128. *Id.*
129. *Id.*

cases, courts must resolve several unanswered questions.

1. How Should Courts Resolve Parental Disagreement over Consent?

There is a basic tension within the *Curran* decision concerning the role of parental consent. The opinion does not state who the relevant parent is for purposes of consent. Mr. Bosze's and Ms. Curran's parentage agreement gave substantial authority to Ms. Curran to consent to all medical care and procedures. The agreement placed a very high burden of proof on Mr. Bosze when challenging Ms. Curran's decisions to withhold consent. Because he did not meet this burden, his wishes were not legally relevant to the court's decision. Thus, the court did not have to resolve the more difficult issues that arise where parents have equal rights in the decision-making process, yet disagree: whether one parent's consent is sufficient; and, if so, which parent's consent is sufficient. If the legal rule governing transplant decisions is designed to give substantial weight to the family decisions of the custodial parent or parents, then this issue is critical to its application.

2. How Should Courts Weigh the Assent of Minor Donors?

In many of the prior cases of nontherapeutic treatment of minors and incompetent adults, courts examined the donors' willingness to undergo the procedure.[130] In the early Massachusetts cases, for example, the justices emphasized the informed consent of all the donors involved.[131] In contrast, the *Curran* analysis does not address the donor's consent or assent. Given the court's conclusion that the treatment was contrary to the twins' best interests, it was not necessary to address the issue.

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130. Commentators have also discussed the importance of a minor donor's participation in transplant decisions. In this view, the donor's consent or assent is important evidence that the transplant is in the donor's best interest. *See, e.g.*, Baron et al., *supra* note 8, at 178-81. Other commentators argue that parental autonomy may be justified when the risk to the donor is low, but when the risks are high, participation of the individual must be required. Willard Gaylin, *Competence*, *in* WHO SPEAKS FOR THE CHILD: THE PROBLEMS OF PROXY CONSENT 27, at 46 (Willard Gaylin & Ruth Macklin eds., 1982).

131. Madsen v. Harrison, No. 68651 Eq. (Mass. June 12, 1957); Foster v. Harrison, No. 68674 Eq. (Mass. Nov. 20, 1957); Huskey v. Harrison, No. 68666 Eq. (Mass. Aug. 30, 1957).

3. How Should Courts Measure the Availability of Emotional Support?

The *Curran* court required that "there must be emotional support available to the child from the person or persons who take care of the child."[132] The court focused exclusively on the mother because she was the primary caretaker, "the only caretaker" the children knew.[133] The court found that Mr. Bosze could not provide the required support because "his involvement in the lives of [the twins was] a limited one."[134] The decision, however, leaves unanswered the questions of whether an involved, non-custodial parent can ever provide sufficient emotional support and whether courts should assume, as a matter of law, that a custodial parent who objects to a procedure cannot provide the required support.

4. How Should Courts Measure the Quality of the Relationship between Donor and Recipient?

The *Curran* court held that in order for nontherapeutic treatment to be in the best interest of the donor a court must find a "close existing relationship" between the donor and the recipient. When it applied the requirement to the facts in *Curran*, the court easily concluded that no such relationship existed. The *Curran* court, however, failed to define what it meant by a "close existing relationship." It is not clear whether the requirement of an existing relationship implies that the child be capable of appreciating and understanding the relationship, and it is not clear how "close" the relationship must be.

5. How Should Courts Weigh the Interests of All Parties?

The *Curran* holding does not restrict a court from considering the recipient's best interest as well as the donor's. The court made clear that, in considering Mr. Bosze's petition to force Ms. Curran to submit the twins for blood testing, it could not consider Jean Pierre's plight. Whether a recipient's interests should be considered, however, is not so clear-cut where the donor's and recipient's parents are the same. The court did not need to address this issue because Ms. Curran had no obligation to act in the best interest of

132. Curran v. Bosze, 566 N.E.2d 1319, 1343 (Ill. 1990).
133. *Id.* at 1344.
134. *Id.*

Jean Pierre. Mr. Bosze could not challenge her decision as contrary to the best interest of the recipient. But *Curran* leaves open the question of whether a parent can consider the interests of the family as a whole, rather than the interests of the individual donor, in his or her decision whether to consent to a transplant for a child.

IV. Three Proposals: Toward a Clear Standard

This section outlines three proposals for addressing the issue of transplants between minor siblings. The first is a rule of deference to custodial parents, based on the assumption that custodial parents are most likely to know and further the best interests of their children. The second proposal is a rule of donor consent, based on the principle of individual autonomy. Each of these rules contains a clear vision of the proper relationship between individual autonomy and the protection of minors on one hand, and between family autonomy and family relationships on the other. This section also outlines a third, hybrid proposal, the goal of which is to encompass the principles underlying both of the two initial proposals. The hybrid proposal is ideal because it addresses, and attempts to reconcile, the rights of all the parties with legitimate interests in the decision—parents, donors, and recipients.

A. *The Deference to Custodial Parents Approach*

Under a rule of deference to parents, courts should defer to the custodial or psychological parents[135] if the donor and recipient are in a close family relationship. Because these issues involve difficult, value-laden choices, the best approach may be to let parents make these determinations with very little judicial oversight. Judicial review of parental decisions is an intrusion that may negatively impact family members, particularly children. Deference to custodial parents minimizes judicial intrusion, demonstrates trust in parents, and recognizes altruism as a valid motive for intra-family tissue donations.

If courts defer to custodial parents, parents gain freedom to make decisions based upon their own values and beliefs.[136] They

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135. *See* Joseph Goldstein et al., Beyond the Best Interest of the Child 17-20 (1973) (discussing the development of the concept of a psychological parent).

136. *See* Peter Brown, *Human Independence and Parental Proxy Consent*, *in* Who Speaks for the Child: The Problems of Proxy Consent 209, 219-20 (Willard Gaylin & Ruth Macklin eds., 1982).

need not adopt a utilitarian analysis in deciding whether to consent to nontherapeutic treatment for their children. They may act to further the best interest of the donor, with individualistic values in mind. Alternatively, they may act to further the best interest of the family as a whole, with collective interests in mind.[137]

The deference rule still presents the courts with the difficult tasks of defining the terms "parent" and "family," and resolving conflicts that arise where the custodial parents disagree. The relationship between the donor and the recipient is not the sole criterion. The court must also focus on the nature of the relationship between the donor and the consenting parent. The "parent" for purposes of consent should be the adult or adults who live with and care for the child.[138] An adult who is not legally the parent of a child but who has lived with and raised the child would qualify as a parent under this analysis. In contrast, a parent such as Tamas Bosze should not qualify as a consenting parent. As one news article remarked, when the twins have grown up they might "have some strong opinions about the father who had little interest in them except as a source of tissue for his legitimate son."[139]

A rule of deference to custodial parents is consistent with parents' rights and responsibilities to make choices affecting their children. Parents are generally permitted to make medical decisions and other choices that expose children to risk. Their freedom to do so is always limited by the state's power to remove a child from the custody of a parent who abuses or neglects the child, or by custody challenges based on the assertion that a custodial parent is unfit. This presumption in favor of parental choice in other family law contexts should hold true in the nontherapeutic medical procedure context as well.[140] The premise underlying this approach—that parents more than any other party can be trusted to act in the best interests of their children—seems accurate in most

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137. Commentators note that courts have used this "family cost-benefit" standard in several cases, weighing the interest of both the donor and recipient to determine whether to authorize the procedure. Baron et al., *supra* note 8, at 172 n.66 (citing Hart v. Brown, 289 A.2d 386 (Conn. Super. Ct. 1972)).

138. The definition could also be based on the concept of the psychological parent proposed by Goldstein et al. *See* GOLDSTEIN ET AL., *supra* note 135.

139. Joan Beck, *supra* note 102, at 17.

140. The author is not aware of any cases where parents' decisions to consent to nontherapeutic treatment were challenged as child abuse or neglect. If such an allegation were made in a particular case, coupled with additional evidence of abuse and neglect, then the shield of parental autonomy should not be available to the parents.

family contexts.

The deference rule also respects the strong emotional bonds between parent and child and between siblings. Members of a family are more than a set of individuals who inhabit the same house; they are defined in part, and they define themselves in part, by the relationships they share with each other.[141] This network of relationships helps to define the moral duties of parents to children, and the moral duties between siblings.[142] Rather than driving a wedge between family members by defining their duties to one another without reference to their relationships, the deference rule recognizes the powerful force of familial bonds. The rule allows individuals to act upon those bonds without judicial intrusion.

Placing responsibility with parents to balance properly the rights and interests of their children may be a simple rule administratively, but it has its flaws. In particular, deference to custodial parents would not address the inherent conflict of interest in the decision to put one child at risk to benefit another. Children who could be considered "less worthy" by parents, especially mentally or physically disabled children, might be "sacrificed" to benefit their siblings. One could argue that this sort of sacrifice is perfectly consistent with the parental autonomy approach.[143] But this sort of sacrifice undermines the basic premise of deference to parents—that a parent is most likely to understand and further a child's best interest. Any attempt to protect children from sacrifice is difficult because courts would need to determine the real motivation of parents who have consented to nontherapeutic procedures for their children. In addition, such an inquiry into motive would be contrary to the parental deference goal of minimizing judicial intrusions.

A second danger that might remain unaddressed is the unchecked influence of doctors. Parents are likely to rely heavily on advice from their doctors in making decisions. The quality of their

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141. *See* ALASDAIR MACINTYRE, AFTER VIRTUE 218-21 (1984) (viewing an individual as the coauthor of a narrative shared by members of the family and community).

142. *See* CAROL GILLIGAN, IN A DIFFERENT VOICE 30 (1982) (arguing that relationships between individuals give rise to feelings of morality and responsibility).

143. For example, in his discussion of *Strunk*, Brown argues that his proposed family autonomy standard permits a comparison of the siblings' quality of life. "[W]here alternative measures *are not possible* it is permissible to impair or even sacrifice the life of an incompetent to save a sibling capable of normal development." Brown, *supra* note 136, at 218.

decision will depend on the information they receive from their doctors. Doctors, however, may not be primarily concerned with the best interest of the recipient, and will often advise parents to proceed based on their medical judgment about the benefits and risks.[144] Doctors' advice may also be subject to their biases in favor of treatment.[145] Thus, to the extent that judicial review ensures that all issues and facts are aired and thoroughly examined in an adversary process, it may be necessary to provide some donors with real protection.[146]

A rule of parental autonomy, limited only by the existing standards concerning abuse and neglect of children, may not adequately account for the realities of these cases. Additional judicial standards are necessary to avoid concerns based on conflicts of interest, people's attitudes toward the disabled, and other factors that could call into question the premise that parents will always act in their child's best interest. Therefore, two limitations on the family autonomy approach are suggested. First, before a transplant from a minor can proceed, alternative sources of bone marrow or kidneys must be exhausted. Though such a requirement would not further family autonomy, it would serve as an effective check on exploitation of minors.[147]

Second, no transplant should occur unless there is reason to believe that the recipient is likely to survive after the transplant. Transplants authorized on the basis of the psychological benefit that will accrue to donors if their siblings survive are not in their best interest if the sibling dies.[148] Therefore, if a transplant has no chance of success, the minor should not be subjected to the procedure. Defining the appropriate level of success to be required is inherently difficult. It involves speculating about survival as well as making a difficult value judgment. Parents, doctors, and siblings

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144. Baron et al., *supra* note 8, at 167.

145. *Id. See also* Robert Bennet, *Allocation of Child Medical Care Decision-Making Authority: A Suggested Interest Analysis*, 62 VA. L. REV. 285, 319-20 (1976) (noting that doctors face a conflict of interest because they have financial and professional incentives to recommend and perform medical procedures).

146. *See supra* sections II.E, II.F, and III.C.1-5.

147. Professor Robertson recommends that courts impose this requirement when they apply the substituted judgment test as well. He acknowledges that this limitation is "inconsistent with the general approach of the substituted judgment doctrine." However, the substituted judgment doctrine is predicated on respect for the individual donor. Therefore, he argues in favor of a limitation that furthers this underlying premise by preventing the abuse of those incapable of consenting for themselves. *See Organ Donations*, *supra* note 27, at 75.

148. *Id.*

may be willing to accept unreasonable risks to provide any increment of benefit to a child facing death. To protect donors, therefore, courts should define, as a matter of law, levels of unreasonable risk and marginal benefit. Given the fact that experts will often disagree about the likelihood for success of a transplant and that success will often depend on psychological factors that doctors cannot predict with accuracy, courts should set this threshold very low. It should be designed to prevent transplants only in extreme cases where the possibility of success is unusually small.

A rule of deference to custodial parents minimizes judicial intrusion into the family. It allows parents, with guidance from their families, doctors, and religious and moral beliefs, to make important ethical and medical decisions for their children. This rule reflects the basic assumption that parents in close relationships with their children are in the best position to judge what is in their children's best interests.

B. The Mature Minor Approach

Another alternative to the problem of consent to minors' tissue donations is a rule that focuses on the desires of the minors themselves. Genuine respect for individual autonomy requires that a person who might be subjected to serious medical risk from nontherapeutic treatment be consulted for his or her opinion. It is possible to craft a rule that respects autonomy and individualism without precluding altruism within the family. In fact, altruism should be encouraged and expressions of it respected when they are the result of an informed choice by the individual making the sacrifice.

The mature minor rule is premised on respect for individual choice. It requires donor consent or assent to nontherapeutic procedures. This alternative is termed the "mature minor" rule because it is similar to the mature minor approach used in other contexts. In several states, children over a certain age are presumed to be competent to consent to specified procedures, including treatment for pregnancy, abortion, and drug abuse.[149] In these contexts,

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149. *See* Bennet, *supra* note 145, at 288-94 (1973); Walter Wadlington, *Minors and Health Care: The Age of Consent*, 11 OSGOODE HALL L.J. 115 (1973). Some of these statutes are arguably broad enough to apply to nontherapeutic treatment. For example, Mississippi has an extremely broad statute, giving the power of consent to any "unemancipated minor of sufficient intelligence to understand and appreciate the consequences of the proposed

the mature minor rule is a legislative or judicial response to a traditional parental consent requirement that often denied minors access to emergency medical treatment as well as treatment for which they would be reluctant or unable to gain their parents' consent. In the context of transplants between minor siblings, the rationale for a mature minor rule would be different. The problem is not the availability of parental consent, but its reliability in light of the inherent conflict of interest that parents face in the context of transplants between siblings.

The mature minor rule applied in the context of transplants would be similar to the flexible standards proposed by Curran and Beecher.[150] Under normal circumstances, they argue that minors should not be subjected to nontherapeutic treatment unless they are fourteen years or older and mature enough to understand and consent.[151] If the procedure is for the benefit of a family member, they recommend greater flexibility. They suggest that a child of seven years may be an acceptable donor if he or she understands the nature and risks of the procedure. Curran and Beecher thus recognize a distinction between nontherapeutic procedures to benefit strangers and those that benefit family members. Citing the Massachusetts decisions of *Madsen v. Harrison, Foster v. Harrison,* and *Huskey v. Harrison,*[152] they emphasize the significance of a minor donor's assent to and understanding of transplant procedures.

Building on Curran and Beecher's analysis, the rule proposed here suggests that children over fourteen years of age have the power to consent, with some judicial oversight to verify that consent was truly voluntary. Courts should give substantial, though not decisive, weight to the assent of children below fourteen who are able to understand the proposed treatment and express a preference in favor of it. In contrast, courts should treat a child's refusal to consent as decisive because it is more objectionable to force transplants on unwilling donors than it is to withhold treat-

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surgical or medical treatment or procedures." MISS. CODE ANN. § 41-41-3(h) (Supp. 1990). Another section of the Mississippi code authorizing blood donations without parental consent would be redundant, however, if a minor's general power to consent includes the power to consent to nontherapeutic procedures. MISS. CODE ANN. § 41-41-15 (1981).

150. William J. Curran & Henry K. Beecher, *Experimentation in Children: A Reexamination of Legal Ethical Principles,* 210 J. AM. MED. ASS'N 77 (1969).

151. *Id.* at 82.

152. Madsen v. Harrison, No. 68651 Eq. (Mass. June 12, 1957); Foster v. Harrison, No. 68674, Eq. (Mass. Nov. 20, 1957); Huskey v. Harrison, No. 68666 Eq. (Mass. Aug. 30, 1957).

ment from willing patients.[153] Under this approach, children who objected to procedures, or children too young to express consent or assent to procedures, could not be donors. This is the opposite of the result reached under the rule of deference to custodial parents.

An important benefit of the mature minor approach is that, consistent with the rule against coerced donations, it treats the decision to donate as a choice and gives real weight to the donor's autonomy. If adults are not required to make these sacrifices for their children, parents should not be permitted to sacrifice one child for another, absent real consent on the part of individual donors.

One potential criticism of the mature minor approach is that it does not address adequately the family's needs. When children are too young to express their assent, transplants would be barred as a matter of law. This rule may hurt the family as a whole, including the potential donor. Another potential criticism of the approach is that it fails to provide sufficient protection for minors. It is possible that consent or assent to transplants by donors may not be truly voluntary. The only way to protect children from pressure to donate would be to adopt a per se rule against transplants from minors.

Safeguards that address the conflicting interests of family and the individual can be built into the mature minor approach. They mirror those proposed for the parental autonomy rule. Transplants from minors should be avoided unless all other sources have been exhausted; and, transplants should not proceed without a reasonable possibility that siblings will survive.[154] In addition, minors must be consulted to ensure that their consent is informed and voluntary.[155] With these safeguards, the mature minor approach carefully respects the rights and autonomy of the donor.

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153. This analysis is premised on the act-omission distinction, as well as a premise of individualism and autonomy. But perhaps courts would do more harm to a minor by allowing a sibling to die than they would by authorizing a relatively minor invasive medical procedure. *Cf.* Kennedy, *supra* note 99, at 1774 (endorsing positive liberty as opposed to negative liberty, and rejecting the latter as "negative, alienated and arbitrary . . . [with] no moral content whatsoever").

154. *See supra* notes 147-48 and accompanying text.

155. For example, if she gives what Nolan describes as "on-again-off-again" consent, it would not be valid. Nolan, *supra* note 71, at 4035.

C. The Hybrid Approach

The final proposal synthesizes the principles of deference to parents and donor consent. It requires the consent of parents but also provides a check on parental decisions to ensure that donors' interests are adequately protected. The approach requires that, in addition to parental consent, there must be consent or assent by the donor, or review of the parental decision by the court. This rule is intended to provide a better framework for reconciling the competing interests of parents, children and families, especially in situations where the facts are particularly difficult (such as where the child is very young, or where the custodial parents do not agree).

Under this approach, when donors are too young to give their assent, courts can authorize transplants on the basis of parental consent because of the presumption that parents will act in their child's best interest. Courts should not interfere with the broad discretion of parents, but they can provide guidelines to protect young children against exploitation or hasty decision making. The court should impose safeguards similar to those discussed previously—it could inquire into whether alternative sources of organs or bone marrow have been exhausted and require a showing that the recipient is likely to survive. It could also ensure that parents are fully informed of all the risks involved. Except in extraordinary cases, however, where the motives of parents are suspect for some reason other than the mere fact of their consent to the transplant, the procedure should go forward.

Parental disagreement over consent would not necessarily bar procedures under this rule. If a donor is old enough to understand and agree to a transplant, then the consent of one custodial parent plus the donor's consent would provide sufficiently strong evidence that the procedure is in the child's best interest.

If the parents disagree and the donor is too young to understand and agree to the procedure, however, it is not immediately clear what is in the child's best interest. In this case alone, a full judicial inquiry into the best interest of the child is appropriate. In contrast to the case where the parents agree on a decision, a court would have no basis upon which to presume whether the transplant is in a child's best interest. A court would conduct a full inquiry, looking to objective evidence, to determine the child's best interest. This review would provide adequate protection for

minors.

This hybrid approach combines the presumptive deference to custodial parents with an additional check to protect the donor's interest. Where possible, this check is accomplished without judicial intrusion, in the form of donor consent or assent. Where the donor is too young to assent, judicial intrusion is minimized by a heavy presumption in favor of the parental decision. It is only where the custodial parents disagree that courts would conduct a full inquiry into the child's best interest. This analysis would be subject to all the problems of the traditional best interest test.

The goal of this approach is to eliminate the need for judicial intervention in the majority of cases and to provide sharper guidelines for authorizing nontherapeutic procedures. This proposal limits the judicial evaluation of a child's best interest to cases involving a very young donor whose custodial parents disagree on the question of consent. This approach provides more guidance and predictability to courts, parents, and doctors than the traditional best interest and substituted judgment tests.

CONCLUSION

Curran v. Bosze is the latest in a series of cases attempting to develop judicial standards for authorizing procedures to be performed on minors for the benefit of their siblings. The Illinois Supreme Court suggested that it will give considerable deference to custodial parents to consent to nontherapeutic treatment. It also articulated a test that formally recognized the importance of a relationship between the potential donor and the recipient, an emphasis which was only implied in prior decisions. But the decision raises more questions than it answers, leaving courts to balance the often conflicting factors and to develop a satisfactory and consistent judicial approach to this issue. This article explicitly identifies the factors which affect the evaluation of this issue and presents three proposals to clarify past judicial approaches to this problem.

The third proposal—the hybrid approach—fuses the principle of deference to parents with that of donor autonomy in an attempt to reconcile the interests of all parties involved. This approach strives, to the extent possible, to remove these decisions from the judicial context and place them in the hands of parents. Judges in future cases should attempt to clarify the issues left unresolved in *Curran* by articulating the proper balance between the principles

of deference to parents and individual autonomy. The hybrid approach outlined in this article is one suggestion for courts as they move toward a clear standard.