LIVE ORGAN AND TISSUE TRANSPLANTS FROM MINOR DONORS IN MASSACHUSETTS

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I. INTRODUCTION

Accelerating progress in medicine continually presents our legal system with complex legal and ethical problems[1] and has resulted in the development of a new forensic medicine. Because some of the world's greatest medical facilities are located in Massachusetts, these medico-legal problems have been especially acute for the Commonwealth's legislature, bar and courts. One such problem, which the Massachusetts legal system was the first to confront, is that of live organ and tissue transplants from minor donors.[2] At the present stage of transplant technology, a minor is frequently the most acceptable prospective donor when a sibling needs a new organ or tissue—such as a kidney or bone marrow—because of the high degree of genetic similarity among siblings.[3] Genetic similarity is important because it decreases the dangers of organ rejection and adverse bodily reactions.[4]

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[1] For an examination of one such problem see Psychosurgery—A Symposium, 54 B.U.L. Rev. 215 (1974).

[2] The first cases involving transplants from minors occurred in Massachusetts in 1957. Foster v. Harrison, Eq. No. 68674 (Mass., Nov. 20, 1957); Huskey v. Harrison, Eq. No. 68666 (Mass., Aug. 30, 1957); Masden v. Harrison, Eq. No. 68651 (Mass., June 12, 1957); *see* Curran, A Problem of Consent: Kidney Transplantation in Minors, 34 N.Y.U.L. Rev. 891 (1959); notes 19-47 and accompanying text *infra*.

[3] Siblings are most frequently called upon to be bone marrow transplant donors. Efforts are presently being made to develop a computer store of information regarding the genetic types of large numbers of individuals with the hope of achieving sufficiently close matching between unrelated individuals. However, there are no reported cases of successful bone marrow transplants between nonsiblings. Telephone interview with Paul I. Terasaki, M.D., Professor of Surgery, U.C.L.A. School of Medicine, Los Angeles, Nov. 15, 1974. Siblings are less frequently called upon to serve as kidney donors because in many cases kidneys from unrelated or nonliving sources can be successfully transplanted; in addition, long-term renal dialysis may be an alternative to a transplant. In some cases, however, the genetically similar, live minor donor presents the most attractive transplant source for a patient with renal failure. For a comparison between rates of success of transplants from cadavers and various living donors see the 11th Report of the Human Renal Transplant Registry, 226 J.A.M.A. 1197 (1973).

[4] The human body has a tendency to destroy foreign tissue, organs, or blood. In order for a transplant operation to be successful, the recipient's immunological system must not reject and destroy the transplanted tissue or organ. In addition, the possibility exists that the

The major legal problem that this type of medical procedure presents is that of obtaining effective consent—that is, consent that will constitute a complete defense to a battery action[5]—for the removal of the organ or tissue from the donor.[6] The prospective donor's minority precludes treating his willingness to proceed as effective consent.[7] Moreover, because the operation cannot provide the donor with any physical benefit[8] and because it presents the parents with a conflict of interests,[9] the strict application of established common law principles may not permit the parents to render effective consent for a donor child.[10]

When this problem first arose in 1957, the Massachusetts legal system could have responded in one of four ways: it could have barred all such operations on the ground that effective consent was impossible; it could have redefined the common law principles governing parents' power to consent to such operations and treated that consent as effective; it could have lowered the age of majority and treated some children's willingness to serve as donors as effective consent;[11] or it could have developed a special procedure through which an official tribunal might authorize the transplant. The Massachusetts courts adopted the fourth alternative. In the landmark case of *Masden v. Harrison,*[12] the hospital planning to perform a kidney transplant operation involving a minor donor instituted a declaratory judgment action seeking a decree authorizing it to perform the operation without liability for nonnegligently caused injuries. A justice of the Massachusetts Supreme Judicial Court, sitting in single justice

transplanted substance may cause adverse reactions in the recipient's body. This condition is called graft-versus-host disease or reaction and may lead to a particularly agonizing death. *See* Bach & Bach, Immunogenetic Disparity and Graft-Versus-Host Reactions, 11 Seminars in Hematology 291 (1974); Levine *et al.,* The Medical Ethics of Bone Marrow Transplantation in Childhood, 86 J. Pediat. 145, 146 (1975). The probability of either organ rejection or adverse bodily reactions is directly related to the genetic characteristics of the donor and the recipient. Because medical technology has not yet attained complete control over the body's immunological system, the use of closely related donors offers the greatest hope of success in a transplant operation. At the present time, only siblings are sufficiently compatible genetic matches for purposes of bone marrow transplants. *See generally* 11th Report of the Human Renal Transplant Registry, *supra* note 3.

[5] *See* W. Prosser, The Law of Torts 101-08 (4th ed. 1971).

[6] For a discussion of the problem of consent in this context see Curran, *supra* note 2, at 892.

[7] The majority rule is that a minor cannot effectively consent to medical procedures. W. Prosser, *supra* note 5, at 102-03. There is, however, support for the proposition that minors should be able to consent to routine operations. *Id.* For a discussion of recent developments in Massachusetts in cases involving minor transplant donors see notes 89-99 and accompanying text *infra.*

[8] *See* notes 20, 41 and accompanying text *infra.*

[9] *See* notes 41-42 and accompanying text *infra.*

[10] Generally, parents only have the power to render consent for their children in contexts in which they will be primarily motivated to promote the best interests of the child. For further discussion see notes 27-31 and accompanying text *infra.* For a general discussion of transplants in the intrafamily context see Nolan, Anatomical Transplants Between Family Members—The Problems Facing Court and Counsel, 1 Fam. L. Rep. 4035 (1975).

[11] A Massachusetts court subsequently adopted this course in Rappeport v. Stott, Civil No. J 74-57 (Mass., Aug. 28, 1974). For a discussion of *Stott* see notes 88-99 and accompanying text *infra.*

[12] Eq. No. 68651 (Mass., June 12, 1957) (all citations are to slip opinion).

session,[13] implicitly agreed that this procedure was appropriate. The court neither dismissed the action on the ground that no effective consent could be rendered nor authorized it on the ground that the consent of either the parents or the 14-year-old donor could be treated as effective. Instead, it heard evidence and decided for itself whether, under the circumstances, the operation should be permitted to go forward.[14] Two similar cases were brought in single justice session of the Massachusetts Supreme Judicial Court in 1957, and each resulted in a decree insulating the hospital from liability.[15] Since 1957, several other jurisdictions have

[13] The single justice session is an extraordinary arm of the Supreme Judicial Court exercising original jurisdiction. Mass. Gen. Laws Ann. ch. 214, § 8 (1974).

[14] The *Masden* court's opinion does not explicitly state the basis upon which the court authorized the minor donor's participation in the transplant. The court found that both the parent and the minor donor had rendered informed and voluntary consent. The court indicated in dictum that Zaman v. Schultz, 19 Pa. D. & C. 309 (C.P. 1933), and Bonner v. Moran, 126 F.2d 121 (D.C. Cir. 1941), impliedly established the proposition that operations of this character were permissible if the parents alone consented. Findings, Rulings and Order for Decree at 3. Neither of the cited cases, however, stands for this proposition. *See* notes 83-86 and accompanying text *infra*. *Masden* should not be read as establishing that the parents' consent is a sufficient basis for authorizing a minor donor's participation in a transplant. Rather, the *Masden* court appeared to authorize the transplant on the ground that it would result in a benefit for the minor donor:

> There is little doubt that an operation may be performed upon a minor if it is an emergency one and done for the benefit of the minor even without his consent or that of his parents. . . .
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> I am satisfied from the testimony of the psychiatrist that grave emotional impact may be visited upon [the prospective donor] if the defendants refuse to perform this operation and [the prospective recipient] should die, as apparently he will. See *Brown v. Board of Education*, 347 U.S. 483, 493-494. Such emotional disturbance could well affect the health and physical well-being of [the prospective donor] for the remainder of his life. I therefore find that this operation is *necessary* for the continued good health and future well-being of [the prospective donor] and that in performing the operation the defendants are conferring a benefit upon [him] as well as upon [the recipient].

Findings, Rulings and Order for Decree at 4 (emphasis added).

[15] Shortly after the *Masden* case, Huskey v. Harrison, Eq. No. 68666 (Mass., Aug. 30, 1957), and Foster v. Harrison, Eq. No. 68674 (Mass., Nov. 20, 1957), were decided. Since 1957, this procedure for authorizing transplants involving legally incompetent donors has been employed on numerous occasions in Massachusetts courts. Nathan v. Flanagan, Civil No. J 74-109 (Mass., Oct. 4, 1974) (bone marrow); Rappeport v. Stott, Civil No. J 74-57 (Mass., Aug. 28, 1974) (bone marrow); Nathan v. Farinelli, Eq. No. 74-87 (Mass., July 3, 1974) (bone marrow); Nathan v. Meekins, Eq. No. 74-109 (Mass., June 14, 1974) (bone marrow); Camitta v. Alcorn, Eq. No. 74-23 (Mass., Feb. 14, 1974) (bone marrow); Camitta v. Schillinger, Eq. No. 74-18 (Mass., Jan. 31, 1974) (bone marrow); Camitta v. Fager, Eq. No. 73-171 (Mass., Sept. 5, 1973) (bone marrow); Camitta v. Martinez, Eq. No. 73-158 (Mass., Aug. 23, 1973) (bone marrow); Camitta v. O'Mealia, Eq. No. 73-86 (Mass., Apr. 25, 1973) (bone marrow); Nathan v. Clark, Eq. No. 73-71 (Mass., Apr. 12, 1973) (bone marrow); Nicosia v. Peter Bent Brigham Hosp., Eq. No. 73-8 (Mass., Feb. 26, 1973) (kidney); Nathan v. Dyer, Eq. No. 72-177 (Mass., Dec. 11, 1972) (bone marrow); Kennedy v. Nathan, Eq. No. 72-136 (Mass., Oct. 3, 1972) (bone marrow); DeCaro v. Klein, Eq. No. 72-88 (Mass., July 18, 1972) (kidney); Wenners v. Hampers, Eq. No. 71-57 (Mass., Sept. 21, 1971) (kidney); Holden v. Hampers, Eq. No. 71-40 (Mass., Aug. 2, 1971) (kidney); Cullen v. Hampers, Eq. No. 71-4 (Mass., May 19, 1971) (kidney); Durant v. Morales, Eq. No. 69823 (Mass., Oct. 7, 1970) (kidney) (record impounded); Chichakly v. Hampers, Eq. No. 69761 (Mass., Apr. 7, 1970) (kidney).

The Suffolk County Probate Court has also authorized skin grafts and bone marrow and kidney transplants. The records of these cases have been impounded on motion of counsel for the hospital involved. *E.g.*, Durant v. Santo, Eq. No. 1017 (P. Ct., Suffolk County, Mass., Sept. 24, 1974); Durant v. Grillo, Eq. No. 1009 (P. Ct., Suffolk County, Mass., Sept. 17, 1973); Durant v. Grillo, Eq. No. 1003 (P. Ct., Suffolk County, Mass., Aug. 23, 1973).

faced the problem, and generally they have adopted similar procedures.[16]

Despite the widespread acceptance of this procedure, there is growing dissatisfaction with its use in Massachusetts. The procedure is troublesome for a number of reasons. It requires the family to appear in court at an extremely traumatic time. Given that the Supreme Judicial Court has always authorized the transplants, one may wonder whether it is necessary to subject the family to this additional trauma. The court proceedings, moreover, are time consuming, expensive and difficult to administer. Preparation for the hearing takes several days and requires extensive interviewing of the parents, doctors, children and outside experts. Legal fees of the hospitals involved are substantial, and the court has experienced increasing difficulty finding qualified attorneys to act as volunteer guardians ad litem for the minor donors. Considerations such as these have led some to suggest that the power to authorize these operations might be given to an administrative tribunal that would make the decisions on an informal basis.[17] The existing procedure is also troublesome because it does not provide the prospective donor with any meaningful protection. The court proceedings are rarely adversarial and generally do not include vigorous advocacy of the donor's interest in not participating in the operation. Moreover, in deciding whether to authorize such operations, the Supreme Judicial Court has not consistently applied a standard that reflects serious concern for the donor's interests. These difficulties, among others, have prompted a special Massachusetts legislative commission to create a subcommittee to consider whether the procedure should continue to be used.[18]

This article will examine the system of providing court approval for organ and tissue transplants from minor donors as it operates in Massachusetts. It will focus principally on the substantive interests of pro-

[16] Hart v. Brown, 29 Conn. Supp. 368, 289 A.2d 386 (Super. Ct. 1972); Howard v. Fulton-DeKalb Memorial Hosp. Auth., Civil No. B-90430 (Super. Ct., Fulton County, Ga., Nov. 29, 1973); Children's Memorial Hosp. v. Lewis, No. 73CH6936 (Cir. Ct., Cook County, Ill., Nov. 21, 1973); Strunk v. Strunk, 445 S.W.2d 145 (Ky. 1969); *In re* Richardson, 284 So. 2d 185 (La. App. 1973); *In re* Bostrom, Eq. No. 49385 (Cir. Ct., Montgomery County, Md., June 7, 1974); Smith v. Smith, Eq. No. 43919 (Cir. Ct., Montgomery County, Md., July 19, 1972); *In re* Bachman, Fid. No. 20828 (Cir. Ct., Fairfax County, Va., Aug. 9, 1974); Lausier v. Pescinski, No. 668 (Wis., Mar. 4, 1975).

One notable exception is the state of Washington, where the medical profession made early advances in the field of bone marrow transplantation. The Washington Attorney General's Office has determined that the written consent of the legal guardian is sufficient to authorize a donation by a minor or other legal incompetent. Letter from Gerald L. Coe, Assistant Attorney General, State of Washington, to Charles Baron, Nov. 14, 1974 (on file at Boston University Law Review). Mr. Coe expressed "serious reservations" regarding the adequacy of the protection of the donor's interests afforded by this procedure. *Id.*

[17] Letter from George Annas, Director, Center for Law and Health Sciences, Boston University School of Law, to Representative William Delahunt, Mar. 10, 1975 (on file at Boston University Law Review); Interview with David Nathan, M.D., Chief of Hematology, Children's Hospital Medical Center, Boston, in Boston, Oct. 9, 1974. This proposal is discussed in notes 46-47 and accompanying text *infra*.

[18] This subcommittee of the Special Legislative Commission on Human Experimentation and Experimental Therapy is scheduled to begin hearings in April 1975. The authors of this article are serving on the subcommittee.

spective donors and on the extent to which the current procedures afford them adequate protection. It will begin by examining the requirement of consent and will demonstrate the necessity of judicial authorization of minor donors' participation in transplant procedures. Next, it will analyze the current Massachusetts practice and assess its capacity to afford minor donors adequate protection from the possible dangers of serving as an organ or tissue donor. It will suggest that the Massachusetts system has not adequately protected minor transplant donors. This article will conclude by proposing a number of reforms in the present practice to increase its capacity to protect minor donors.

II. The Requirement of Court Approval

The Massachusetts requirement that a court authorize a minor donor's participation in an organ or tissue transplant represents a principled rejection of alternative methods of handling the problems posed by such medical procedures. Foreclosing minors from participating as donors would be undesirable because transplant operations offer the greatest likelihood of prolonging the life of the recipient[19] without unduly threatening the well-being of the donor.[20] Moreover, the operation may

[19] A transplant may significantly improve the prognosis for a critically ill patient. Kidney transplants are performed for several types of renal failure. Bone marrow transplants are most frequently performed in cases of aplastic anemia and leukemia but may also be appropriate in other situations. *See generally* Thomas *et al.*, Bone Marrow Transplantation, 292 New Eng. J. Med. 832 (1975).

A recent study indicates that the chances of survival for a victim of severe aplastic anemia may double, from 20 percent to 40 percent, as a result of a bone marrow transplant. Camitta *et al.*, Selection of Patients for Bone Marrow Transplantation in Severe Aplastic Anemia, 45 Blood 355 (1975). However, the required destruction of the patient's own marrow may cause a number of adverse conditions, such as reproductive failure and genetic damage. Levine *et al.*, *supra* note 4, at 146. Doctors at the University of Washington report significant benefits from bone marrow transplants for some patients suffering from acute myelogenous leukemia and acute lymphoblastic anemia. Thomas *et al.*, *supra*. Unfortunately, one consequence of a bone marrow transplant is that, if the transplant is unsuccessful, the patient may suffer a far more agonizing death than he would have experienced without the transplant. *See* A. Etzioni, Genetic Fix 142 (1973).

An assessment of the benefits of a kidney transplant is complicated by the availability in many instances of long-term machine dialysis. In some cases, dialysis may be preferable to a transplant. On the other hand, a particular individual may be a poor candidate for long-term dialysis. Interview with Robert Morrison, M.D., Director of Renal Unit, Lemuel Shattuck Hospital, Boston, in Boston, Nov. 18, 1974. Thus, the extent of benefit offered by a transplant varies in each case. An illustration of an assessment of benefits is provided by Hart v. Brown, 29 Conn. Supp. 368, 289 A.2d 386 (Super. Ct. 1972), which involved a kidney transplant from a seven-year-old to her twin sister. In that case the court found that with a transplant "there is substantially a 100 percent chance that the twins will live out a normal life span—emotionally and physically." *Id.* at 372, 289 A.2d at 388. The probability of the prospective recipient's survival for five years with dialysis therapy was estimated to be 50 percent. *Id.*, 289 A.2d at 388.

This article focuses on the interests of the donor in transplant cases and will not discuss the controversial aspects of the benefit to the recipient. It is noteworthy, however, that at least one judge who hears transplant cases involving minors appoints a guardian ad litem for the recipient as well as for the donor. Interview with Mary Fitzpatrick, Judge, Suffolk County Probate Court, Boston, in Boston, Dec. 5, 1974.

[20] The most immediate cost to any transplant donor is the risk attendant to general anesthesia. This is estimated to be a one in 5,000 chance of death or paralysis. Among the

offer the donor the possibility of receiving significant psychological benefits.[21] It would be equally undesirable to permit such operations solely on the approval of either the parents[22] or the prospective donor because the minor donor would be deprived of the protections provided by the general requirement that *effective* consent be given prior to medical treatment.

The requirement that consent be rendered before an individual is given

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thousands of kidney transplants that have been performed, at least five donors have died from perioperative complications. Bennett & Harrison, Experience with Living Familial Renal Donors, 134 Surg., Gyne. & Obstet. 894 (1974).

In a bone marrow transplant, the donor is subjected to as many as 200 aspirations of the pelvic bone with a needle specially designed to remove bone marrow. Approximately one pint of marrow is removed from an adult and considerably less from a child. The marrow regenerates in a matter of weeks. However, there is a slight possibility of bone fracture, bone infection, or rupture of an artery with loss of limb. Letter from David Nathan, M.D., Chief of Hematology, Children's Hospital Medical Center, Boston, to William Swift, Esq., July 18, 1974 (on file at Boston University Law Review). In addition, there is a possibility of skin scarring. Levine *et al.*, *supra* note 4, at 146.

In kidney transplants, the greatest physical risk other than that due to anesthesia is the possibility that the donor's remaining kidney may someday fail. This risk appears to be so small that life insurance actuaries do not consider individuals with one kidney a greater risk than those with two. Hart v. Brown, 29 Conn. Supp. 368, 373, 289 A.2d 386, 389 (Super. Ct. 1972). "The only real risk would be trauma to the one remaining kidney, but testimony indicated that such trauma is extremely rare in civilian life." *Id.*, 289 A.2d at 389. In over 20 years of experience with kidney transplants, there has never been a reported case of total renal failure in a donor through trauma or disease. Interview with Theodore Steinman, M.D., Director of Dialysis Unit, Beth Israel Hospital, Boston, in Boston, Nov. 18, 1974.

Finally, there may be psychological costs to the donor. These include the effects of a fear of operations, a fear of losing part of one's body and hostility toward the recipient. *See* Eisendrath, Guttman & Murray, Psychologic Considerations in the Selection of Kidney Transplant Donors, 129 Surg., Gyne. & Obstet. 243, 245-48 (1969); Kemph, Psychotherapy with Patients Receiving Kidney Transplant, 124 Am. J. Psychiat. 623 (1967). One adolescent developed a depressive reaction a month after a transplant operation, apparently due to a fear that he was developing kidney disease. Bernstein & Simmons, The Adolescent Kidney Donor: The Right to Give, 131 Am. J. Psychiat. 1338, 1340 (1974). There is also the risk of psychological harm to the donor if the recipient rejects the transplanted organ or tissue. This may be especially harmful if the recipient dies a more agonizing death after an unsuccessful transplant than he would have otherwise. *See* note 19 *supra*.

[21] Studies of adult donors indicate that the main benefits are an increase in self-esteem, an avoidance of the guilt feelings that might result if the donor did not participate, and the satisfaction that follows from the family's gratitude. *See, e.g.*, Fellner & Marshall, Kidney Donors—The Myth of Informed Consent, 126 Am. J. Psychiat. 1245 (1970); S. Schwartz, The Activation of Personal Norms and Prosocial Behavior (unpublished paper delivered at the Conference on Mechanisms of Psychological Sciences of the Polish Academy of Sciences, Warsaw, Poland, Oct. 1974). One study found that donors generally view the act of donation "as a feat of heroism." Fellner & Marshall, *supra* at 1249.

For discussion of the nature and likelihood of psychological benefits to older minor donors see Bernstein & Simmons, *supra* note 20, at 1339-41. For a similar discussion relating to younger donors see Lewis, Kidney Donation by a 7-Year-Old Identical Twin Child: Psychological, Legal and Ethical Considerations, 13 J. Am. Acad. Child Psychiat. 221, 228-32 (1974). One authority on the psychological effects of transplant operations expressed the belief that a young donor may subsequently feel a personal responsibility for a donation or a refusal to donate despite the fact that he was not consulted when the decision was made. Telephone interview with Shalom Schwartz, Professor of Sociology, University of Wisconsin, Madison, Dec. 13, 1974.

[22] Parents generally can give effective consent for beneficial medical treatment performed on their child. W. Prosser, *supra* note 5, at 103.

medical treatment that will benefit the individual alone is a well-established principle in our common law tradition.[23] The requirement is enforced by subjecting medical providers who act in the absence of consent to liability for battery.[24] The underlying theory is that the individual, not society at large, should decide whether medical treatment is in his best interests; it is "the patient's right to make his decison in light of his own individual value judgment."[25] The opinions of the doctors or of the community at large are legally irrelevant.[26] The requirement that consent be rendered prior to medical treatment applies a fortiori in situations in which the primary benefit from the medical procedure will run to another individual, as in the case of a transplant, or to society as a whole, as in the case of medical experimentation. No matter how great the benefit to be conferred nor how small the cost of conferring it, the procedure will constitute a battery if performed without effective consent.

Children generally are not competent to consent to medical treatment. A child's lack of capacity to consent is predicated on the belief that, because a child is inexperienced and immature, he is incapable of deciding what is in his own best interests.[27] In the typical case in which medical treatment is likely to benefit the child, the best means of protecting the child is to permit the child's parents to consent for the child. The parents are probably best able to determine what is in the best interests of the child and can generally be presumed to act to promote these interests.[28] Thus, when a child needs medical treatment, his incompetence to consent usually presents no problem because his parents are empowered to supply the required consent.[29]

However, parents only have the power to make critical decisions affecting the welfare of their child in those contexts in which the parents are

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[23] *See* 2 F. Harper & F. James, The Law of Torts § 17.1 n.15 (Supp. 1968); W. Prosser, *supra* note 5, at 101-04. There are, of course, situations in which society decides that other values outweigh the values protected by the requirement of consent prior to medical treatment. For example, mandatory vaccination laws have been upheld against constitutional challenges. Jacobsen v. Massachusetts, 197 U.S. 11 (1905). These situations, however, are largely confined to those in which the individual's failure to receive treatment would endanger the community at large and do not negate the traditional doctrine that each individual has the power to consent to medical treatment.

[24] *See* W. Prosser, *supra* note 5, at 102-06. Alternatively, it is possible to hold doctors who proceed with medical treatment without procuring informed consent liable for negligence. *See* Fraser & Chadsey, Informed Consent in Malpractice Cases, 6 Willamette L.J. 183 (1970).

[25] Wilkinson v. Vesey, 110 R.I. 606, 624, 295 A.2d 676, 687 (1972).

[26] The keystone of this doctrine is every competent adult's right to forego treatment, or even cure, if it entails what for him are intolerable consequences or risks however unwise his sense of values may be in the eyes of the medical profession, or even the community.

Id., 295 A.2d at 687.

[27] *See* Bonner v. Moran, 126 F.2d 121 (D.C. Cir. 1941); Rogers v. Sells, 178 Okla. 103, 61 P.2d 1018 (1936); W. Prosser, *supra* note 5, at 103.

[28] Generally, a parent "has the strongest interest in the successful nurture and training of the child and in his protection from harm." Dobson, The Juvenile Court and Parental Rights, 4 Fam. L.Q. 393, 396 (1970).

[29] W. Prosser, *supra* note 5, at 102-04.

likely to be motivated to do what is best for the child. Under its parens patriae power,[30] the state has traditionally intervened in the parent-child relationship when the parents are not acting to further the child's best interests.[31]

There has been a discernible trend toward the use of the parens patriae power by the courts in the field of medical care for children. Many cases involve parents who refuse to consent to medical treatment for their children on religious grounds.[32] When the life of the child was immediately threatened, the courts have used or upheld the use of available statutory procedures to deprive the parents of custody temporarily in order to approve the treatment.[33] In addition, the courts have overriden the parents in cases involving vaccination,[34] removal of tonsils and adenoids,[35] and other medical procedures to cure nonlife-threatening problems.[36] In contrast, courts have acceded to the parents' wishes in refusing treatment for conditions such as rickets,[37] a disfigured arm,[38] a speech impediment[39] and the need for a spinal fusion operation.[40] In each of the latter cases, however, the evidence indicated both that the efficacy or safety of the proposed treatment was reasonably open to question and that the parents sincerely believed that the decision was in the best interests of the child.

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[30] The doctrine of parens patriae is that the state is the ultimate guardian of every child. Under this doctrine, which is predicated in part on the belief that there is a correlation between the welfare of the child and the welfare of society, the state has not only the right but also the duty both to establish standards for the care of children and to interfere with the parent-child relationship when necessary to ensure that those standards are met. Dobson, *supra* note 28, at 396.

[31] There are many situations in which the state has intervened to promote a child's interests. When necessary, the state has permanently deprived parents of custody of their child in order to protect the child from abusive treatment or the consequences of neglect. *See generally* Paulsen, The Legal Framework for the Protection of Children, 66 Colum. L. Rev. 679, 693-703 (1966). Even apparently well-intentioned parents have been temporarily deprived of custody in instances in which they were perceived not to be acting in the child's best interests.

[32] *See, e.g.,* Jehovah's Witnesses v. King County Hosp., 278 F. Supp. 488 (D.D.C. 1967); *In re* Karwath, 199 N.W.2d 147 (Iowa 1972); *In re* Sampson, 29 N.Y.2d 900, 278 N.E.2d 918, 328 N.Y.S.2d 686 (1972).

[33] People *ex rel.* Wallace v. LaBrenz, 411 Ill. 618, 104 N.E.2d 769, *cert. denied,* 344 U.S. 824 (1952); State v. Perricone, 37 N.J. 463, 181 A.2d 751, *cert. denied,* 371 U.S. 890 (1962); Hoener v. Bertinato, 67 N.J. Super. 517, 171 A.2d 140 (Juv. & Dom. Rel. Ct. 1961); Application of Brooklyn Hosp., 45 Misc. 2d 914, 258 N.Y.S.2d 621 (Sup. Ct. 1965); Heinemann's Appeal, 96 Pa. 112 (1880); Mitchell v. Davis, 205 S.W.2d 812 (Tex. Civ. App. 1947).

[34] Mannis v. State *ex rel.* Dewitt School Dist. No. 1, 240 Ark. 42, 398 S.W.2d 206 (1966).

[35] *In re* Karwath, 199 N.W.2d 147 (Iowa 1972).

[36] *In re* Sampson, 29 N.Y.2d 900, 278 N.E.2d 918, 328 N.Y.S.2d 686 (1972) (disfigurement); *In re* Carstairs, 115 N.Y.S.2d 314 (N.Y. Dom. Rel. Ct. 1952) (emotional illness); *In re* Rotkowitz, 175 Misc. 948, 25 N.Y.S. 624 (N.Y. Dom. Rel. Ct. 1941) (deformity of foot resulting from polio); *In re* Weintraub, 166 Pa. Super. 342, 71 A.2d 823 (1950) (emotional illness).

[37] *In re* Tuttendario, 21 Pa. Dist. 561 (Dist. Ct. 1911).

[38] *In re* Hudson, 13 Wash. 2d 673, 126 P.2d 765 (1942).

[39] *In re* Seiferth, 309 N.Y. 80, 127 N.E.2d 820 (1955); *In re* Frank, 41 Wash. 2d 294, 248 P.2d 553 (1952).

[40] *In re* Green, 448 Pa. 338, 292 A.2d 387 (1972).

The situation presented by a transplant involving siblings is a compelling one for taking the power of decision away from the parents of the prospective minor donor. One may seriously question whether an operation to remove an organ or tissue will be in the best interests of the prospective minor donor,[41] and the child's parents assuredly are not in a position in which they are likely to be motivated solely to do what is best for the prospective donor.

In a bone marrow or kidney transplant case involving sibling donor and recipient, the parents necessarily are confronted with a painful dilemma. Although they have a desperately ill child who may die if no transplant is performed, and although they wish to do whatever may save his life, presumably they do not want to injure their healthy child, the prospective donor. Generally, the only possible resolution of this conflict for the parents will be to attempt to save the life of the sick child by consenting to the minor donor's participation because of the comparatively minimal risk to the healthy child.

If the decision whether the minor donor should participate were made by the parents, no forces outside the family unit would restrain the parents from risking the health of the donor for the benefit of the recipient. Absent official intervention, the only persons outside the family unit with whom the parents are likely to consult are the doctors. Because the doctors by this time will have made the medical judgment that the potential benefits from the operation outweigh the costs, they will probably favor proceeding with the operation.[42] Moreover, there are several factors operating on a subconscious level that may prevent doctors from exercising an entirely objective judgment on the decision to recommend the transplant operation. A successful transplant operation obviously gives the medical transplant team a deep sense of accomplishment. Even if an operation fails, the team must realize that it has made every effort possible to save the life of the recipient. Finally, the performance of transplant operations is important to medical research.[43]

Even if the court proceedings generally will result in authorization of the operation, the requirement of court approval serves a critical function. Although not the only condition for proceeding, as a practical

[41] For example, in Camitta v. Fager, Eq. No. 73-171 (Mass., Sept. 5, 1973), the prospective donor's guardian ad litem contended that the minor donor's mental state—characterized as a combination of mild retardation and schizophrenia—precluded the realization of any psychological benefits.

[42] This article is not suggesting that the doctors do not consider the effect of the operation on the prospective donor in deciding whether to recommend that the transplant should proceed. The opposite is the case. In many hospitals the practice is to give the prospective donor a battery of psychological tests. For discussion of the Minnesota practice see Bernstein & Simmons, *supra* note 20, at 1338-39. *See also* Lewis, *supra* note 21, at 222, 227-28. Once the doctors have determined that the operation should occur, however, they are not likely to encourage parents to question that recommendation seriously.

[43] Most bone marrow transplants are performed under the auspices of research grants from the National Institutes of Health. Interview with Dr. David Nathan, *supra* note 17. Although kidney transplants are no longer "experimental" from the recipient's point of view, additional scientific knowledge may be gained from each operation.

matter, the consent of the parents[44] and the doctors is necessary. By removing the decision from a context in which all parties favor the operation and by impressing upon both the parents and the doctors the gravity of the decision, the court proceedings increase the possibility that either the parents or the doctors will decline to consent in those cases in which there is substantial doubt whether an operation would be in the best interests of the prospective donor.[45] This consideration constitutes a strong argument against a proposal to remove the decision from the courts and place it either entirely in the hands of the parents or in the hands of a nonjudicial tribunal that would resolve the matter through informal, nonadversary proceedings.[46]

The practice of court authorization has the potential for ensuring that the substantive interests of the prospective minor donor will be respected and considered *before* he participates in the operation, just as those of an adult would be.[47] Whether the practice succeeds in attaining this objective is a function of two factors: the substantive rule that the court applies in deciding whether to authorize the donation and the procedural safeguards that are afforded the prospective donor. The Massachusetts practice has been inadequate in both respects. The Massachusetts courts have not consistently applied a standard for authorizing transplants that provides the donor with the protection that the system was presumably designed to afford, and, in most of the cases, they have permitted the parties to structure the court proceedings in such a way that there is no assurance that the donor's interests will be represented at all, much less

[44] In a case in which both the donor and the recipient are minors, it is hard to conceive of the operation proceeding without the parents' consent. Under traditional common law principles, the parents would have to consent to both the donor *and* the recipient's participation in the procedure. *See* note 29 *supra*. Conceivably, a court could temporarily deprive the parents of custody of both children—rather than of only the donor—and consent on behalf of both children. However, there is no reported case in which a court has done so.

[45] At least one judge who has handled minor transplant donor cases conducts the proceedings in a manner designed to impress upon the parents the gravity of their decision. Interview with Judge Mary Fitzpatrick, *supra* note 19.

[46] The appeal of such a tribunal is that the informal proceedings would be much less painful for the family members. The tribunal could hear the cases within the hospital setting, without resort to adversary proceedings. The expertise that such a body would develop arguably would enable it not only to hear and decide cases expeditiously but would also enhance its ability to refine the standard that it was instructed to apply.

However, formal proceedings encourage the parents and doctors to reflect seriously with respect to whether the transplant will benefit the donor. If these matters are handled informally within the hospital, the concerned parties will treat the matter far less seriously. There is a real danger that such a tribunal would be dominated by the hospital and develop a bias toward the hospital's position. Moreover, the need for expertise is greatest not in the tribunal, but in the representative of the interests of the donor. If he understands the critical medical and psychological facts and has sufficient time to investigate and prepare evidence, there may not be any need for expertise in the tribunal. The medical and psychological expertise of the tribunal is arguably far less important than its sensitivity to the ethical and legal questions.

[47] The adult's interests are at least in theory respected and considered through the requirement of informed, voluntary consent. *See* notes 23-26 and accompanying text *supra*. Absent a requirement of court authorization, the question whether the child's interests were adequately considered could be raised only in a battery action brought after the operation.

adequately. In examining the system in operation, this article will offer proposals for legislative reform, both with respect to the substantive rule that should be applied and with respect to ensuring adequate representation of the prospective donor's interests.

III. The Basis upon Which Transplants Are Authorized

Although the justices of the Supreme Judicial Court have issued 22 decrees authorizing transplant operations, they have not yet articulated a consistent standard for ascertaining the conditions under which such authorizations are appropriate.[48] In the vast majority of Massachusetts cases, the justices have not clearly articulated the legal theory upon which their decrees have been based. They have merely authorized the operations after stating various findings of fact as to the extraordinary benefits to the recipient from the proposed transplant, the minimal risks to the donor, the parents' consent, the donor's consent and, usually, the existence of some benefit to the donor.[49] The reason for this approach is easily understood; an examination of Massachusetts decisions that have attempted to articulate a principled standard reveals that each of the theories that a court might use to justify its intuitive conclusions presents difficult problems.

There are three basic theories upon which the Supreme Judicial Court has relied. Under the first, the "best interests" test, the court authorizes the transplant if it determines that participation in the operation will result in a net benefit to the prospective donor.[50] The Massachusetts court appears to have followed the best interests approach in almost all cases. Under the second theory, which was initially applied in *Nathan v. Farinelli,*[51] the court characterized its duty not as one of deciding itself whether the operation should go forward but rather as one of reviewing the parents' weighing of the relative costs and benefits of the operation to both children.[52] Under the third theory, the court determines whether the minor is sufficiently mature so that his consent to the transplant operation may be deemed effective. This approach was utilized in *Rappeport v. Stott.*[53] Each theory will be examined in terms of a court's ability to administer it to protect the substantive interests of the prospective donor.

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[48] The Suffolk County Probate Court has also decided a number of cases authorizing transplant operations. *E.g.,* Durant v. Santo, Eq. No. 1017 (P. Ct., Suffolk County, Mass., Sept. 17, 1974). However, the hospital involved successfully moved to have the records of these cases impounded. This impoundment makes it impossible to discuss the rationale utilized in these cases in support of authorization.

[49] *See, e.g.,* Nathan v. Meekens, Eq. No. 74-109 (Mass., June 14, 1974); Camitta v. Alcorn, Eq. No. 74-23 (Mass., Feb. 14, 1974); Nathan v. Clark, Eq. No. 73-71 (Mass., Apr. 12, 1973).

[50] This test was first used in the 1957 kidney transplant cases. Foster v. Harrison, Eq. No. 68674 (Mass., Aug. 30, 1957); Huskey v. Harrison, Eq. No. 68666 (Mass., Aug. 30, 1957); Masden v. Harrison, slip op.

[51] Eq. No. 74-87 (Mass., July 3, 1974) (all citations are to slip opinion).

[52] *Id.* at 10.

[53] Civil No. J 74-57 (Mass., Aug. 28, 1974) (all citations are to slip opinion).

A. *The Best Interests Test*

Under this theory, a court will authorize the donation only if it determines that participation in the operation will promote the best interests of the prospective donor. Courts traditionally employ this test, or the closely related substituted judgment test,[54] whenever they are called upon to make decisions for incompetent individuals. They have used it extensively in authorizing beneficial medical treatment for children whose parents refuse to consent for religious reasons.[55]

A court ordinarily will authorize medical treatment of a minor only if it finds that the operation is likely to result in a net physical benefit to the child.[56] A transplant donor, of course, does not benefit physically from participation in the transplant operation. In the transplant context, therefore, the decision must turn on proof that the psychological benefits that will flow to the donor as a result of the operation outweigh the possible physical harm.[57] Few situations provide the opportunity for the type of compelling testimony on this point that was given in the Kentucky case of *Strunk v. Strunk.*[58] In that case, the court authorized a kidney transplant from a mentally retarded 27-year-old to his brother largely because of the overwhelming psychiatric evidence that under the circumstances the

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[54] Usually thought to be the creation of Lord Eldon in *Ex parte* Whitbread, 35 Eng. Rep. 878 (Ch. 1816), this doctrine empowers a court of equity to authorize gifts from an incompetent's estate on the sole ground that the incompetent would choose to do so if he were competent. Courts have traditionally used this test in contexts involving real or personal property. *See generally* Note, Substitution of Judgment Doctrine and Making of Gifts from an Incompetent's Estate, 7 Real Prop. Probate & Trust J. 479 (1972). In applying the best interests test, a court attempts to evaluate objectively what is best for the person involved. Under the substituted judgment test, the court, in effect, is determining the subjective question of what this person would decide to be in his best interests were he competent. *In re* Flagler, 248 N.Y. 415 (1928); *In re* Fleming, 175 Misc. 851, 19 N.Y.S.2d 234 (Sup. Ct. 1970). In the case of a minor donor, there is no prior period of competency upon which to base a determination of the donor's altruism. Therefore, in applying the substituted judgment test in a case involving a minor, a court is simply applying a form of the best interests test. It must make a decision based upon its perception of what a reasonable person would do if he were in the minor's position. The two reported transplant cases in which the courts have purported to use the substituted judgment test in reaching their decision are Strunk v. Strunk, 445 S.W.2d 145 (Ky. 1969), and Hart v. Brown, 29 Conn. Supp. 368, 289 A.2d 386 (Super. Ct. 1972). For discussion of the use of the substituted judgment rationale in transplant cases see Lausier v. Pescinski, No. 668, at 4-5 (Wis., Mar. 4, 1975); Note, Spare Parts from Incompetents: A Problem of Consent, 9 J. Fam. L. 309, 310-11 (1969); 74 Dick. L. Rev. 530 (1970); 10 Washburn L.J. 157, 160 (1970).

[55] *See* text accompanying notes 32-33 *supra; cf.* Larsen, Child Neglect in the Exercise of Religious Freedom, 32 Chi.-Kent L. Rev. 283 (1954).

[56] *See, e.g.,* People *ex rel.* Wallace v. Labrenz, 411 Ill. 618, 104 N.E.2d 769, *cert. denied,* 344 U.S. 824 (1952) (blood transfusion to infant); State v. Perricone, 37 N.J. 463, 181 A.2d 751, *cert. denied,* 371 U.S. 890 (1962) (same); *In re* Clark, 21 Ohio Op. 2d 86, 185 N.E.2d 128 (C.P. 1962) (same).

[57] The early Massachusetts cases were reportedly the first cases to treat purely psychological or emotional benefit as sufficient to satisfy the requirements of the test. *See* Curran, *supra* note 2, at 892-94; Savage, Organ Transplantation with an Incompetent Donor: Kentucky Resolves the Dilemma of *Strunk v. Strunk,* 58 Ky. L.J. 129, 136 (1970); Note, Equity—Transplants—Power of Court to Authorize Removal of Kidney from Mental Incompetent for Transplantation into Brother, 16 Wayne L. Rev. 1460, 1464-67 (1970).

[58] 445 S.W.2d 145 (Ky. 1969).

death of the donee would have had an extremely traumatic effect upon the donor.[59]

In the Massachusetts cases, the determination of net benefit to the donor has turned upon similar psychiatric testimony.[60] Perhaps because of the lack of genuinely adversary proceedings in most of these cases,[61] the testimony seems quite contrived. It appears that the medical witnesses are consciously providing the court with the necessary words to satisfy the psychological benefit finding required as a condition to granting the requested relief.[62] The sense of contrivance is strongest when the donor, as in some recent cases,[63] is too young to have developed the kind of deep ties with his sibling that the testimony suggests. Indeed, in Massachusetts cases in which guardians ad litem for the donors have explicitly adopted an adversary approach, the testifying psychiatrists have admitted that any testimony that they were prepared to give regarding future psychological benefit or detriment to the donor would be highly speculative.[64] The uncertain quality of the psychiatric testimony presents the court with a difficult problem. If there is no stronger evidence regarding potential psychological benefit than "speculative" psychiatric testimony, it is doubtful whether a court can administer the best interests test so as to provide the prospective donor with the protection that the proceeding is intended to afford.

In *Nathan v. Farinelli,* which involved a six-year-old donor, the Massachusetts court refused to apply the best interests test because of the admittedly speculative quality of the psychiatric testimony. The court's decision not to apply the best interests test may be justified because of the present inadequacies of its application. However, an examination of the tests utilized in *Farinelli* and *Rappeport v. Stott* suggests that the best interests test nevertheless may offer the only means by which the legal system's apparent objectives in this area may be satisfied.

B. *Review of Parental Decision*

In *Farinelli,* the Supreme Judicial Court did not apply the best interests test because it believed that any findings concerning the psychological benefits of the transplant operation to the minor donor would be unduly speculative.[65] The court preferred to treat the parents as having the "primary right and responsibility for deciding" whether one sibling

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[59] *Id.* at 146.

[60] *See, e.g., Masden v. Harrison,* discussed in note 14 *supra.*

[61] *See* text accompanying notes 113-33 *infra.*

[62] The *Strunk* case has been criticized for this reason. *See, e.g.,* Note, *supra* note 57, at 1464-65; Note, *supra* note 54, 9 J. Fam. L. at 315.

[63] *E.g.,* Nathan v. Farinelli, slip op. (six-year-old donor); Camitta v. Alcorn, Eq. No. 74-23 (Mass., Feb. 14, 1974) (four-year-old donor); Camitta v. Schillinger, Eq. No. 74-18 (Mass., Jan. 31, 1974) (five- and eight-year-old prospective donors; recipient less than one year old).

[64] *See* Nathan v. Flanagan, Civil No. J 74-109 (Mass., Oct. 4, 1974); Nathan v. Farinelli, slip op.

[65] Slip op. at 7.

should donate an organ or tissue to another and to permit the parents to make a decision by weighing the interests of each child.[66] However, the court considered it necessary to exercise its equity power to review the parents' decision in such cases

> because of the possibility of a conflict between their responsibility for the care and custody of [the recipient], and their similar responsibility for [the donor] . . . . [T]he safeguard of judicial review is necessary because of the potential temptations resulting from the built-in conflict of [the parents'] position.[67]

The court's review of the parental decision demonstrates that the court did not consider its primary duty to be protection of the prospective donor. Rather, the court weighed the interests of both children. On the one hand, the court assessed

> the nature and urgency of [the recipient's] physical condition, his need for the transplant, the probable benefit to him from the transplant, the probable risks or consequences to him if the transplantation is withheld, and the availability and efficacy of alternative methods of treatment for his condition.[68]

On the other hand, it considered the donor's "physical condition, the nature and extent of her physical participation in the transplant, and the probable and possible risks and consequences to her by reason of her participation."[69]

This emphasis on the need for judicial review because of the parents' conflict of interests with respect to their two children seems at first inconsistent with the court's approval of parental balancing of the interests of both children. As discussed above,[70] one of the primary reasons that parental consent for the prospective minor donor is ineffective under the best interests test is the parents' conflict of interests. Such a conflict in motivation, however, appears to be inherent in the *Farinelli* rationale. The parents are empowered specifically to make their decision based on an assessment of the interests of *both* children.[71] In effect, they are given the authority to sacrifice the interests of the prospective donor if they reasonably conclude that the costs to him are outweighed by the potential benefits to the recipient.

Nevertheless, even under the *Farinelli* utilitarian standard, in which the parents initially resolve the conflict of interests, there are sound reasons why judicial review should be retained. The extreme need of the recipient

[66] *Id.* at 10. Several courts in other jurisdictions also have authorized such donations on the basis of parental consent that was itself based on a family cost-benefit standard. *See, e.g.*, Hart v. Brown, 29 Conn. Supp. 368, 289 A.2d 386 (Super. Ct. 1972); *In re* Bostrom, Eq. No. 49385 (Cir. Ct., Montgomery County, Md., June 7, 1974); Smith v. Smith, Eq. No. 43919 (Cir. Ct., Montgomery County, Md., July 19, 1972); *In re* Bachman, Fid. No. 20828 (Cir. Ct., Fairfax County, Va., Aug. 9, 1974).

[67] Slip op. at 10.

[68] *Id.* at 11.

[69] *Id.*

[70] *See* text accompanying notes 41-43 *supra*.

[71] Slip op. at 10.

renders suspect the parents' ability to assess objectively the interests of the prospective donor—specifically, to give proper weight to the risks of injury arising from the donation. Moreover, there is a danger that the parents may be particularly insensitive to the risks to be incurred by a disfavored donor or particularly impressed with the benefits to be gained by an especially favored recipient.

The *Farinelli* court appeared to recognize these considerations when it stated that it would exercise its review power for the purpose of ensuring that the parental decision is "fair and reasonable."[72] The court apparently intended to ensure that the extreme need of the recipient did not lead the parents to impose risks upon the donor that the court would not consider "reasonable" in relation to the potential benefits to the recipient. Although the court did not indicate what it meant by the word "fair," it may have used the term to express the requirement that the parental decision be made in a manner that did not differentiate between the donor and the recipient on the basis of their relative status in the family.[73]

Nevertheless, the *Farinelli* decision is disturbing when one considers the factors that parents and courts, deliberately or unconsciously, may include in the balancing process. There may be cases in which a transplant operation will provide an important medical advance that will benefit society at large. Moreover, in a case in which the prospective donor is mentally retarded and his sibling is perceived to be a potentially contributing member of society, there will always be a temptation to weigh the relative social "worth" of the individuals. Authorization of organ or tissue donations on a basis other than the furtherance of the donor's best interests may lead ineluctably to inclusion of such societal values in the balance.[74]

[72] *Id.* at 11.

[73] This meaning of the term is suggested by the concept of justice as fairness. *See generally* J. Rawls, A Theory of Justice (1971). This concept is directly applicable to the transplant situation. For example, in one of the Massachusetts cases,

> [t]here seemed to be three possible donors: a retarded 13-year-old sibling and two normal ones. The parents wanted the retarded child to be the donor and refused to consider the 11-year-old (their only daughter) for this . . . . Appropriate tests confirmed the retarded child to be the only histocompatible donor.

Levine *et al.*, *supra* note 4, at 147. Were the decision to have the mentally retarded child be the donor made partially on the basis of his retarded condition, one might question its fairness. Even when such obvious unfairness is not present, the court might wish to inquire into the parental decision in order to examine the extent to which the parents were making the decision on grounds that would produce the same result if the roles of the children were reversed.

[74] Presumably it was this concern that prompted Justice Steinfeld's dissent in Strunk v. Strunk:

> Apparently because of my indelible recollection of a government which, to the everlasting shame of its citizens, embarked on a program of genocide and experimentation with human bodies I have been more troubled in reaching a decision in this case than in any other. My sympathies and emotions are torn between a compassion to aid an ailing young man and a duty to fully protect unfortunate members of society.

445 S.W.2d at 149.

> To hold that committees, guardians or courts have such awesome power even in the persuasive case before us, could establish legal precedent, the dire result of which we cannot fathom. Regretfully I must say no.

Id. at 151.

The most troublesome aspect of the *Farinelli* standard, however, is its fundamental inequity. Society does not require adults to donate organs or tissue whenever the likelihood of benefit to the recipient appears to outweigh the cost to the donor. Why then should a parent be permitted to require a child to participate as a donor in a transplant operation without proof that doing so would promote the donor's best interests simply because the cost to the donor is deemed acceptable?[75]

A parent, of course, has the power to make some purely utilitarian decisions that will benefit the family unit to the detriment of one child, and the law recognizes this power in a variety of situations.[76] Tort law, for example, recognizes that a parent may consider the influence of the example upon other siblings in deciding how severely to punish a child for disobedience.[77] In addition, parents are entitled to a minor child's services and earnings while the child lives with and is supported by them.[78] Under this principle, parents presumably have the power to require one child to seek employment to help pay the medical bills incurred for a chronically ill second child.

Yet some interests of the child traditionally have been deemed so fundamental that the parents have been denied the power to invade them even when doing so would benefit the entire family, except upon a showing that the best interests of the child would be promoted. For example, the general rule with respect to the *property* of a minor is that the property that a child acquires, except as compensation for services rendered by him, "belongs to him absolutely, and the parent, as such, has no

[75] One possible source of analogous authority for justifying parental decision making on a cost-benefit basis in transplant cases is the line of decisions that have established an "incomplete privilege" to invade the interests of others on the ground of "private necessity." Vincent v. Lake Erie Transp. Co., 109 Minn. 456, 124 N.W. 221 (1910); Ploof v. Putnam, 81 Vt. 471, 71 A. 188 (1908). The existence of this incomplete privilege has been recognized by the Second Restatement of Torts §§ 197-98 (1965), as well as by commentators. *E.g.,* 1 F. Harper & F. James, *supra* note 23, §§ 2.43-.44. *See generally* Bohlen, Incomplete Privilege to Inflict Intentional Invasions of Interests of Property and Personality, 39 Harv. L. Rev. 307 (1926). It could be argued on the authority of these cases that, when the need to save the life of the recipient far outweighs the relatively minor risks to the donor, the recipient or someone acting on his behalf has a privilege to transplant the organs or tissue involved.

The application of this line of authority to the transplant cases would raise a number of problems. It would require that no distinction be drawn between invasions of property interests, such as in *Ploof* and *Vincent,* and invasions of the person. Moreover, it would seem to create an obligation on the part of the recipient to compensate the donor for any injury sustained by the invasion. *See* Vincent v. Lake Erie Transp. Co., *supra* at 459, 124 N.W. at 222. Finally, the application of the "incomplete privilege" theory to prospective minor donors would be grossly unfair unless it were applicable to adults as well. Indeed, the theory is not restricted to family members; its use to justify the taking of organs or tissue on the grounds of necessity would entitle any person to take parts of the body of another if there were an acceptable balance of benefits and costs.

[76] American jurisprudence recognizes a broad "natural right" in parents to determine the upbringing of their children. Note, State Intrusion into Family Affairs: Justification and Limitations, 26 Stan. L. Rev. 1383, 1384-85 (1974); *see* Wisconsin v. Yoder, 406 U.S. 205, 232 (1972); *cf.* Pierce v. Society of Sisters, 268 U.S. 510 (1925); Meyer v. Nebraska, 262 U.S. 390 (1923).

[77] Restatement of Torts § 150 (1934).

[78] J. Madden, The Law of Persons and Domestic Relations § 120, at 403 (1931).

claim to it."[79] Massachusetts not only has recognized this doctrine but also has extended it. The Supreme Judicial Court has held that a bounty paid to a minor for enlisting in the army is the property of the minor, rather than earnings, because it was "given to the recruit for the purpose of inducing him personally to undertake a service of an arduous and hazardous nature."[80] Accordingly, his father lacked the power or authority to use or spend any part of it.

It seems incongruous for Massachusetts to protect vigorously a minor's property rights yet acquiesce in a parental decision to authorize an organ or tissue transplant. In refusing to authorize a kidney transplant operation, a Louisiana court noted that its law affords a minor unqualified protection against intrusion into mere property rights and concluded, "[it] is inconceivable to us that [our law should afford] less protection to a minor's right to be free in his person from bodily intrusion to the extent of loss of an organ unless such loss be in the best interest of the minor."[81]

The court in *Farinelli* cited only one case to support the proposition that parents could authorize an operation not of therapeutic benefit to the child involved.[82] That case, *Bonner v. Moran,*[83] involved a 15-year-old boy who had willingly donated skin to his cousin for a skin graft to relieve her from the crippling effects of extensive burns. In a subsequent action by the child's parent, the court held that the consent of the parent, which had not been obtained, was necessary to authorize the minor's participation.[84] Although the court did indicate that parental consent would be sufficient for authorization,[85] the facts of the case did not require a ruling on this question.[86] Moreover, the *Bonner* case differs in at least one important respect from cases such as *Farinelli*: the recipient of the donation in *Bonner* was not another child of the parent. The conflict of interests on the part of the parent was not present as it is in transplant cases involving immediate family members. There was, therefore, a basis in *Bonner* for continuing the presumption that the parental decision would be made in the donor's best interests—a factor that is not present in intrafamily transplant cases. Thus, even the dictum in *Bonner* does not support the proposition that parents may require one sibling to participate in an operation for the benefit of another.

Farinelli permits parents, subject to court review, to impose an obligation upon children that society does not impose upon adults. It is plain that our society is not yet prepared to require adults to donate organs or

[79] *Id.* § 132, at 439 (footnote omitted).

[80] Banks v. Conant, 96 Mass. (14 Allen) 497, 498 (1867); *accord,* Taylor v. Mechanics Sav. Bank, 97 Mass. (14 Allen) 345 (1867).

[81] *In re* Richardson, 284 So. 2d 185, 187 (La. App. 1973).

[82] Slip op. at 4.

[83] 126 F.2d 121 (D.C. Cir. 1941).

[84] *Id.* at 123. Another case frequently cited with *Bonner* as authority for this proposition is Zaman v. Schultz, 19 Pa. D. & C. 309 (C.P. 1933) (dictum).

[85] 126 F.2d at 123 (dictum).

[86] *See* Capron, Legal Considerations Affecting Clinical Pharmacological Studies in Children, 21 Clinical Research 141, 143 (1972).

tissue when the benefits to the recipient appear to outweigh the costs to the donor.[87] The *Farinelli* utilitarian approach is, therefore, inconsistent with a sincere desire to afford minors and other incompetents the protection from potentially harmful medical procedures that adults enjoy.[88] The irony implicit in any standard that imposes such an obligation upon minors and other incompetents but not upon adults is that its use would take advantage of a judicial proceeding designed to protect the most vulnerable in our society in order to exploit them in a way that adults cannot be exploited.

C. *The Minor Donor's Consent as Effective*

In *Rappeport v. Stott,* the Massachusetts Supreme Judicial Court approved a minor's donation of bone marrow on the express ground that the 17-year-old donor was "capable of consenting to the proposed procedure so as to prevent the creation of liability therefor."[89] At least one commentator has suggested that consent of the donor be the sole criterion for authorizing donation in cases involving minors.[90] For several reasons, this approach to the minor donor problem is not a justifiable alternative to the best interests test.

One objection to this approach is that consent would be effective in only a few cases. In *Stott,* the donor was 17, and the psychiatrist who examined him concluded: "[H]e should be allowed to make his own independent decision about any matters affecting his welfare."[91] Such a finding could not be made in many cases involving minor donors. The same commentator who suggested that the donor's consent be the sole legal question in transplants involving minors also argued that children under the age of conscription or marriage should never be donors.[92] However, such a rule is undesirably rigid. The law should not deny absolutely the life-saving potential of transplants to individuals for whom the only suitable prospective donors are young minors, especially in cases in which there is an overwhelming probability that the prospective donor would consent were he old enough to make an informed and considered decision.

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[87] The Department of Health, Education and Welfare's regulations regarding funded experiments involving human subjects exemplify the current concern for the rights of the individual. In addition to requiring an assurance that the benefits of the experimental activity warrant the risks to the subjects, the regulations require elaborate procedures for ensuring that consent is informed and voluntary. *See* 45 C.F.R. §§ 46.1-.22 (1974).

[88] *Cf.* Lausier v. Pescinski, No. 668 (Wis., Mar. 4, 1975):

> An incompetent particularly should have his own interests protected. Certainly no advantage should be taken of him. In the absence of real consent on his part, and in a situation where no benefit to him has been established, we fail to find any authority for the county court, or this court, to approve this operation.

Id. at 5 (involving request to authorize kidney transplant from 39-year-old mental incompetent to his sister).

[89] Slip op. at 3.

[90] Daube, Transplantation—Acceptability of Procedures and the Required Legal Sanctions, *in* Ethics in Medical Progress: With Special Reference to Transplantation 188, 199 (G. Wolstenholme & M. O'Connor eds. 1966).

[91] Report of Psychiatric Interview at 2.

[92] Daube, *supra* note 90, at 198-99.

An alternative approach would be to abolish the status of minority altogether.[93] Under this approach, "empirical" differences among children would be the sole basis for making individual exceptions to the general rule of competence.[94] The First Restatement of Torts supported such a subjective standard of competence to consent to intentional invasions of personal interests.[95] However, the Second Restatement abandoned this approach because of its widespread nonacceptance by courts.[96]

Judicial or legislative action lowering the age of consent generally from the present age of 18 appears highly unlikely. Nevertheless, a special rule lowering the age of consent for donation of organs or tissue might be considered. Some jurisdictions have granted minors the power to consent to blood transfusions[97] and to other types of medical procedures.[98] Michigan now has a statute permitting a minor of 14 years or older to give effective consent to a transplant donation to a member of his immediate family.[99] Because of the nature of the decision to serve as a donor in a transplant operation, however, such a special rule seems inappropriate.

A special rule lowering the age for a minor's consent to organ or tissue donation could be justified only if there were sound reasons to believe that minors are more competent to make this decision than other decisions for which competence begins at age 18. However, such decisions are less likely to be within the competence of children. The medical and

[93] *See* Rodham, Children Under the Law, *in* The Rights of Children 22 (1974).

[94] *Id.* In the specific area of consent to medical care, some courts have developed a "mature minor" rule, the effect of which "is to allow a subjective appraisal of at least some cases in which the physicians proceed with nonemergency medical care for minors with only the patient's consent." *See generally* Wadlington, Minors and Health Care: The Age of Consent, 11 Osgoode Hall L.J. 115, 117 (1973). At least one state has codified the "mature minor" subjective approach by providing that consent is effective from "[a]ny unemancipated minor of sufficient intelligence to understand and appreciate the consequences of the proposed surgical or medical treatment or procedures . . . ." Miss. Code Ann. § 41-41-3(h) (1972). In all of the "mature minor" cases, however, a preliminary determination was made that "[t]he treatment was undertaken for the benefit of the minor rather than a third party." Wadlington, *supra* at 119.

[95] Restatement of Torts § 59, comment *a* at 111 (1934).

[96] Savage, *supra* note 57, at 134.

[97] *E.g.*, Ind. Stat. Ann. § 16-8-2-1 (Burns Supp. 1974) (any person 17 years of age or older may give blood in a noncompensatory program without parental authorization); N.Y. Pub. Health Law § 3123 (McKinney Supp. 1974) (same).

[98] *E.g.*, Ind. Stat. Ann. § 16-8-5-1 (1973) (any person is competent to consent to treatment of venereal disease); Mich. Stat. Ann. § 18.1151(1) (1971) (a minor may give valid consent to treatment for drug addiction). An Oregon statute provides that "a minor 15 years of age or older may give consent to hospital care, medical or surgical diagnosis or treatment by a physician . .... without the consent of a parent or guardian." Ore. Rev. Stat. § 109.640 (1974). England has set the age of consent at 16 years for "surgical, medical or dental treatment." The Family Law Reform Act 1969, c. 46, §§ 1, 8. *See generally* Pilpel, Minors' Rights to Medical Care, 36 Albany L. Rev. 462 (1972).

[99] Mich. Stat. Ann. § 27.3178(19b) (Supp. 1974). In order to authorize the donation, the probate court must find that "the prospective donor is sufficiently sound of mind to understand the needs and probable consequences of the gift to both the donor and donee and agrees to the gift." *Id.* The Province of Quebec has enacted a similar provision, Quebec Civil Code art. 20, S.Q. 1971 c. 84, *noted in* Bowker, Experimentation on Humans and Gifts of Tissue: Articles 20-23 of the Civil Code, 19 McGill L.J. 161 (1973).

moral considerations involved in a transplant reach a level of complexity and abstraction with which few children have experience. If the objective of judicial proceedings is to protect the minor from ill-considered action, it appears manifest that minor donors generally should not be treated as adults for purposes of consent to donation.

Perhaps the administrative infeasibility of any other standard for authorizing a minor's participation as a transplant donor will force the courts to allow participation only by those minors who are considered competent to make all personal decisions. However, the development of a reasonable method of applying the best interests test would avoid the necessity of such a restrictive conclusion. Furthermore, as will be discussed below, the unacceptability of considering the minor's consent to be legally effective does not preclude its use as *evidence* in a court's application of the best interests test.

D. *The Best Interests Test Reconsidered*

The *Farinelli* court rejected the best interests test primarily because of its belief that the only available evidence regarding benefit to the donor was "speculative" psychological testimony concerning the relationship between the donor and the recipient.[100] However, it may be possible to develop more concrete evidence on this point. Such evidence would enable courts to apply the best interests test in a more meaningful way.[101]

A number of studies of adults who served as kidney transplant donors indicate that those who have done so have derived great psychological benefit from the experience.[102] The significance to adults of the act of donation provides a strong basis for the conclusion that donation by a minor may well produce psychological benefits, either at the time of the act or in later life, thereby indicating that donation may be in the minor's best interests and that he would consent if he were competent. There is no psychological data, however, to support the view that all children would benefit psychologically. Thus, the question in each case remains whether the donation will be beneficial to the particular prospective donor. Nevertheless, further research into the psychological dynamics of the donation decision and similar decisions may provide a basis for psychiatric testimony that is less speculative than that presented in past cases.[103]

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[100] Slip op. at 5-7, 10.

[101] Psychological testimony is given considerable weight in juvenile proceedings. *See, e.g.,* Painter v. Bannister, 258 Iowa 1390, 140 N.W.2d 152, *cert. denied,* 385 U.S. 949 (1966); Bradbook, The Relevance of Psychological and Psychiatric Studies to the Future Development of the Laws Governing the Settlement of Inter-Parental Child Custody Disputes, 11 J. Fam. L. 557 (1971).

[102] *See* note 21 *supra.*

[103] A significant problem may develop if the psychiatric testimony consists of comparisons between the characteristics of the minor involved and those of others who have benefited from altruistic acts. The danger lies in a court's denying authorization for a particular donor's participation in the transplant because the court finds that the child is not sufficiently unselfish to derive satisfaction from the act. The possibility of harm to the

An important, additional source of evidence of psychological benefit—to be accorded greater or lesser weight depending on the age and maturity of the minor—is the prospective donor's willingness to participate in the transplant operation. In all of the reported transplant cases, except those that involved very young or severely retarded individuals, the prospective donors expressed willingness to make the donations. The fact that the age of consent for most jurisdictions is 18 presumably reflects a legislative belief that each individual who has attained that age is the best judge of what is in his best interests.[104] A reasonable implication of this is that the individual's wishes should be accepted as *evidence* of his best interests, even when society believes that the individual is too young to make the ultimate choice himself.[105] In transplant cases, it is suggested that courts treat the willingness of the prospective donor to participate as positive evidence that the donation would be in his best interests.

Of course, use of the minor's stated desire to participate as evidence of his best interests presents serious problems. In a particular case, it is difficult to determine the relative weight this evidence should be given. It is even more difficult to delineate criteria for determining the ability of a particular minor to decide what is in his best interests. The statutory solution to the competence question—the relatively arbitrary designation of the age of consent—reflects a recognition of the difficulty of developing more flexible criteria. Psychologists and psychiatrists may be no better equipped than lawyers to develop and articulate clear guidelines by which to judge a child's competence.[106] If relatively clear criteria are not formulated, there will be a risk that a cost-benefit analysis will prejudice the court's determination of the "best interests" question in favor of authorizing the transplant. Finally, to the extent that "consent" becomes an impor-

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development of the child from such a finding could be minimized by restricting the testimony regarding psychological benefit to the donor to positive evidence that supports a finding of benefit.

[104] Mill expressed succinctly the basis for generally accepting the individual's judgment of his best interests: "[W]ith respect to his own feelings and circumstances, the most ordinary man or woman has means of knowledge immeasurably surpassing those that can be possessed by any one else." J. Mill, On Liberty, *in* The Utilitarians 475, 554 (1961). Mill recognized, however, that "[t]hose who are still in a state to require being taken care of by others, must be protected against their own actions as well as against external injury." *Id.* at 484.

[105] Several states already make the preferences of children over certain ages binding or extremely strong factors in custody awards. In addition, most states require written consent of the child prior to adoption at a certain age. Kleinfeld, The Balance of Power Among Infants, Their Parents, and the State, Part II, 4 Fam. L.Q. 409, 441-42 (1970).

[106] This possibility was illustrated by an interview with the psychiatrist who testified in Nathan v. Flanagan, Civil No. J 74-109 (Mass., Oct. 4, 1974). Although he was not asked the question in court, he was prepared to testify that the 14-year-old donor was competent to consent to the operation. However, he acknowledged having difficulty upon being asked whether he believed that she would be competent to decide to marry. Upon reflection, he said that he would probably conclude that she was competent to make the marriage decision if he were convinced, after questioning her, that she had deliberated as a competent adult would. Interview with John O'Malley, M.D., Associate in Psychiatry, Children's Hospital Medical Center, Boston, in Boston, Oct. 1, 1974.

tant evidentiary factor, the courts will have to set requirements for obtaining the consent that ensure that it is fully informed and acceptably voluntary.[107] Nevertheless, these problems, although serious, should not be prohibitive. Hopefully, they can be dealt with adequately by establishing procedures that ensure appropriate advocacy for the interests of the donor.[108]

A court adopting this suggestion should accept the willingness of a prospective donor to participate as persuasive evidence if the donor has almost reached the age of majority and appears to be mature. In a case involving a younger child or a mentally incompetent individual, the court should authorize the transplant donation only if the prospective donor's willingness is supplemented by substantial independent evidence of benefit.[109] On the other hand, the prospective donor's unwillingness to participate should preclude the court from authorizing the operation unless there is overwhelming evidence that the operation would promote the donor's best interests.[110]

Among the possible advantages to be obtained by using the donor's willingness to proceed as evidence of his best interests is that, together with other evidence on the question, it might justify authorizing a transplant in cases where the donor is too young to be considered competent even under a lowering of the age of majority.[111] However, when the potential donor is very young or mentally retarded, the best interests standard may still be impossible to satisfy. In order to carry the burden of

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[107] This has already been done, to some extent, by the courts and hospitals in Massachusetts. In recent bone marrow cases, the hospitals have made informal efforts to relieve potential minor donors from any sense of pressure from either the hospital or parents and to supply the minors with all of the information thought relevant to the decision. *But see* Lewis, *supra* note 21, at 228. Guardians ad litem have typically made predeterminations for the court that the consent was informed and voluntary.

[108] For discussion of procedural improvements suggested by this article see notes 133-41 and accompanying text *infra.*

[109] Such independent evidence could include an objective analysis of the alternative consequences of participation in and refusal of a transplant operation. *See* Howard v. Fulton-DeKalb Hosp. Auth., Civil No. B-90430 (Super. Ct., Fulton County, Ga., Nov. 29, 1973) (the recipient—the donor's mother—would probably die if the transplant were not performed); Strunk v. Strunk, 445 S.W.2d 145 (death of the recipient would deprive the retarded donor of his only sibling, with whom the donor had a particularly strong relationship).

[110] *Cf. In re* Seiferth, 309 N.Y. 80, 127 N.E.2d 820 (1955). In that case, the appellate court upheld the lower court's decision not to compel surgery to correct the hairlip and cleft palate of a 14-year-old. The lower court had found that although surgery would be highly beneficial to the child physically, the child's opposition to the operations, based upon his belief in natural healing and his fear of surgery, was sufficient to justify refusing authorization. *Id.* at 82, 127 N.E.2d at 823.

[111] One author has concluded that the lowest age at which the mature minor rule, *see* note 94 *supra,* has been applied is 15 years. Wadlington, *supra* note 94, at 119. The author's conclusion is based on a somewhat controversial interpretation of *Bonner v. Moran,* and the case law may not, therefore, justify an extension as far as 15 years. However, even if this age were accepted, a number of Massachusetts cases have involved donors below that age. *E.g.,* Nathan v. Farinelli, slip op. (six-year-old); Camitta v. Alcorn, Eq. No. 74-23 (Mass., Feb. 14, 1974) (four-year-old donor); Camitta v. Schillinger, Eq. No. 74-18 (Mass., Jan. 31, 1974) (five- and eight-year-old prospective donors).

proof, substantial evidence of benefit other than the donor's willingness to participate will have to be introduced because very little weight, if any, can be given to the fact that the prospective donor is willing. Moreover, in the case of a severely retarded donor, it may be impossible for the donor to realize any psychological benefit.

In those cases in which the best interests standard would not permit a court to authorize the transplant, there are only two alternatives open to society. First, it can refuse to permit the operations despite the profound consequences that a refusal will have for the recipient. Alternatively, it may decide to authorize them not because they will promote the best interests of the donor, but because the operations will promote the best interests of the recipient at an acceptable cost to the donor.[112] However, society could justifiably follow the latter approach only if it were prepared to impose upon all citizens the same obligation.

At the present time our society does not appear ready to require adults to donate organs or tissue for transplantation. Therefore, it is submitted that the only justifiable basis upon which a court may authorize a transplant involving a minor or mentally incompetent donor is on the ground that it will further the best interests of the donor. Unlike the utilitarian standard in *Farinelli,* the best interests test can be administered to afford prospective minor donors the protection that the requirement of consent provides adults. There is, to be sure, a danger that the standard will be applied in such a way that the result is determined sub silentio by weighing the respective costs and benefits. Whether the best interests test will protect adequately the substantive interests of the prospective minor donor is a function of the procedural protections that are afforded the donor at the court hearing.

IV. The Procedural Problems

In the overwhelming majority of bone marrow and kidney transplant cases decided by the Supreme Judicial Court, there has not been adequate representation of the donors' interest in not participating in the transplant. The court has never appointed guardians ad litem to represent prospective kidney donors. Although it has appointed guardians ad litem to represent bone marrow donors, the confusion concerning the proper role of the guardian has precluded uniformly adequate representation. This article will now examine the Massachusetts practice and demonstrate how it has been procedurally unfair to minor donors. The primary recommendation of this article is that representation by guardians ad litem be made mandatory in all transplant cases involving minor donors and that the guardian's role be defined as that of a traditional adversary rather than that of a master.[113]

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[112] *See* text accompanying notes 65-88 *supra.*

[113] Courts have recognized the value of having guardians ad litem represent the interests of children in proceedings involving intrafamily conflict and have employed such guardians in a variety of contexts. *See, e.g.,* Zinni v. Zinni, 103 R.I. 417, 238 A.2d 373 (1968) (custody

A. *The System in Operation*

In the recent bone marrow and kidney transplant cases, the general pattern has been for the hospital to bring a declaratory judgment action against the members of the family before a single justice of the Supreme Judicial Court sitting in trial session.[114] In those cases in which a guardian ad litem is appointed, the court locates an attorney willing to serve in that capacity and appoints him to represent the child.[115] The cases are usually concluded swiftly because of the time pressures created by the critical illness of the potential recipient and the fact that the action is not filed until the doctors have decided to perform a transplant operation and have found a compatible donor. Frequently, less than a week elapses between the commencement of the action and the hearing on the merits.[116] After a short evidentiary hearing, the court authorizes the transplant and thereby immunizes the hospital from liability for any nonnegligently caused injuries. Although an appeal from a decision of a single justice lies to the full bench of the Supreme Judicial Court,[117] no appeal has ever been taken.

The prospective kidney donor suffers more from procedural unfairness because no guardian ad litem is appointed to represent his interests. One side of the litigation will be controlled by the prospective donor's parents, who will have decided that the transplant should take place.[118] The other side will comprise the attending physicians and the hospital,

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proceeding); Wendland v. Wendland, 29 Wis. 2d 145, 138 N.W.2d 185 (1965) (custody proceeding). *See also* Campbell, The Neglected Child: His and His Family's Treatment Under Massachusetts Law and Practices and Their Rights Under the Due Process Clause, 4 Suffolk L. Rev. 631, 681-84 (1970); Hansen, Guardians Ad Litem in Divorce and Custody Cases: Protection of the Child's Interests, 4 J. Fam. L. 181 (1965); Note, An Appraisal of New York's Statutory Response to the Problems of Child Abuse, 7 Colum. J.L. & Soc. Prob. 51, 67-68 (1971).

[114] Such cases have also been tried in the Suffolk County Probate Court. However, because those records have been impounded on motion of counsel for the plaintiff, Massachusetts General Hospital, little is known about these cases and they will not be considered in this section. *See* note 48 *supra.*

[115] The guardians ad litem who have represented bone marrow donors have generally been volunteers because the prospective donor is not in a position to pay counsel fees and because the Supreme Judicial Court is understandably reluctant to tax counsel fees either to Suffolk County, the Commonwealth, or the petitioner hospital.

[116] Counsel for the Children's Hospital Medical Center have taken the position that no action should be filed until the transplant physicians are certain that an acceptable donor is available. However, once such a donor is identified, the doctors generally press for immediate permission to perform the transplant. Thus, the filing of a complaint is usually followed by the setting of an immediate hearing date. Such a situation makes adequate representation of the donor extremely difficult because the guardian ad litem can hardly be expected to prepare his case in the space of several days. Further, the situation can lead to abuse. For instance, in *Farinelli,* the original complaint was filed in April 1974, but, because of changing medical circumstances, no action was taken to appoint a guardian ad litem until two months later. Counsel for the Children's Hospital Medical Center nevertheless insisted on an immediate hearing following the guardian's appointment. The hearing was postponed for a week, but it could have been further postponed because the transplant did not occur for several weeks thereafter.

[117] Mass. Gen. Laws ch. 214, §§ 19-29 (Supp. 1974-1975).

[118] *See* Curran, *supra* note 2, at 892.

who also will have determined that the transplant should go forward but who are unwilling to perform it unless the court insulates them from liability.[119] Both sets of parties, therefore, want the court to issue a decree authorizing the transplant.[120] No one represents whatever interest the child may have in not donating an organ or tissue. Consequently, it is unusual to find more than a pretext of adverseness on any issue. The family is often represented by its own counsel, but invariably the parents admit or allege the facts necessary for authorization of the operation.[121]

It is highly unlikely that such proceedings can attain their ostensible objective of protecting the prospective donor's substantive interest in not participating in the operation. The hospital and the parents assuredly are not engaged in a dispassionate search for truth. They want the transplant to occur and go into court with the intention of proving that the participation of the prospective donor is consistent with whatever standard the court decides to apply. Because no party presents any evidence or arguments that indicate that the child should not donate a kidney, the only possible source of opposition to the petition for declaratory relief is the judge, who might take the initiative and question the favorable evidence and arguments of the parents and hospital. Unfortunately, there is little incentive for a judge to adopt such a posture. He may recognize the grave consequences of denying authorization and may perceive that the probable benefits to the recipient outweigh the possible costs to the donor. When no one is charged with the responsibility for developing the case on behalf of the donor nor anxious to raise all evidence and issues favorable to the donor, it becomes too easy for the judge to gloss over the evidence and issues in an effort to reach quickly and efficiently what seems to be the right result. Of course, such action need not reach the level of a conscious effort to take the path of least resistance. It may operate merely through the unconscious development of a mental set as to the merits of the case, blinding the judge to the lines of opposing argument and evidence that could have been developed.[122]

The absence of adversary proceedings in these cases undoubtedly also has contributed to the failure of the courts to develop adequate substantive standards and to apply them consistently. Because advocates are not

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[119] *See, e.g.,* Petition for Declaratory Relief, Nathan v. Farinelli, slip op.; Curran, *supra* note 2, at 892.

[120] It is arguable that this coincidence of interests deprives the court of jurisdiction over the subject matter. *Cf.* Pickard v. Worcester, 338 Mass. 644, 156 N.E.2d 689 (1959) (there must be an actual controversy between the parties for an action for declaratory relief to lie).

[121] *See, e.g.,* kidney transplant cases cited note 15 *supra.*

[122] A joint committee of the American Bar Association and the American Association of Law Schools has cogently described the consequences of dispensing with adversary presentation of evidence and arguments.

> [F]ailure generally attends the attempt to dispense with the distinct roles traditionally implied in adjudication. What generally occurs in practice is that at some early point a familiar pattern will seem to emerge from the evidence; an accustomed label is waiting for the case and, without awaiting further proofs, this label is promptly assigned to it.

Report of the Joint Conference on Professional Responsibility of the Joint Conference of the American Bar Association of American Law Schools, 44 A.B.A.J. 1159, 1160 (1958).

present to question the courts' bases for issuing the requested decrees, no one has challenged the courts to justify their results.

The procedural unfairness to prospective donors has been partially mitigated in those cases in which the Supreme Judicial Court has appointed guardians ad litem to represent the minor donors. Ironically, the Massachusetts practice has been to appoint guardians in cases involving bone marrow transplants, which generally entail only minimal risks to the donors, but not in cases involving kidney transplants, which pose a significantly greater threat to the well-being of the donors.[123] Yet, even when guardians ad litem have been appointed, frequently they have not fully represented the interests of the prospective donors. There are a number of reasons why they have not been fully effective.

The first is that the court often has appointed guardians who were not disposed to represent the prospective donors with vigor. In several bone marrow cases, doctors, rather than lawyers, were appointed.[124] As a class, doctors certainly are likely to be more sensitive to the medical aspects of the operation than to the donors' interests. This sensitivity may prejudice such guardians' judgment of their wards' interests. In these cases, moreover, the court appointed doctors who were employed by the very hospitals seeking authorization to perform the operations, thereby creating serious conflicts of interests. Even in the absence of such conflicts, doctors are less likely to represent minor donors effectively than are lawyers, who are accustomed to vigorous advocacy.

The second reason is that, in most cases, the guardians have functioned as masters rather than as advocates;[125] they have conducted individual investigations into the facts of the cases and have reported their findings and conclusions to the courts, which have adopted them without exception.[126] Adopting the role of a master is both natural and understandable

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[123] *See* note 20 *supra.*

[124] *See, e.g.,* Camitta v. Fager, Eq. No. 73-171 (Mass., Sept. 5, 1973); Camitta v. Martinez, Eq. No. 73-158 (Mass., Aug. 23, 1973); Camitta v. O'Mealia, Eq. No. 73-86 (Mass., Apr. 25, 1973); Nathan v. Clark, Eq. No. 73-71 (Mass., Apr. 12, 1973).

[125] The traditional view of the proper role of the guardian ad litem in most court proceedings is that he is under an obligation to adopt an adversary posture on behalf of whatever substantive interests his ward might assert. *See* Tyson v. Richardson, 103 Wis. 397, 399-400, 79 N.W. 439, 440 (1899). The guardian's duty to take all lawful steps to secure a judgment favorable to his ward precludes the guardian from making any concessions. *See* Rankin v. Schofield, 71 Ark. 168, 66 S.W. 197 (1902). The guardian, in addition, lacks the power to bind his ward by admissions, waivers and stipulations, except as to minor procedural matters that do not affect the ward's substantive rights. *See* Kingsbury v. Buckner, 134 U.S. 650, 680 (1889). However, guardians ad litem have functioned quite differently in some family law proceedings in recent years. *See* notes 126, 134 *infra.*

[126] Apparently, this is a familiar role for guardians ad litem in some jurisdictions. Guardians ad litem in Maryland and Virginia continue to perform in this manner in bone marrow cases handled for the National Institutes of Health. *See In re* Bostrum, Eq. No. 49385 (Cir. Ct., Montgomery County, Md., June 7, 1974); *In re* Bachman, Fid. No. 20828 (Cir. Ct., Fairfax County, Va., Aug. 9, 1974).

Statutory authorization exists for the appointment of guardians in certain Massachusetts probate proceedings, Mass. Gen. Laws Ann. ch. 215, § 56A (Supp. 1974-1975), and the Supreme Judicial Court has the inherent power to appoint guardians in other proceedings.

for attorney-guardians. Attorneys are accustomed to making critical decisions for their clients based either on consultation with their clients or on the attorneys' views of what is in the best interests of the clients. In these transplant cases, the guardians' wards are incompetent to give them direction. Hence, it is natural for the guardians to make strategic decisions for the prospective donors based on their own determination of their clients' best interests.

The guardian's adoption of the role of master seriously undermines the judicial decision-making process. A guardian-master necessarily will make decisions based solely on his own investigations. If, for example, the guardian decides that the donor is likely to benefit, he will decide this question without the aid of adversary development of the evidence. Because of this predetermination, the guardian may not present the court with arguments and evidence that suggest that the ward might not benefit. The court, consequently, cannot decide on the basis of a fully developed record whether the donor's participation is consistent with the applicable standard.

Several guardians have been reluctant to adopt the role of master because they realized that to do so would leave their wards unrepresented. The guardian in *Camitta v. Schillinger*[127] seriously questioned the propriety of functioning as a master, and the guardian in *Nathan v. Farinelli* refused to instruct the court as to whether he believed the donation would be best for the prospective minor donor, contending that it was the court's responsibility to make the critical factual and legal determinations based upon a record fully developed by adversaries.[128] The guardian believed that the only means by which he could effectively represent his ward would be to refuse to make findings concerning the best interests question and to present the evidence and arguments oppos-

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See Doe v. Doe, 1974 Mass. Adv. Sh. 1089, 314 N.E.2d 128. Both the Supreme Judicial Court and the probate courts have broad discretion in defining the guardian's role. Doe v. Doe, *supra,* in which an estranged husband sought to enjoin his wife from having an abortion, illustrates the extent to which guardians ignore the interests of their ward in court proceedings. In *Doe,* the guardian who was appointed to represent the interests of the fetus took the position that his ward had no rights to be protected in the litigation and filed a brief supporting this view. The court permitted the guardian to advocate this position although it was clearly antagonistic to that of his ward. The court then permitted another member of the bar to present the contrary position. Although the court's opinion fails to discuss the novel problems of the guardian ad litem's professional responsibility, it seems that the guardian ad litem, admittedly faced with a difficult decision, acted improperly. Rather than sacrifice the interests of his ward, he should have withdrawn from the case. Furthermore, the court should have stricken his brief and appointed another individual—most appropriately, the lawyer who did defend the fetus' interests. *See In re* Jaeger's Will, 218 Wis. 1, 11-12, 259 N.W. 842, 846 (1935), in which the court struck the guardian's brief under analogous circumstances. Although *Doe v. Doe* may be a striking example of confusion over the proper role of the guardian ad litem, it is not unusual. The guardians in the bone marrow cases have taken similar action, *see, e.g.,* Report of Guardian Ad Litem, Nathan v. Dyer, Eq. No. 72-177 (Mass., Dec. 11, 1972), and probably will continue to do so until instructed to abandon the role of a master.

[127] Eq. No. 74-18 (Mass., Jan. 31, 1974).

[128] *See* Report and Memorandum of Guardian Ad Litem.

ing the position taken by the hospital and the parents.[129] To develop a suitable record for the court, therefore, the guardian filed motions and presented the evidence and arguments that supported denial of authorization of the transplant.[130] However, there have been very few Massachusetts cases in which the guardians ad litem have adopted an adversary position.[131]

A third reason most guardians have not been effective is that they usually are given little time to develop cases on behalf of donors—often less than five days.[132] This problem has been aggravated by the fact that few guardians have had the opportunity to develop expertise in the area.

The final reason that the guardians ad litem have not provided their wards with effective representation is that some justices of the Supreme Judicial Court have resisted the introduction of full adverseness into these proceedings.[133] The justices' resistance is partly a consequence of their natural distaste for subjecting family members to full adversary inquiries. But here, as in intrafamily and juvenile delinquency proceedings, the imposition of some emotional burdens on family members is necessary because the interests protected by the process are substantial and the costs of using a nonadversarial system are quite high.

B. *Means to Ensure Effective Representation of the Prospective Donor*

Courts should be required to appoint guardians ad litem to represent prospective minor donors in all transplant proceedings. The guardian's role should be defined as that of an advocate of the child's interest in not acting as a donor; the guardian should be instructed to present all the evidence and arguments against his ward's donation and to oppose the positions taken by the hospital and family, regardless of the guardian's personal perception of the child's actual interests.

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[129] The statement of the guardian ad litem in *Farinelli* summarizes the reasons he adopted an adversary posture.

> While one might be greatly tempted to conclude that the [donor's] interests in this case can best be advanced by permitting her participation in the proposed procedure, I have reached the conclusion that this is a judgment for the Court to make. To my mind, the best way I can zealously protect and advance my client's interests is to assure that she is provided with due process of law, and due process cannot be afforded unless the Court has the benefit of a full adversary proceeding.

Id. See also Kay & Segal, The Role of the Attorney in Juvenile Court Proceedings: A Non-Polar Approach, 61 Geo. L.J. 1401, 1413-15 (1973).

[130] The motions included a motion to dismiss or for an order authorizing an adversary proceeding, a motion for continuance, a motion to dismiss for lack of subject matter jurisdiction, a motion to dismiss for failure to join an indispensable party (the United States), a motion to dismiss for failure to state a claim upon which relief can be granted, and an answer containing counterclaims and cross-claims.

[131] *Farinelli* and Nathan v. Flanagan, Civil No. J 74-109 (Mass., Oct. 4, 1974), are the two most prominent cases.

[132] *See* note 116 *supra.*

[133] For example, the judge in Nathan v. Flanagan, Civil No. J 74-109 (Mass., Oct. 4, 1974), resisted the guardian's efforts to function as a full adversary. In the pretrial conference, the judge stated that it was his desire that the guardian ad litem express his opinion as to the correct result in the case.

The circumstances surrounding these proceedings strongly support having the guardian perform such a function. Unless there is someone who advocates that no operation occur, there is no assurance that the arguments against the donor's participation will ever be seriously considered. Further, it is too easy for anyone, even with the best motives, to slip into a cost-benefit analysis and advocate to the court that the operation proceed. A transplant proceeding arguably differs from a juvenile delinquency case, for example, where, at least in theory, all concerned advocate the optimal treatment among several alternative dispositions that are theoretically designed to serve the best interests of the child.[134] Even in juvenile delinquency proceedings, however, the role of the guardian is the subject of considerable controversy,[135] and there is an emerging trend toward having the child's guardian function as more of a traditional adversary.[136]

In transplant cases there are only two possible dispositions, and the parents and the hospital will provide all the evidence and arguments in support of authorization. What is institutionally necessary if the prospective donor is to be protected adequately is not the guardian's more objective opinion whether the operation is in the child's best interests but a party to present the arguments that support denying authorization.

Although it is essential that the guardian adopt a posture opposed to the transplant and present all the evidence and arguments in support of denying authorization, it does not follow that the guardian should be obligated to take every action that will diminish the likelihood of the authorization of the operation. The guardian's function is to facilitate the development of a full record and thus increase the likelihood that the court's disposition will be consistent with the proper substantive standard. The guardian need not employ every available strategy nor appeal every unfavorable decision. However, he should attempt to discredit any evidence introduced by the hospital, even if he believes it to be essentially accurate. The determination of the accuracy of the evidence is the court's function, not the guardian's. Like any other adversary, the guardian should not feel obligated to reveal evidence that favors the hospital's position but that its counsel failed to discover. Unless counsel for each side feels tested, there is the danger that neither side will be motivated to put forth its best efforts.[137]

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[134] For discussions of both the adversary and nonadversary aspects of the attorney's role in representing the child in delinquency proceedings see Coxe, Lawyers in Juvenile Court, 13 Crime & Delinq. 488 (1967); Ferster, Courtless & Snethen, The Juvenile Justice System: In Search of the Role of Counsel, 39 Fordham L. Rev. 375 (1971); Isaacs, The Role of the Lawyer in Representing Minors in the New Family Court, 12 Buffalo L. Rev. 501 (1963); Kay & Segal, *supra* note 129; McMillan & McMurty, The Role of the Defense Lawyer in the Juvenile Court: Advocate or Social Worker, 14 St. Louis L.J. 561 (1970); Comment, The Attorney-Parent Relationship in the Juvenile Court, 12 St. Louis L.J. 603 (1968); Comment, The Attorney and the Dispositional Process, 12 St. Louis L.J. 644 (1968).

[135] *See* McMillan & McMurty, *supra* note 134.

[136] *See, e.g., In re* Gault, 387 U.S. 1 (1967); Kent v. United States, 383 U.S. 541 (1966).

[137] Justice Jackson's observations concerning the analogous area of pretrial discovery are

Determining which tactics are justified by the need for the development of the record will be difficult and will require the careful reflection of experienced, dedicated guardians. To promote the development of the necessary expertise, this article recommends that a panel of guardians be established to serve as advocates for the donors in all transplant cases. Such a system would help attorneys acquire experience in functioning as guardians and would enable them to develop the medical and psychological expertise they need to function effectively.

To increase the protection afforded the prospective donor, the Massachusetts legal system should take two further steps. First, to provide a guardian ad litem with sufficient time to develop the donor's case, the legislature should require that the hospitals notify the court at the earliest possible time of the possibility that it will request court authorization of a transplant involving a particular minor donor. Second, to provide a better environment for hearing these cases, the legislature should encourage their trial in the probate court. The probate court is experienced in dealing with problems involving intrafamily conflict and tension,[138] and probate judges probably will be far more comfortable with the distasteful necessity of subjecting parents to adversary inquiry than will the justices of the Supreme Judicial Court.

The introduction of genuine adverseness into transplant proceedings unquestionably has its costs. It will be painful for the family to subject itself to adversary inquiries. The procedural tactics or arguments may delay the authorization of urgent medical procedures and exacerbate the parties' feelings of guilt and depression. Trial of these cases in the probate courts might mitigate these consequences, but, in any event, the benefits of adverseness are substantial. It was not until the cases characterized by vigorous advocacy on the behalf of the donor that the Massachusetts courts finally confronted several problems squarely: the basis upon which transplants should be authorized;[139] the measures that should be taken to compensate the donor for injury resulting from the donation procedure;[140] and the dangers of donating bone marrow.[141] Increased and more sophisticated use of the adversary process in these cases should both improve the explicit development of the substantive legal principles involved and provide prospective donors with the best possible protection against ill-considered action.

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particularly apt in this context: "[A] common law trial is and always should be an adversary proceeding. Discovery was hardly intended to enable a learned profession to perform its function either without wit or on wits borrowed from the adversary." Hickman v. Taylor, 329 U.S. 495, 516 (1947) (concurring opinion).

[138] The jurisdiction of the Probate Court is set forth in Mass. Gen. Laws Ann. ch. 215, § 3 (Supp. 1974-1975). The Probate Court has been able to retain a sense of informality during essentially adversarial proceedings. *See* Interview with Judge Mary Fitzpatrick, *supra* note 19.

[139] Nathan v. Farinelli, slip op.

[140] Nathan v. Flanagan, Civil No. J 74-109 (Mass., Oct. 4, 1974); Nathan v. Farinelli, slip op.

[141] Nathan v. Flanagan, Civil No. J 74-109 (Mass., Oct. 4, 1974); Nathan v. Farinelli, slip op.

V. Compensating the Donor for Harm Caused by Participation in the Transplant

Thus far, this article has analyzed the Massachusetts transplant authorization procedure in terms of its capacity to protect a prospective minor donor's interest in not serving as an organ or tissue donor. However, the legal system's concern with the prospective donor should not end with the court's authorization of the transplant operation. Even when the court finds that participation is in the minor donor's best interest, a possibility exists that the donor will suffer serious physical or psychological harm.[142] Because donation by a minor is an act of extraordinary altruism performed in a context in which the critical decisions are made not by the minor donor but by a judicial tribunal, forcing the child to bear any loss resulting from the donation seems grossly inequitable. Therefore, it is highly desirable that the legal system develop a method for compensating minor donors for any harm they suffer as a result of their participation in a transplant procedure.

No adequate system for donor compensation exists in Massachusetts. The effect of the suits brought before the Supreme Judicial Court has been to immunize the hospital and doctors from liability for nonnegligently caused injuries.[143] Of course, the possibility exists that an injured donor could bring a tort action against the recipient or his parents.[144] However, intrafamily litigation obviously is not a desirable method of compensating injured donors. First, the donor may experience difficulty collecting a judgment in his favor. More important, the donor will naturally hesitate to sue members of his own family. It seems inequitable not to

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[142] *See* note 20 *supra.*

[143] *See, e.g.,* Nathan v. Farinelli, slip op.; Masden v. Harrison, slip op. Cases in other jurisdictions have assumed a variety of forms, including petitions for approval of parental consent, *In re* Bachman, Fid. No. 20828 (Cir. Ct., Fairfax County, Va., Aug. 9, 1974), for authority for an incompetent's committee to approve a transplant, Strunk v. Strunk, 445 S.W.2d 145, for declaratory and injunctive relief, Howard v. Fulton-DeKalb Hosp. Auth., Civil No. B-90430 (Super. Ct., Fulton County, Ga., Nov. 29, 1973), and an action by one parent to compel the consent of another, Smith v. Smith, Eq. No. 43919 (Cir. Ct., Montgomery County, Md., July 19, 1972).

[144] Because the donor, recipient and parents are all defendants in the typical suit, it is unlikely that the standard decree would preclude a determination in a subsequent proceeding that the recipient or parents were liable to the donor. *See* F. James, Civil Procedure § 11.24 (1965).

An injured child is free to seek tort damages from a sibling, H. Clarke, The Law of Domestic Relations in the United States § 9.3 (1968), and recently many courts have permitted children to sue their parents for intentional torts despite traditional family law principles to the contrary. *See id.* § 9.2, at 258-60; W. Prosser, *supra* note 5, at 867-68. In any event, the parents would be required to support the donor beyond majority if he were injured by the donation and became totally dependent upon them. *See, e.g.,* Perla v. Perla, 58 So. 2d 689, 690 (Fla. 1952); Strom v. Strom, 13 Ill. App. 2d 354, 361-67, 142 N.E.2d 172, 176-79 (1957); *In re* Estate of Glass, 175 Kan. 246, 250, 262 P.2d 934, 937 (1953); Clark v. Graves, 282 S.W.2d 146, 148 (Ky. 1955); Van Tinker v. Van Tinker, 38 Wash. 390, 391, 229 P.2d 333, 335 (1951). Some states now impose by statute a duty upon parents to support any child unable to maintain himself. *See, e.g.,* Ga. Code Ann. § 23-2302 (1974); N.D. Cent. Code § 50-01-19 (1974). Thus, on the basis of either common law or statute, parents in most states would have a duty to support a child injured and incapacitated as a result of participating as a transplant donor.

provide the minor donor with a more satisfactory means of obtaining compensation.

A possible solution may be for the court to require insurance coverage for the donor as part of its decree authorizing the transplant operation. The question then becomes whether the recipient, parents, or hospital should pay the insurance premium. If the insurance premium were treated as part of the cost of medical care for a transplant recipient, the cost would probably be paid by the recipient's medical insurer.[145] Alternatively, the court might require the parents to procure insurance covering possible injuries to the donor. Both of these possibilities are unsatisfactory because of the reluctance of insurance companies to provide coverage on a case-by-case basis.[146] The hospital is in the best position to negotiate with the insurance companies for comprehensive protection of transplant donors.[147] An insurance company would be understandably hesitant to issue a policy covering a single individual because of the difficulty in determining an appropriate premium. Moreover, in the typical transplant case, the recipient or parents would be seeking coverage on short notice.

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[145] Some health insurers—for example, CHAMPUS, the military insurance program for dependents of armed forces personnel—already assume the costs of the subsequent medical care. Interview with Albert Broseghini, Ph.D., Director of Research Administration, Children's Hospital Medical Center, Boston, in Boston, Oct. 9, 1974. *See generally* 32 C.F.R. §§ 577, 728, 732 (1974).

[146] Lloyd's of London, for example, is interested in providing strict liability insurance of the kind sought in *Farinelli* but believes that serious involvement of the hospitals and medical schools in the Boston area would make a substantial difference in the cost and coverage of any insurance that Lloyd's might provide. Interview with James Longacre, Wohlreich & Anderson (agent for Lloyd's of London), in Boston, Sept. 11, 1974; *see* Transcript of Hearing, Oct. 9, 1974, at 42-44, Nathan v. Farinelli, slip op. *But see id.* at 38-39.

[147] Children's Hospital Medical Center has recently entered negotiations with several insurance companies to provide a medical benefit program for minor bone marrow donors. One company out of the seven that were contacted expressed an interest in developing an acceptable policy. Its preliminary proposal called for a premium of $50 per donor and the following scale of benefits: $250,000 for accidental loss of life; $250,000 for dismemberment or loss of sight; and up to $2,500 per month in cases of total disability. The insurance company would exclude coverage for mental illness because such illness would be extremely difficult to diagnose. A. Yarchin & Co., Inc., Accident Proposal for Children's Hospital Medical Center (on file at Boston University Law Review).

These negotiations indicate the magnitude of the problems that will accompany attempts to develop satisfactory insurance coverage for injured minor donors. Although one insurance company did indicate a willingness to develop the coverage, it did so "not because of sound business pursuit, but only because of their relationship with [Children's Hospital's agent] and their accepted civil and moral attitude to help Children's Hospital." Letter from Michael A. Virusso, A. Yarchin & Co., Inc., to Jeffrey W. Lemkin, Feb. 14, 1975 (on file at Boston University Law Review). The other insurance companies that were contacted had several objections to providing coverage and expressed a general unwillingness to work with the hospital.

However, the Aetna Insurance Company has provided the University of Washington with insurance coverage protecting subjects of human experimentation from nonnegligently caused injuries for several years at a cost of $.50 per experimental subject. The coverage is a rider to the University's professional malpractice coverage and has a total cost of $17,500 per year for 35,000 experimental subjects. Letter from Diana McCann, Director of Research Services, University of Washington, Seattle, to Garrick Cole, July 2, 1974 (on file at Boston University Law Review).

On the other hand, the insurance company might be considerably less hesitant to negotiate with the hospital for an insurance plan covering all prospective minor donors. Insurance companies would appear to be better equipped to devise a plan covering a class of persons than they would be to offer protection to a single individual against a fairly unusual sort of risk. Additionally, the hospital undoubtedly would seek coverage well in advance of any particular transplant case if it were required to insure all prospective minor donors. Consequently, the insurance company and hospital would have sufficient time to arrive at reasonable rates.

Several courts have demonstrated a willingness to impose the costs of insurance on the medical providers. One Maryland court's decree expressly reserved the question whether the providers would be required to offer the donor follow-up psychiatric care.[148] In two cases, the Supreme Judicial Court has considered requiring the hospital and doctors to obtain adequate strict liability insurance for the donor.[149] As part of the decree in *Farinelli,* the court required the hospital, its counsel and the guardian ad litem to exert their best efforts to obtain such insurance "at a reasonable cost" before the transplant operation took place.[150] Unfortunately, the process of procuring reasonably priced insurance took more time than the urgency of that case permitted. The guardian was able to make tentative arrangements for coverage with Lloyd's of London, but the court found the policy to be unreasonable and authorized the transplant to go forward without insurance.[151] *Farinelli* is evidence of the difficulty of developing adequate, reasonably priced insurance coverage on a case-by-case basis.

Finally, there is a possibility that the federal government might assume part of the cost of obtaining insurance for minor donors. Bone marrow transplant operations are partly financed by grants from the National Institutes of Health.[152] In two cases, the National Institutes of Health committed itself to insure against any medical costs that might be incurred by the donor as a result of the transplant.[153]

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[148] Smith v. Smith, Eq. No. 43919, at 2 (Cir. Ct., Montgomery County, Md., July 19, 1972).

[149] Nathan v. Flanagan, Civil No. J 74-109 (Mass., Oct. 4, 1974); Nathan v. Farinelli, slip op.

[150] Partial Judgment and Interlocutory Order at 2.

[151] Justice Quirico, who decided the *Farinelli* case, held a hearing on the issue of donor insurance in chambers on August 23, 1974. After examining the only policy that was available at that time, which would have covered only death and permanent disability for a premium of about $650, the judge declined to order its purchase.

[152] Support from the National Institutes of Health and its component National Cancer Institute takes a variety of forms. For example, direct grants support the Clinical Research Center at the Children's Hospital Medical Center in Boston, and these funds are available to defray the costs of bone marrow transplants that are not recoverable from private insurers. *See* Interview with Dr. Albert Broseghini, *supra* note 145. The National Institutes of Health also provides technical services in these cases—for example, the provision of platelets for a recipient who has become sensitized to those available locally. Interview with Dr. David Nathan, *supra* note 17.

[153] Affidavit of Robert G. Graw, Jr., M.D., Head of Experimental Hematology Section,

Thus, the most effective means of protecting the minor donor would seem to be to require the medical personnel to procure broad insurance policies covering all transplant donors.[154] Until the legislature enacts a statute imposing this duty on the medical providers, courts should require insurance coverage as a condition to authorizing the minor donor's participation in the operation.

VI. Conclusion

As previously noted, the Massachusetts Special Legislative Commission Concerning Human Clinical Investigation and Experimental Therapy recently created a subcommittee to consider whether there is a need for special legislation concerning organ and tissue transplants from minors. This development is a favorable one because the legislature is best able to develop solutions to the problems that this article has described.

The Commission can perform a valuable service by considering the standard that the courts should apply in deciding whether a prospective donor should be permitted to participate in a transplant. In view of the problems inherent in requiring a minor to serve as a donor in situations in which it is *not* in his best interests, the best interests test should not be abandoned as the sole permissible basis for authorizing a minor's organ or tissue donation without further study. The kind of study that is needed is most properly done by an investigative commission of the legislature. A determination whether the best interests standard is workable in most cases requires careful consideration both as to the probability that minor donors will receive significant psychological benefit from participation in the operation and as to the medical profession's capacity to predict such benefit in individual cases. To determine what weight, if any, should be given to the prospective donor's willingness to participate, the Commission should consider studies concerning the ability of minors of varying ages to ascertain what is in their best interests. Investigations of this scope are beyond the institutional competence of a trial court, especially one that must render a decision in the life or death context of a typical transplant case. On the other hand, it is precisely the type of an inquiry that a properly staffed legislative commission is institutionally designed to conduct.

If our legal system is to abandon the best interests test in favor of a standard that empowers the parents to require a child to serve as a donor

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Pediatric Oncology Branch, National Cancer Institute, National Institutes of Health, Bethesda, Md., *In re* Bachman, Fid. No. 20828 (Cir. Ct., Fairfax County, Va., Aug. 9, 1974); Affidavit of James A. Stauchen, M.D., Clinical Associate, Pediatric Oncology Branch, National Cancer Institute, National Institutes of Health, Bethesda, Md., *In re* Rabins, Eq. No. 50190 (Cir. Ct., Montgomery County, Md., Sept. 9, 1974).

[154] Some commentators have argued that the federal government should provide disability insurance for all subjects of experimentation. *See* Statement of Points and Authorities Supporting Motion to Dismiss 10-15, Nathan v. Flanagan, Civil No. J 74-109 (Mass., Oct. 4, 1974); Note, Medical Experiment Insurance, 70 Colum. L. Rev. 965 (1970). Some governmental programs have done so. *E.g.*, Federal Employee's Compensation Act, 5 U.S.C. § 8101 (1974). *See also* Capron, *supra* note 86, at 148.

whenever the costs are acceptable—regardless of his best interests—the appropriate branch of the legal system to do so is the legislature. For our society to obligate one of its members to make this type of sacrifice would constitute such a departure from our common law tradition that only the legislature should take such action. The use of such a standard and its application raises profound questions of democratic political philosophy.

Although the Massachusetts courts have the inherent power to institute the needed procedural reforms, the Commission recommendations in this area will be valuable either to provide the impetus for judicial reform or, in its absence, to lay the groundwork for a legislative solution. The reforms that are needed are uncomplicated but essential to the protection of the class of prospective minor donors. The legal system must develop some means to supply prospective minor donors with effective representation of their interests in not participating in the transplant. This article's primary recommendation is that the prospective minor donor be supplied with a guardian ad litem who is instructed to present all evidence or arguments adverse to the authorization of the transplant.

A final area in which the Commission could serve a valuable function is in recommending means to compensate minor donors for harm caused by their participation in the operation. The most appropriate means for doing so is the development of a system of mandatory disability insurance. Legislative action is probably necessary to establish such coverage because courts are restricted to responding to the needs of the cases before them.

It has been 18 years since the Supreme Judicial Court was first called upon to deal with the difficult problems presented by this area of the new forensic medicine. It is time that the Massachusetts legal system take action to ensure that prospective minor donors are afforded the protections that the original decisions first attempted to provide.