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Proposed Legislation for Safely Regulating the Increasing Number of Living Organ and Tissue Donations by Minors

INTRODUCTION

The increasing shortage of transplantable organs and tissues has been widely documented.¹ According to data released by the United Network for Organ Sharing (UNOS),² more than six thousand patients died in the United States during 1999 while awaiting an organ transplant.³ These statistics reveal a disappointing nineteen percent increase over the total deaths in 1998.⁴ Data on tissue donation are not as readily available. However, the shortage of transplantable tissues has been blamed for countless deaths.⁵

Due to the shortage of transplantable organs and tissues, the medical profession has begun to view alternative donor sources with increasing approval. Cadaveric donors are no longer the sole source of transplantable organs and tissues; in fact, the number of living organ donors now rivals the number of cadaveric organ donors.⁶ There were 5,848 cadaveric organ donors in the United States in 1999,

1. See Charles T. Carlstrom & Christy D. Rollow, *Organ Transplant Shortages: A Matter Of Life And Death*, USA Today, Nov. 1999, at 50 ("The growing shortage of transplantable organs has reached crisis proportions and is getting worse."); Joyce Howard Price, *A Dearth Of Donor Organs*, Insight On The News, June 28, 1999, at 41; TransWeb's website, (visited June 6, 2000) <<http://www.transweb.org>> (discussing the shortages in transplantable tissues) (quoting Tom Taddouio, Director, University of Michigan Skin Bank). In Louisiana, only one out of four patients waiting for a kidney transplant will receive one because of the shortage of suitable kidney donors. See The National Kidney Foundation of Louisiana's website, (visited June 9, 2000) <<http://www.gnofn.org/~kidneyla/>>.

2. The United Network for Organ Sharing [hereinafter UNOS] is a private, nonprofit, membership corporation qualified as a charitable organization under section 501(c)(3) of the Internal Revenue Code. UNOS administers the national Organ Procurement and Transplantation Network (OPTN) and the U.S. Scientific Registry on Organ Transplantation under contracts with the U.S. Department of Health and Human Services. The U.S. Scientific Registry is the most complete medical database in the world, tracking all solid organ transplants since Oct. 1, 1987. See UNOS's website, (visited June 6, 2000) <<http://www.unos.org>>.

3. See UNOS's website, *supra* note 2. The actual number of patients who died awaiting an organ transplant in 1999 was 6,012 compared to 5,034 in 1998. Patients waiting for an organ transplant increased by twelve percent in 1999. There were 67,755 patients on the waiting list at the end of 1999 compared to 60,656 at the end of 1998. The waiting list has continued to grow in 2000 and as of April 18, 2000, stood at 68,905. *Id.*

4. *Id.*

5. See Mark F. Anderson, *Encouraging Bone Marrow Transplants From Unrelated Donors: Some Proposed Solutions To A Pressuring Social Problem*, 54 U. Pitt. L. Rev. 477, 479 (1992) (discussing bone marrow donation and stating "despite the existence of millions of potential donors, many lifesaving transplants are never performed"); see TransWeb's website, *supra* note 1.

6. A donation by a "living organ donor" and "living tissue donor" refers to a donation wherein the donor is "living." A "living organ donor" and "living tissue donor" should be contrasted respectively from a "cadaveric organ donor" and "cadaveric tissue donor" wherein the donor is deceased. See Transplant Square's website, (visited June 9, 2000) <<http://www.transplantsquare.com>>. "Living organ and tissue donors" are further subdivided into "living related organ and tissue donors" and "living unrelated organ and tissue donors." See UC Davis Transplant Center's website, (visited

only forty-one more than in 1998; however, there were 4,662 living organ donors in the United States during 1999, nearly a seven percent increase over the 4,361 in 1998.⁷

Undoubtedly, the increase in living donors has saved lives. But, the medical and legal professions have voiced concern because currently there is no federal legislation and limited state legislation regulating who may consent to living organ or tissue donation or how consent for such donations might be obtained.⁸ This concern becomes even more alarming when one considers that the number of living organs and tissues donated annually by minors has drastically increased since 1995⁹—herein lies the impetus for this article.¹⁰

June 15, 2000) <<http://transplant.ucdmc.ucdavis.edu>>. For information concerning the increase in "living organ donations," see Christine Gorman, *Spare A Kidney?*, Time, Mar. 13, 2000, at 98; Associated Press, *Donation Of Organs By Live Donors Rises*, The Advocate, Mar. 1, 2000, at 7A ("The number of people donating kidneys and, increasingly, sections of their livers, while still alive has more than doubled over the past decade, as transplant patients facing years on a waiting list look for other options."); Jeffrey P. Kahn, *Giving 'Til It Hurts: How Far To Go In Living Organ Donation?*, (visited June 20, 2000) <<http://www3.cnn.com>> ("With improved surgical techniques, living donation has become commonplace—the number of kidneys transplanted from living donors now rivals the numbers from cadavers."); Tim Bonfield, *Living Organ Donations Soar*, (visited June 5, 2000) <<http://enquirer.com>> ("With waiting lists getting longer every year for cadaver-donated organs, living organ donations are soaring in popularity.").

7. See UNOS's website, *supra* note 2. In fact, in 1999, living liver donation increased by approximately two hundred percent, rising from 56 donors in 1998 to 173 in 1999. *Id.*

8. See Joel D. Kallich & Jon F. Merz, *The Transplant Imperative: Protecting Living Donors From The Pressure To Donate*, 20 J. Corp. L. 139 (1995) [hereinafter Kallich & Merz] (discussing the use of living organ donors and stating that many physicians believe that the shortage of cadaveric organs, long waiting times on cadaveric transplant waiting lists, better outcomes for recipients, low risk for donors, and the right to donate all support the use of living donors, while other physicians quote from the Hippocratic oath and believe that physicians should not contribute to the risk of adverse outcomes to any patient, that short term risks are not low, that long term risks are unknown, and that potential donors should not be put under such psychological pressure to undergo major surgery when it is not physiologically beneficial to them); Jennifer K. Robbennolt, Victoria Weisz, Craig M. Lawson, *Advancing The Rights Of Children And Adolescents To Be Altruistic: Bone Marrow Donation By Minors*, 9 J.L. & Health 213, 218 (1995) [hereinafter Robbennolt et al.] ("[I]t is unclear whether a parent may give legal consent for their child to undergo a bone marrow harvest in order to benefit a sibling."); Arthur L. Caplan, *Am I My Brother's Keeper?*, 27 Suffolk U. L. Rev. 1195 (1993) [hereinafter Caplan] (discussing the propriety of living organ donation).

9. An individual is considered a "minor" until he or she reaches the age of "majority." In Louisiana, "[m]ajority is attained upon reaching the age of eighteen years." La. Civ. Code art. 29. See also La. Ch. C. art. 603(5) ("Child" means a person under eighteen years of age who, prior to juvenile proceedings, has not been judicially emancipated under Civil Code Article 385 or emancipated by marriage under Civil Code Article 379 through 384."); Jessica A. Penkower, *The Potential Right Of Chronically Ill Adolescents To Refuse Life-Saving Medical Treatment—Fatal Misuse Of The Mature Minor Doctrine*, 45 DePaul L. Rev. 1165, 1166 n.6 (1996) [hereinafter Penkower] (citing authority for the proposition that the age of majority in all states is now 18). Moreover, "minors" fall within the broader category of "incompetents." The term "incompetents" includes several subcategories of individuals who, for various reasons, are incapable of giving legal effect to their preferences. See, generally Black's Law Dictionary 765 (6th ed. 1990) (defining "incompetency").

10. There were ten reported living kidney donations by minors in 1995 and thirty-three in 1998, a tripling in number over three years. See UNOS's website, *supra* note 2. At this time, there is no

This article explores the current legal framework within which living organ and tissue donations by minors occur and concludes that legislation such as that proposed in this article is desperately needed to protect the physiological and psychological health of minors. The current judicial standards are inadequate because they merely regulate the disposition of the donation under review and, thus, fail to provide any substantive protection for the welfare of all donating minors.¹¹ On the other hand, the legislation proposed in this article ensures that the best interests of all donating minors are protected by requiring judicial approval of all living organ and tissue donations by minors which are not regulated by other law. Moreover, the proposed legislation—which encompasses two standards, namely, a standard for living organ and nonregenerative tissue donations by minors and a standard for living regenerative tissue donations by minors—lists several factors which may be considered by an adjudicating court in determining the propriety of a particular donation. While the two proposed legislative standards are nearly identical, they differ in one important respect. The proposed legislative standard for living regenerative tissue donations by minors accords greater deference to the donating minor's parents. The deference to parental authority is implemented in the form of a rebuttable presumption (operative under certain circumstances) that the living regenerative tissue donation is in the best interests of the donating minor.

Section I of this article precludes the following sections by briefly discussing the medical implications of living organ and tissue donations by minors. This section discusses what human organs and tissues are transplantable and how these organs and tissues are medically distinguishable. Particular attention is placed on distinguishing between regenerative and nonregenerative transplantable body parts and describing the medical risks associated with living organ and tissue donations. Section II provides an overview of the constitutional implications of living organ and tissue donations by minors and concludes that legislation such as that proposed by this article is constitutional. Section III discusses how living organ and tissue donations by minors are regulated nationally, with emphasis placed on the problems associated with this regulating approach. Section IV gives an overview of cases involving organ and tissue donations by minors. Section V introduces and thoroughly discusses the proposed legislative standards for regulating living organ and tissue donations by minors. Finally, this article concludes by reiterating the need for legislation to regulate living organ and tissue donations by minors and explaining how the legislation proposed in this article can protect minors as the number of per year living organ and tissue donations continues to rise.

UNOS data on the number of living kidney donations by minors past 1998; however, UNOS reports a substantial increase in per year number of living organ donations since 1998, therefore, it is reasonable to assume that the number of per year living kidney donations by minors has also risen since 1998. See *supra* notes 6 and 7. While there is no comparable data on the rising number of tissue donations by minors, several hospitals and clinics throughout Louisiana were contacted and reported performing an increasing number of bone marrow transplants with minor donors.

11. Black's Law Dictionary 1404 (6th ed. 1990) defines "standard" as "[a] measure or rule applicable in legal cases such as the 'standard of care' in tort actions."

I. MEDICAL IMPLICATIONS OF LIVING ORGAN AND TISSUE DONATIONS BY MINORS

The human body has approximately thirty transplantable organs and tissues combined.¹² These organs and tissues include: a variety of glands (e.g., pancreas, pituitary, thyroid, parathyroid, and adrenal), parts of the ear, blood vessels, tendons, cartilage, muscles (including the heart), testicles, ovaries, fallopian tubes, nerves, skin, fat, bone marrow, blood, livers, lungs, kidneys, and corneas.¹³ Transplantable organs and tissues are either regenerative or nonregenerative.¹⁴ Transplantable regenerative body parts are replenished by the body and usually include only tissues such as blood, ovum, skin, bone marrow, and sperm.¹⁵ Transplantable nonregenerative body parts are not replenished by the body and include organs such as the heart and kidneys and tissues such as the lobe of a lung.¹⁶

When a transplantable organ or tissue is donated by a living minor, the donation is usually made to a sibling. Moreover, the organ or tissue donated is usually either a kidney, a nonregenerative organ, blood or bone marrow (both of which are regenerative tissues).¹⁷ Data released by UNOS, which covers the period of 1989 to 1998, reveal that only two living organ donations by a minor have been of an organ other than a kidney.¹⁸ However, living adult donors have donated other organs, including a lobe of a lung, a portion of the liver, and a portion of the

12. See Gloria J. Banks, *Legal & Ethical Safeguards: Protection Of Society's Most Vulnerable Participants In A Commercialized Organ Transplantation System*, 21 Am. J.L. & Med. 45, 46 (1995) [hereinafter Banks]; Christine Allgeier, *Organ Donation: A Review Of Issues And Laws*, 71 Radiologic Technology 23 (1999) [hereinafter Allgeier]. For a table of the history of transplantation, see TransWeb's website, *supra* note 1.

13. *Id.* See also Cheryl Johnston, *Winding Yet Certain Growth*, (visited June 9, 2000) <<http://www.stadtlander.com/transplant/tishabruni.html>> (describing living lung donation and stating that "[l]iving-related lung lobe transplants were first performed in 1990 to stop imminent death in patients with failing lungs too sick to wait for cadaveric organs"); HIV and Hepatitis.com's website, (visited June 9, 2000) <<http://www.hivandhepatitis.com/hepb/b0000012.html>> (describing living liver donation); see TransWeb's website, *supra* note 1, for a description of what tissues can be donated ("Currently transplanted human tissues include bone, corneas, skin, heart valves, veins, cartilage and other connective tissues. These tissues can be used to treat patients suffering from congenital defects, blindness, visual impairment, trauma, burns, dental defects, arthritis, cancer, vascular and heart disease. Many heart valves are used to treat children with congenital defects of their own heart valves.").

14. See Jeffrey Prottas, *Human Tissues As Medical Treatment*, 65 S. Cal. L. Rev. 445, 445-46 (1991); Banks, *supra* note 12, at 46; Lloyd R. Cohen, *Increasing The Supply Of Transplant Organs: The Virtues Of A Futures Market*, 58 Geo. Wash. L. Rev. 1, 3 (1989).

15. *Id.* However, the human liver, an organ, has the ability to regenerate itself. See HIV and Hepatitis.com's website, *supra* note 13 (describing living liver donation).

16. *Id.*

17. A living kidney donor who is the sibling of the donee-recipient is more likely to have a kidney that "biologically matches"—this is due to histocompatibility, which refers to the compatibility of tissues. There is a 25% chance that siblings will be completely identical as regards histocompatibility (HLA) antigens. The only better, albeit rare, combination is that of identical twins. See Transplant Square's website, *supra* note 6. The same phenomena applies to bone marrow donation. Close relatives, especially siblings, are more likely than unrelated persons to have "matched" bone marrow. However, only 30% to 40 % of patients have a "matched" sibling or parent. *Id.*; see also, Gale Encyclopedia Of Medicine 1700 (1st ed. 1999).

18. See UNOS's website, *supra* note 2.

pancreas.¹⁹ Data on the donation of tissue are not as prevalent as data on organ donation because there is no central registry for donative tissue;²⁰ however, medical and legal literature only discuss the donation of blood and bone marrow by minors, which gives rise to a fair assumption that blood and bone marrow are the primary, if not the exclusive, tissues currently donated by living minors.

The medical risks associated with living organ and tissue donations vary according to the body part donated. However, all living donations entail some pain and discomfort for the donor and include such risks as wound infections, urinary tract infections, phlebitis, and isolated cases of pulmonary embolism or wound bleeding.²¹ There is also the potential risk that a living donor may suffer negative psychological feelings of resentment if the donee-recipient's body rejects the donated body part.²² Aside from these universal risks, living organ and tissue donations are quite safe.²³ The mortality rate for living kidney donation is extremely low—around 0.03-0.06 percent.²⁴ The risks associated with blood

19. *Id.*

20. However, there is a central registry for bone marrow in the United States and many other countries. In the United States, call 1-800-MARROW-2 (1-800-627-7692) or visit the National Marrow Donor Program website, (visited June 6, 2000) <<http://www.marow.org>>. Also, see the list of bone marrow donor centers in the United States compiled by the American Bone Marrow Donor Registry, (visited June 6, 2000) <<http://www.abmdr.org>>. There is also another listing of bone marrow donor centers, (visited June 6, 2000) <<http://www.slip.net/~rwwood/centers.html>>.

21. See UNOS's website, *supra* note 2; Transplant Square's website, *supra* note 6.

22. *Id.*

23. When all living organ donations are factored in, the mortality rate is estimated at 0.06%. See UNOS's website, *supra* note 2.

24. See Transplant Square's website, *supra* note 6. For further information concerning the risks associated with living kidney donation for the donor, see TransWeb's website, *supra* note 1:

The evidence is very strong that people without a predisposition to kidney disease (not diabetic, normal blood pressure, normal kidney anatomy) have a very low likelihood of developing kidney failure because they donated a kidney. In fact, the likelihood of developing kidney failure after donating a kidney is likely to be significantly less than the rest of the population. While this sounds incredible, it is because of the fact that the population of people that donate a kidney have been carefully screened and those people that are destined to develop kidney failure have been excluded from donating. Therefore it is not surprising to find that the chance of renal failure is lower among this group that is healthier than the population at large.

For a description of kidney transplantation, see Gale Encyclopedia Of Medicine 1700 (1st ed. 1999); Ann Carter, *Chronic Kidney Failure*, Clinical Reference Systems, July 1, 1999, at 287; Jay I. Meltzer, *Kidney Transplantation*, The Columbia Univ. Coll. Of Physicians & Surgeons Complete Home Medical Guide, 707 (3d ed. 1995). The surgical procedure to remove a kidney from a living donor is called a nephrectomy. Laparoscopic nephrectomy is an alternative to the traditional nephrectomy and involves a minimally-invasive surgery using instruments on long, narrow rods to view, cut, and remove the donor kidney. Although this surgical technique takes slightly longer than a traditional nephrectomy, preliminary studies show that it promotes a faster recovery time, shorter hospital stays, and less post-operative pain for kidney donors. *Id.* See also Charles W. Henderson, *Living-Donor Transplants Now Being Done Laparoscopically*, Transplant Weekly, Nov. 15, 1999. For information concerning the costs of nephrectomy, see Charles W. Henderson, *Transplants From Living Donors Reduce Long-Term Costs Of Care*, Transplant Weekly, May 31, 1999 (reporting a study which suggests that the total cost of care within five years of transplant surgery is roughly \$47,000 less than dialysis treatments would be for five years). See also Charles W. Henderson, *Less Long-Term Care Needed With Well-Matched*

donation are nonfatal and include such complications as hyperventilation, increased heart rate, infection, hematoma, seizures, and convulsions.²⁵ The risks associated with bone marrow donation are principally caused by the anesthesia administered to the donor—a risk inherent in nearly all living organ and tissue donations.²⁶ The mortality rate for bone marrow donation is approximately 0.01 percent, consistent with the mortality rate for anesthesia administrations.²⁷ Aside from the risks associated with anesthesia, bone marrow donation entails a slight risk of bone fracture, bone infection, artery rupture, skin scarring, and the inherent risks associated with blood transfusion, should it be necessary.²⁸

II. CONSTITUTIONAL IMPLICATIONS OF LIVING ORGAN AND TISSUE DONATIONS BY MINORS

A. *The Rights of Minors*

Minors are protected by the United States Constitution and possess constitutional rights.²⁹ One of the most important rights held by minors is the right of privacy,

Donor Organs, Transplant Weekly, May 31, 1999; Charles W. Henderson, *Live Kidney Donors Could Hold Key To Organ Shortage*, Transplant Weekly, Mar. 1, 1999.

25. See American Association Of Bloodbanks Technical Manual 99-101 (13th ed. 1999).

26. See Gale Encyclopedia Of Medicine 497 (1st ed. 1999) (discussing bone marrow transplantation).

27. *Id.* See also Bone Marrow Transplantation And Peripheral Blood Stem Cell Transplantation, National Cancer Institute, Nov. 1994 (pamphlet); Gale Encyclopedia Of Medicine 311 (1st ed. 1999); *Evaluation And Preparation Of Pediatric Patients Undergoing Anesthesia*, 98 *Pediatrics* 502 (1996), which describes the risks associated with anesthesia in children as follows:

Minor complications such as sore throat, nausea, vomiting, croup, and oral trauma are frequently quoted to patients. Major complications would include dental trauma, postoperative apnea, major drug reaction, aspirative pneumonia, hypoxemia, arrhythmias, and cardiac arrest. In a 1985 study examining outcome data from a large general patient population, the incidence of cardiac arrest caused solely by anesthesia was approximately 1.7 per 10,000 anesthetics; the death rate was approximately 1 per 10,000 anesthetics. [citation omitted]. The incidence of cardiac arrest in children younger than 12 years (4.7 per 10,000) was three times greater than in adults (1.4 per 10,000). In a 1988 study, Tiret et al. [citation omitted] reported on the incidence of major anesthesia-related complications, defined as any fatal or life-threatening event or any incident resulting in severe sequelae that occurred during or within 24 hours of administration of anesthesia. They reported the incidence of such major complications to be 7 per 10,000 anesthetics administered and only 1 death in 40,000 anesthetics administered to children younger than 15 years. In children younger than 12 months, the incidence of major complications was 43 per 10,000, compared with 5 per 10,000 in older children. More serious complications are likely to occur in patients with predisposing conditions that compromise organ system function.

28. *Id.* See also *Curran v. Bosze*, 566 N.E.2d 1319, 1337 (Ill. 1990) (quoting Dr. Lechtor for the three areas of risk to a healthy child who donates bone marrow: "One, the risk of anesthesia per se; secondly, with a bone marrow harvest there are many times the donors receive blood, so there is the risk of blood transfusion; and, finally, there are psychological risks that are associated with the administration of anesthesia."); Robbenolt et al., *supra* note 8, at 216.

29. See *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 74, 96 S. Ct. 2831,

emanating from the Fifth and Fourteenth Amendments.³⁰ However, minors do not possess the full panoply of constitutional rights enjoyed by adults and often are unable to exercise their rights independently.³¹ Minors are endowed with less autonomy under the law because of their young age;³² the presumption is that young age reflects

2843 (1976) (discussing right of mature minor to consent to an abortion); *Bellotti v. Baird*, 443 U.S. 622, 633, 99 S. Ct. 3035, 3043 (1979) (discussing right of mature minor to consent to an abortion); *In re Gault*, 387 U.S. 1, 13, 87 S. Ct. 1428, 1436 (1967) (extending procedural rights of notice, of counsel, and of protection against self-incrimination to minors) (“[N]either the Fourteenth Amendment nor the Bill of Rights is for adults alone.”); *Carey v. Population Servs. Int’l*, 431 U.S. 678, 689, 97 S. Ct. 2010, 2018 (1976) (blanket prohibition on the distribution of contraceptives to minors is unconstitutional); *Parham v. J.R.*, 442 U.S. 584, 600, 99 S. Ct. 2493, 2503 (1979) (“It is not disputed that a child, in common with adults, has a substantial liberty interest in not being confined unnecessarily for medical treatment”); *Tinker v. Des Moines Indep. Community Sch. Dist.*, 393 U.S. 503, 511, 89 S. Ct. 733, 739 (1969) (First Amendment) (“Students in school as well as out of school are ‘persons’ under our Constitution. They are possessed of fundamental rights which the State must respect, just as they themselves must respect their obligations to the State.”); *Wisconsin v. Yoder*, 406 U.S. 205, 242, 92 S. Ct. 1526, 1546 (1972) (Douglas, J., dissenting) (“Where the child is mature enough to express potentially conflicting desires, it would be an invasion of the child’s rights to permit such an imposition without canvassing his views.”); *Troxel v. Granville*, 530 U.S. 57, 88-89, 120 S. Ct. 2054, 2072 (2000) (Stevens, J., dissenting). Stevens states:

At a minimum, our prior cases recognizing that children are, generally speaking, constitutionally protected actors require that this Court reject any suggestion that when it comes to parental rights, children are so much chattel. The constitutional protection against arbitrary state interference with parental rights should not be extended to prevent the States from protecting children against the arbitrary exercise of parental authority that is not in fact motivated by an interest in the welfare of the child. (citation omitted).

See also Rochelle D. Jackson, *The War Over Children’s Rights: And Justice For All? Equalizing The Rights Of Children*, 5 Buff. Hum. Rts. L. Rev. 223 (1999).

30. See *Roe v. Wade*, 410 U.S. 113, 93 S. Ct. 705 (1973) (establishing the contours of the right of privacy in the abortion context); *Planned Parenthood of Cent. Missouri v. Danforth*, 428 U.S. 52, 96 S. Ct. 2831 (1976) (right of mature minor to consent to an abortion); *Bellotti v. Baird*, 443 U.S. 622, 99 S. Ct. 3035 (1979) (right of mature minor to consent to an abortion); *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 112 S. Ct. 2791 (1992) (recognizing a woman’s right to choose an abortion before fetal viability, but adopting an undue burden test for evaluating abortion restrictions before viability). For a discussion on the substantive component of the Fifth and Fourteenth Amendments, see *Bowers v. Hardwick*, 478 U.S. 186, 106 S. Ct. 2841 (1986). The Court in *Bowers* states:

It is true that despite the language of the Due Process Clauses of the Fifth and Fourteenth Amendments, which appears to focus only on the processes by which life, liberty, or property is taken, the cases are legion in which those Clauses have been interpreted to have substantive content, subssuming rights that to a great extent are immune from federal or state regulation or proscription.

Id. at 191, 106 S. Ct. at 2844.

31. See *Vernonia Sch. Dist. v. Acton*, 515 U.S. 646, 654, 115 S. Ct. 2386, 2391 (1995) (Fourth Amendment) (“Traditionally at common law, and still today, unemancipated minors lack some of the most fundamental rights of self-determination—including even the right of liberty in its narrow sense, i.e., the right to come and go at will.”); *Hazelwood Sch. Dist. v. Kuhlmeier*, 484 U.S. 260, 266, 108 S. Ct. 562, 567 (1988) (First Amendment) (“We have nonetheless recognized that the First Amendment rights of students in the public schools ‘are not automatically coextensive with the rights of adults in other settings[.]’ . . .”).

32. See *Parham v. J.R.*, 442 U.S. 584, 602, 99 S. Ct. 2493, 2504 (1979).

inexperience and an inability to fully comprehend the ramifications of the chosen action.³³ This reasoning has shaped the law pertaining to medical consent, which traditionally has held that minors may not effectively consent to their medical treatment.³⁴ And without consent, any medical procedure performed on a minor is considered a battery.³⁵ Therefore, the law delegates the power to make medical care

33. *Id.* at 602, 99 S. Ct. at 2504. See also *Belotti*, 443 U.S. at 634, 99 S. Ct. at 3043 ("We have recognized three reasons justifying the conclusion that the constitutional rights of children cannot be equated with those of adults: the peculiar vulnerability of children; their inability to make critical decisions in an informed, mature manner; and the importance of the parental role in child rearing."); Emily Buss, *What Does Frieda Yoder Believe?*, 2 U. Pa. J. Const. L. 53 (1999). Whether the law's presumptions pertaining to minors are grounded in accurate social science is, however, an issue often debated. See Preston A. Britner et al., *Evaluating Juveniles' Competence To Make Abortion Decisions: How Social Science Can Inform The Law*, 5 U. Chi. L. Sch. Roundtable 35, 62 (1998) ("Simply put, the research conducted over the past two decades suggests that adolescents are more similar than dissimilar to adults in their decision-making, although some differences may exist."); Maggie O'Shaughnessy, *The Worst Of Both Worlds?: Parental Involvement Requirements And The Privacy Rights Of Mature Minors*, 57 Ohio St. L.J. 1731, 1733-34 (1996) ("While the Court has rejected the proposition that pregnant minors must be presumed mature enough to make their pregnancy disposition decision, the weight of research provides a convincing challenge to this position by showing that minors exhibit adult-level reasoning."); Susan D. Hawkins, *Protecting The Rights And Interests Of Competent Minors In Litigated Medical Treatment Disputes*, 64 Fordham L. Rev. 2075, 2128-29 (1996) [hereinafter Hawkins]. Hawkins states:

Regardless of the standard employed to assess competence, many medical commentators agree that minors under the age of fourteen should not be permitted to consent to or refuse treatment on their own behalf. By contrast, others recommend a case-by-case determination of a minor's capacity to consent and recommend involving her in the decision-making process to a degree commensurate with her current capacity.

Id.

34. See Hawkins, *supra* note 33, at 2075 ("In the United States, minors are generally considered legally incompetent to consent to or refuse most forms of medical treatment."). The granting of "consent" should be contrasted from the granting of "informed consent." One may grant "consent," but not "informed consent," to a medical procedure; however, if one grants "informed consent," they have also granted "consent." See Black's Law Dictionary 305 (6th ed. 1990) (defining "consent" as "permission") and Black's Law Dictionary 779 (6th ed. 1990) (defining "informed consent" as "[a] person's agreement to allow something to happen (such as surgery) that is based on a full disclosure of facts needed to make the decision intelligently; i.e., knowledge of risks involved, alternatives, etc. Informed consent is the name for a general principle of law that a physician has a duty to disclose what a reasonably prudent physician in the medical community in the exercise of reasonable care would disclose to his patient as to whatever grave risks of injury might be incurred from a proposed course of treatment, so that a patient, exercising ordinary care for his own welfare, and faced with a choice of undergoing the proposed treatment, or alternative treatment, or none at all, may intelligently exercise his judgment by reasonably balancing the probable risks against the probable benefits.").

35. See Neil C. Abramson, *A Right To Privacy Tour De Force Into Louisiana Medical Informed Consent*, 51 La. L. Rev. 755, 756 (1991). Abramson states:

The general rule is that a physician must obtain his patient's consent, expressed or implied, to a medical procedure before performing a procedure. A patient's cause of action for lack of consent arises in intentional torts, i.e., battery, for the performance of procedures different from or in excess of those to which he has consented. A patient's cause of action for lack of informed consent, however, arises in negligence. In these situations, the physician performs the procedure to which his patient consented, but the physician fails to disclose to his patient certain risks and results involved in the procedure.

decisions for minors to surrogate decision-makers, such as parents.³⁶ The surrogate decision-maker's consent serves as a substitute for the minor's consent and ensures that the minor's liberty interests are protected and thus respected.

On the other hand, while requiring the consent of a surrogate decision-maker provides an effective tool for guarding the rights of a minor, it also creates an obstacle which may prevent a minor from obtaining the medical treatment he needs. If surrogate consent is required under all circumstances before needed medical treatment may be provided, the health of minors, and the stability of society would be foolishly sacrificed. To ameliorate the potentially harsh consequences of the general rule of surrogate consent, courts have crafted several jurisprudential exceptions. State legislators have also enacted several statutory exceptions to the general rule of surrogate consent.³⁷ Statutes in most states now permit health care providers to render emergency medical treatment to minors without surrogate

Id. For a further discussion on the distinctions between consent and informed consent in Louisiana, see *Hondroulis v. Schuhmacher*, 553 So. 2d 398 (La. 1988) (discussing the cause of action for lack of informed consent) and *Pizzalotto v. Wilson*, 437 So. 2d 859 (La. 1983) (performance of a medical procedure on the body of a patient without consent is a battery). See also Kallich & Merz, *supra* note 8, at 148-51; Danny R. Veilleux, *Medical Practitioner's Liability For Treatment Given Child Without Parent's Consent*, 67 A.L.R. 4th 511 (1989) (discussing several cases).

36. See Susan C. Lonowski, *Recognizing The Right Of Terminally-Ill Mature Minors To Refuse Life-Sustaining Medical Treatment: The Need For Legislative Guidelines To Give Full Effect To Minors' Expanded Rights*, 34 U. Louisville J. Fam. L. 421 (1996) ("Courts commonly allow parents, legal guardians or court-appointed surrogates to make decisions regarding medical treatment of children."); La. R.S. 40:1299.53 (2000) (granting a parent the authority and power, on behalf of his or her minor child, "to consent, either orally or otherwise, to any surgical or medical treatment or procedures including autopsy not prohibited by law which may be suggested, recommended, prescribed, or directed by a duly licensed physician"). See also La. Ch. C. art. 116(17) ("'Parent' means any living person who is presumed to be a parent under Civil Code Articles 184 through 190, a biological or adoptive mother or father of a child.").

37. For a complete discussion on the jurisprudential and statutory exceptions, see generally Penkower, *supra* note 9 (discussing the jurisprudential exceptions of emergency, emancipated minor, and mature minor); Jennifer L. Rosato, *The Ultimate Test Of Autonomy: Should Minors Have A Right To Make Decisions Regarding Life-Sustaining Treatment?*, 49 Rutgers L. Rev. 1 (1996) [hereinafter Rosato]; Nancy Batterman, *Under Age: A Minor's Right To Consent To Health Care*, 10 Touro L. Rev. 637 (1994) [hereinafter Batterman]. The emergency exception is a jurisprudential exception recognized in every state. The first case in Louisiana to recognize the emergency exception is *Wells v. McGehee*, 39 So. 2d 196, 202 (La. App. 1st Cir. 1949) ("In such a case, where the emergency endangers the life or health of the patient, it is the surgeon's duty to do that which the case demands within the usual and customary practice among physicians and surgeons in the same or similar localities, without the consent of the patient or his parents."). The other two jurisprudential exceptions, the emancipated minor exception and the mature minor exception, are found in the common law of most states, but have never been recognized in the civil law of Louisiana. These common law exceptions permit minors to consent to their own medical care and obviate the need for obtaining surrogate consent. Moreover, when properly employed, these common law exceptions permit a minor to make the relevant medical care decision notwithstanding the wishes of the minor's parents. In *Bellotti v. Baird*, 443 U.S. 622, 99 S. Ct. 3035 (1979), the United States Supreme Court raised the common law mature minor exception to constitutional status in the limited context of permitting minors to consent to abortions. Application and effect of the exception is the same in common law and constitutional law—if the minor is found competent, there is no need to obtain surrogate consent and the minor's parents do not retain a veto over the minor's medical care decision.

consent.³⁸ Moreover, statutes in many states now permit minors to make their own medical care decisions if they have established independence through marriage, parenthood, or service in the armed forces.³⁹ Statutes in many states also permit minors to consent to their medical treatment with respect to specific diseases or conditions.⁴⁰ In a few states, such as Louisiana, minors are broadly permitted to consent to any "medical or surgical care or services" in conjunction with an "illness or disease."⁴¹

The exceptions to the general rule of surrogate consent were not created to grant autonomous rights to minors. Rather, the exceptions were created to further paternalistic goals by allocating consensual authority in a way that ensures minors obtain needed medical treatment.⁴² Thus, while minors may have the right to

38. In Louisiana, see La. R.S. 40:1299.54 (2000) (stating in part that "[i]n addition to any other instances in which a consent is excused or implied at law, a consent to surgical or medical treatment or procedures suggested, recommended, prescribed, or directed by a duly licensed physician will be implied where an emergency exists.").

39. See Judith C. Areen, *Cases And Materials On Family Law* 1030-31 (2d ed. 1985); La. Civ. Code art. 379 ("The minor, whether male or female, is emancipated of right by marriage."); La. Civ. Code art. 385 (judicial emancipation); La. Civ. Code art. 366 (emancipation by notarial act).

40. In Louisiana, see, e.g., La. R.S. 40:1065.1 (2000) (minor may consent for treatment of venereal diseases); La. R.S. 40:1096 (2000) (minor may consent for treatment of drug abuse); La. R.S. 40:1098.3 (2000) (minor may consent for preventive alcoholism and addiction counseling and treatment for alcohol or drug abuse).

41. See La. R.S. 40:1095(A) (2000), which provides:

Consent to the provision of medical or surgical care or services by a hospital or public clinic, or to the performance of medical or surgical care or services by a physician, licensed to practice medicine in this state, when executed by a minor who is or believes himself to be afflicted with an illness or disease, shall be valid and binding as if the minor had achieved his majority. Any such consent shall not be subject to a later disaffirmance by reason of his minority.

42. See Penkower, *supra* note 9, at 1205-06. Penkower states:

Paternalism is at the heart of all legal policies governing allocation of consensual rights in the health care context. The common law rules requiring parental consent for the treatment of minors, and their exceptions, further paternalistic goals by allocating decision-making capacity in a way that yields maximum benefit not only to the specific minor whose treatment is at issue, but to the general public as well. For example, exceptions to the common law rule under emergency circumstances were premised on the idea that it is always in the best interests of a child to receive prompt medical attention when his or her health or life is endangered. Similarly, minor treatment statutes were enacted in response to society's fear that minors would rather suffer from sexually transmitted diseases, alcohol and substance abuse, and mental disorders than risk the consequences of consulting their parents, who may be angry, accusative, or unsupportive. Finally, in the abortion context, it was feared that if minors were denied access to legal abortions, they would alternatively seek potentially harmful illegal abortions.

Id. Jonathan O. Hafen & Bruce C. Hafen, *Abandoning Children To Their Autonomy: The United Nations Convention On The Rights Of The Child*, 37 *Harv. Int'l L.J.* 449, 454-55 (1996) ("Thus, with the exception of abortion choices by minors found to be 'mature,' virtually all of the modern American children's rights cases have been concerned not with children's rights of autonomous personal choice, but with their rights to protection."); Rosato, *supra* note 37, at 31. Rosato states:

The condition or disease exception does not appear to be motivated by a desire to recognize a minor's right to make certain health care decisions. For many of these conditions,

consent to medical treatment in many states, they usually do not have the right to refuse medical treatment when that treatment is consented to by the minors' parents.⁴³ Moreover, generally, if consensual authority is extended to a minor, that authority does not include the right to consent to nontherapeutic medical procedures such as living organ or tissue donations.⁴⁴

B. The Rights of Parents

Parents have a fundamental constitutional right to make medical care decisions concerning their minor children.⁴⁵ However, parental authority is not without

including venereal disease, drug abuse, and mental health problems, the exception exists because requiring parental consent may discourage a minor from seeking treatment. If the minor failed to seek treatment, the minor's health or the welfare of the community could be jeopardized. For example, a minor's failure to obtain pregnancy-related services because of a fear of parental reprisals could detrimentally affect the health of the mother and the unborn child. Additionally, the failure to treat venereal disease could cause the spread of the disease, thus causing harm to the community.

Id. See also Batterman, *supra* note 37, at 639-40.

43. See 40 Op. Att'y Gen. No. 88-232 (Nov. 16, 1988) ("A minor, while having the right to consent to medical treatment, has no right to refuse medical treatment when that treatment is consented to by his parents and proposed by a licensed physician."); Rosato, *supra* note 37, at 32. Rosato states:

The statutes also may be limited to consent to treatment. Most of the statutes apply to consent to treatment, but do not refer to refusal of treatment at all. By specifically including consent and excluding refusal, the legislature may have intended to allow minors only to consent to treatment. This reading would be consistent with the state's interest in protecting children's lives because it would prevent a minor from refusing necessary health care, and thus would prevent self-inflicted harm.

Id. However, most adults do have a right to refuse medical treatment. In Louisiana, see La. R.S. 40:1299.56 (2000) ("Nothing contained herein shall be construed to abridge any right of a person eighteen years of age or over to refuse to consent to medical or surgical treatment as to his own person.").

44. See Batterman, *supra* note 37, at 672-73 (stating that when the treatment is for the minor's own benefit rather than for the benefit of another, courts are more receptive to finding the minor's consent legally sufficient). A "nontherapeutic" medical procedure does not provide any direct medical benefit to the patient. See Janet B. Korins, Curran v. Bosze: *Toward A Clear Standard For Authorizing Kidney And Bone Marrow Transplants Between Minor Siblings*, 16 Vt. L. Rev. 499, 500 n.6 (1992) [hereinafter Korins]. A careful reading of La. R.S. 40:1095(A) (2000) reveals that Louisiana minors may only consent to "medical or surgical care or services" in conjunction with treatment for an actual or perceived affliction of an "illness or disease." However, blood donation statutes are the typical exception to the rule that minors may not consent to nontherapeutic medical procedures. In Louisiana, see La. R.S. 40:1097 (2000) (seventeen-year-old minor may consent to donation of blood). Two states, Alabama and Wisconsin, have made a further exception to the rule by allowing minors to consent to bone marrow donation. See Ala. Code § 22-8-9 (West 2000) and Wis. Stat. Ann. § 146.34 (West 2000), discussed at *infra* note 61. Moreover, an exception to the rule also applies with respect to abortion. In Louisiana, see La. R.S. 40:1299.35.5 (2000) (mature minor may consent to an abortion).

45. See *Troxel v. Granville*, 530 U.S. 57, 66, 120 S. Ct. 2054, 2060 (2000) ("[I]t cannot now be doubted that the Due Process Clause of the Fourteenth Amendment protects the fundamental right of parents to make decisions concerning the care, custody, and control of their children."); *Wisconsin v. Yoder*, 406 U.S. 205, 232, 92 S. Ct. 1526, 1541 (1972) (upholding the decision by Amish parents to withdraw their children from public school after a careful balancing of parental and state interests and

bounds. Parents have neither a constitutional right to withhold needed medical treatment for their minor children nor a constitutional right to expose their minor children to the medical risks associated with nontherapeutic medical procedures, such as living organ or tissue donations.⁴⁶

stating: "The history and culture of Western Civilization reflect a strong tradition of parental concern for the nurture and upbringing of their children."); *Pierce v. Society of Sisters*, 268 U.S. 510, 534-35, 45 S. Ct. 571, 573 (1925) (striking down a law requiring attendance at public schools due to interference with the "liberty of parents and guardians to direct the upbringing of children under their control"); *Meyer v. Nebraska*, 262 U.S. 390, 399, 43 S. Ct. 625, 626 (1923) (striking down a law prohibiting the teaching of German and holding that the liberty interest protected under the Fourteenth Amendment included the right to "bring up children"); *Parham v. J.R.*, 442 U.S. 584, 602, 99 S. Ct. 2493, 2504 (1979) ("Our jurisprudence historically has reflected Western civilization concepts of the family as a unit with broad parental authority over minor children."). In *Bellotti v. Baird*, 443 U.S. 622, 638, 99 S. Ct. 3035, 3045 (1979), the Court stated:

[W]e cannot ignore that . . . deeply rooted in our Nation's history and tradition . . . is the belief that the parental role implies a substantial measure of authority over one's children. Indeed, "constitutional interpretation has consistently recognized that the parents' claim to authority in their own household to direct the rearing of their children is basic in the structure of our society."

Id. (quoting *Ginsberg v. New York*, 390 U.S. 629, 639, 88 S. Ct. 1274, 1280 (1968). *Prince v. Massachusetts*, 321 U.S. 158, 166, 64 S. Ct. 438, 442 (1944) ("It is cardinal with us that the custody, care, and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder."); *Griswold v. Connecticut*, 381 U.S. 479, 495, 85 S. Ct. 1678, 1688 (1965) (striking down a Connecticut law interfering with the right to use contraceptives, and holding: "[T]he entire fabric of the Constitution and the purposes that clearly underlie its specific guarantees demonstrate that the rights to marital privacy and to marry and raise a family are of similar order and magnitude as the fundamental rights specifically protected."). *See also* La. Civ. Code art. 216 ("A child remains under the authority of his father and mother until his majority or emancipation. In case of difference between the parents, the authority of the father prevails."); *Hawkins*, *supra* note 33, at 2081:

Because society values privacy and family integrity, courts accord great deference to parental decisions. Two presumptions drive such deference to parental authority. First, courts believe that "parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions." Second, lawmakers presume that the "natural bonds of affection" cause parents to act in their child's best interests. Courts also recognize that parental autonomy in decision making is an essential element of preserving integrity of the family.

46. *See Wisconsin v. Yoder*, 406 U.S. 205, 233-34, 92 S. Ct. 1526, 1542 (1972) ("[T]he power of the parent . . . may be subject to [significant] limitation[s] . . . if it appears that parental decisions will jeopardize the health or safety of the child, or have a potential for significant societal burdens."). *See also Troxel v. Granville*, 530 U.S. 57, 68-69, 120 S. Ct. 2054, 2061 (2000) ("Accordingly, so long as a parent adequately cares for his or her children (i.e., is fit), there will normally be no reason for the State to inject itself into the private realm of the family to further question the ability of that parent to make the best decisions concerning the rearing of that parent's children.") (emphasis added); *Prince v. Massachusetts*, 321 U.S. 158, 170, 64 S. Ct. 438, 444 (1944). Moreover, *see* Leslie A. Fithian, *Forcible Repatriation Of Minors: The Competing Rights Of Parent And Child*, 37 *Stan. L. Rev.* 187, 200-01 (1984), stating:

The state has never allowed parents unlimited control over their children, however. Parental rights, though constitutionally protected from unwarranted state intervention, are still subject to the superior right of the state to protect children against abuse of parental authority. Under the *parens patriae* doctrine, the state shares the duty of parents to safeguard the welfare of children and may intervene when parents fail to meet this obligation.

C. *The Rights of the State*

The state has a strong interest in the preservation of human life.⁴⁷ Generally, whenever the actions of an individual threaten this interest, the state is permitted to intervene and protect the sanctity of human life. Moreover, the state has an important interest in protecting individuals who are unable to protect themselves, such as minors.⁴⁸ Therefore, the state may usurp the authority of parents under its *parens patriae*⁴⁹ power when the health of a minor is endangered.⁵⁰

The state usually protects the health of minors through its child abuse and neglect statutes.⁵¹ In many states, these statutes permit the state to obtain temporary legal custody of minors in order to compel necessary medical treatment.⁵² Aside from the child abuse and neglect statutes, a state may also protect the health of minors by enacting protectionist legislation that proscribes medical procedures which pose what might be considered too great a health risk for minors.

47. In Louisiana, see, e.g., La. R.S. 14:29 (defining the crime of homicide) and 14:32.5 (defining the crime of feticide) (2000).

48. See *Carey v. Population Servs. Int'l*, 431 U.S. 678, 97 S. Ct. 2010 (1977) (discussing the state's protective power over minors) and *Prince v. Massachusetts*, 321 U.S. 158, 64 S. Ct. 438 (1944) (discussing the state's interest in protecting the welfare of children).

49. "*Parens patriae*" literally means "parent of the country." Black's Law Dictionary 1114 (6th ed. 1990) defines "*parens patriae*" as the "principle that the state must care for those who cannot take care of themselves, such as minors who lack proper care and custody from their parents." See also *Ready v. State Dept. of Health and Human Resources*, 707 So. 2d 1250, 1260 (La. App. 3rd Cir. 1997), writ denied, 720 So. 2d 687 (La. 1998), ("Clearly, the state, as *parens patriae*, may interfere with a parent's custody under certain circumstances . . .").

50. See *Prince*, 321 U.S. at 170, 64 S. Ct. at 444 ("Parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves."); *Stanley v. Illinois*, 405 U.S. 645, 649, 92 S. Ct. 1208, 1212 (1972) (state has power to assert the child's best interests); *In re Phillip B.*, 92 Cal. App. 3d 796, 801 (Cal. App. 1979), cert. denied, 445 U.S. 949, 100 S. Ct. 1597 (1980) ("One of the most basic values protected by the state is the sanctity of human life. Where parents fail to provide their children with adequate medical care, the state is justified to intervene."). The state intervenes into matters involving the health of minors for three basic reasons. First, intervention ensures the continuance of society by protecting minors so that they may later contribute as productive citizens and, in-turn, ensure the well-being of future posterity. Second, intervention ensures the efficient allocation of limited fiscal and administrative resources. The state must preserve its limited resources and thus has an interest in preventing minor children from becoming wards of the state. Third, intervention ensures the integrity of the medical profession. Unchecked parental authority over medical decisions regarding minors could have a deleterious impact on the respect and trust accorded the medical profession. Considering the vital role that the medical profession plays in today's society, the state's interest in protecting this vitality is paramount. See Matthew S. Feigenbaum, *Minors, Medical Treatment, And Interspousal Disagreement: Should Solomon Split The Child?*, 41 DePaul L. Rev. 841, 857-58 (1992).

51. In Louisiana, see La. Ch. C. arts. 601, 606.

52. See *Hawkins*, *supra* note 33, at 2079. In Louisiana, see La. Ch. C. arts. 1551, 1553 (deprivation of comfort care prohibited), art. 1554 (deprivation of medical or surgical care generally prohibited), and art. 1560 (wrongful refusal to consent to medical care and treatment of a child).

As the above discussion reveals, minors retain some liberty interests with respect to their bodies.⁵³ However, the law has assumed a paternalistic role with regard to minors, extending rights, constitutional or otherwise, and promulgating legislation in an effort to protect them.⁵⁴ This paternalistic approach is particularly obvious in medical consent law where the allocation of consensual rights serves to protect the health of minors and the interests of society.⁵⁵ Consequently, states have extended jurisprudential and statutory consensual rights to minors permitting them to consent to medical treatment. But, generally speaking, these rights neither include a correlative right to refuse medical treatment nor a right to consent to nontherapeutic medical procedures.⁵⁶ Furthermore, parents have a vested constitutional right to consent to medical treatment for their minor children, but this constitutional right includes neither a correlative right to withhold needed medical treatment for their minor children nor a constitutional right to consent to nontherapeutic medical procedures for their minor children.⁵⁷ These limitations demonstrate that the state's interest in protecting the health of minors and the stability of society is paramount; therefore, the state may constitutionally enact legislation to regulate, including prohibit, living organ and tissue donations by minors.

III. NATIONAL REGULATION OF LIVING ORGAN AND TISSUE DONATIONS BY MINORS

The approach taken by the United States to regulate living organ and tissue donations is remarkably different from the European approach.⁵⁸ While every

53. See *supra* note 30 and accompanying text.

54. See *supra* note 42 and accompanying text. See also Penelope Alysse Brobst, *The Court Giveth And The Court Taketh Away: State v. Fernandez—Returning Louisiana's Children To An Adult Standard*, 60 La. L. Rev. 605 (2000), citing well over twenty paternalistic laws, including, in pertinent part, La. R.S. 14:93.11 (2000) ("Unlawful sales to persons under twenty-one is the selling or otherwise delivering for value of any alcoholic beverage to any person under twenty-one years of age unless such person is the lawful owner or lawful employee of an establishment to which the sale is being made and is accepting such delivery pursuant to such ownership or employment."); La. R.S. 14:91.8(c) (2000) ("It is unlawful for any manufacturer, distributor, retailer, or other person knowingly to sell or distribute any tobacco product to a person under the age of eighteen."); La. R.S. 14:91(A) (2000) ("Unlawful sales of weapons to minors is the selling or otherwise delivering for value of any firearm or other instrumentality customarily used as a dangerous weapon to any person under the age of eighteen."); La. R.S. 14:91.11(A)(1) (2000) ("The unlawful sale, exhibition, rental, leasing, or distribution of material harmful to minors is the intentional sale, allocation, distribution, advertisement, dissemination, exhibition, or display of material harmful to minors, to any unmarried person under the age of seventeen years, or the possession of material harmful to minors with the intent to sell, allocate, advertise, disseminate, exhibit, or display such material to any unmarried person under the age of seventeen years, at a newsstand or any other commercial establishment which is open to persons under the age of seventeen years."); La. R.S. 32:405.1, 407 (2000) (restricting right of minors to drive).

55. See *supra* note 42.

56. See *supra* notes 43 and 44 and accompanying text.

57. See accompanying text, *supra* note 46 and accompanying text.

58. Many European countries have specific legislation addressing living organ and tissue

state has passed the Uniform Anatomical Gift Act (UAGA),⁵⁹ which regulates cadaveric organ and tissue donations, no state has passed legislation regulating living organ donation or, more particularly, living organ donation by minors. Moreover, while most states have passed legislation regulating blood donation

donations by minors. While the age of majority and legislation differs in these countries, generally European law is less permissive of living organ and tissue donations by minors than by adults: Romania (prohibits the donation of organs and tissues, including blood, by living minors); Spain (prohibits the donation of organs and tissues, including blood, by living minors); Greece (prohibits living organ donation by minors, but bone marrow may be donated by minors provided the donating minor and donee-recipient are fully histocompatible siblings and consent has been obtained from the person legally responsible for the donating minor); Portugal (living nonregenerative organ and tissue donations by minors and incompetent adults are prohibited; however, parents may consent to the living donation of regenerative tissue from their minor children, but when the donating minor is capable of understanding and able to express his wishes, the consent of the minor must also be obtained); Denmark (living organ donation is permitted by persons under 18 years of age if the donor has consented, the approval of the person exercising parental authority over the donor has been obtained, and there are special medical needs for the particular donation); Norway (living organ donation is permitted by persons under 18 years of age when there exists a special medical need, the minor's guardian has consented, and permission has been granted by the Directorate of Health Services; in addition, the minor must consent and understand the nature of the operation and its concomitant risks); Sweden (living organ donation is permitted by persons under 18 years of age when there are special medical needs for the particular donation and the donating minor consents; in addition, the authorization of the National Board of Health and Welfare must be obtained, which is only granted when the person exercising parental authority consents and the board agrees that there are special medical needs for the particular donation); Finland (only persons of at least 18 years of age may make living nonregenerative organ and tissue donations; persons under 18 years of age may consent to living regenerative tissue donations only with the written consent of the person's guardian or trustee, and approval by the National Board of Health; moreover, before any living tissue donation by a minor proceeds, an expert in child psychology or pediatrics must submit a report to the board to accompany the application for approval of the donation; the donating minor's opinion on the donation is also considered by the board, with due regard to the donor's age and level of development); France (minors of any age may make living organ donations, but only to a brother or sister with the consent of the minor's legal representative and authorization by an independent committee; the consent of the donating minor is also required if the minor is capable of reaching an independent decision about whether to donate); Luxembourg (minors of any age may make living organ donations with the consent of the minor's legal representative and authorization by an independent committee; the consent of the donating minor is also required if the minor is capable of reaching an independent decision about whether to donate). The legislation of Bolivia, Colombia, Mexico, Lebanon, Russia, and Turkey prohibit living organ donation by minors. Moreover, the World Health Organization (WHO) has established nine guiding principles (i.e., the WHO Guiding Principles on Human Organ Transplantation) which do not bind members but, nevertheless, provide guidance for governments and health professionals; Principle 4 calls for the absolute ban of living organ donation by minors. For citation to the pertinent laws discussed above, see David Price & Austin Garwood-Gowers, *Aspects Of Transplant Laws In European Jurisdictions*, EuroTold's website, (visited June 5, 2000) <<http://www.maths.lancs.ac.uk/~henderr1/EuroTold/Legisearch/#it4>>; Maria N. Morelli, *Organ Trafficking: Legislative Proposals To Protect Minors*, 10 Am. U. J. Int'l L. & Pol'y 917, 935-40 (1995) [hereinafter Morelli].

59. In Louisiana, see La. R.S. 17:2351 (2000). For a discussion of the UAGA, see Allgeier, *supra* note 12, and Banks, *supra* note 12, at 64-71. The UAGA primarily prescribes certain mechanics concerning the giving of anatomical gifts, such as who may give, who may receive, and how the gift document is executed, delivered, and amended or revoked.

by minors,⁶⁰ no state has passed legislation broadly regulating living tissue donation by minors.⁶¹

The United States has instead taken a common law approach to regulating living organ and tissue donations by minors, leaving the power to adjudicate the disposition of a donation within the purview of a judge's discretion. The adjudicating courts have purported to apply one of two judicial standards when reaching their decisions on the propriety of a living organ or tissue donation by a minor, namely, the "substituted judgment" standard or the "best interests" standard.

A court applying the substituted judgment standard in its purest form attempts to substitute itself as nearly as possible for the incompetent and to act upon the same motives and considerations that would move the incompetent but for the lack of competency.⁶² Benefit is not a proper element to be considered in making a substituted judgment; rather, the substituted judgment standard allows a court to make decisions for the incompetent that may be contrary to the incompetent's best interests, but which are based on the incompetent's personal preferences.⁶³ Therefore, the substituted judgment standard requires that the subjective personal preferences of the incompetent control what decisions are made for the incompetent.⁶⁴

However, a court applying the best interests standard in its purest form attempts to protect the best interests of an incompetent by evaluating benefits and risks in

60. See, e.g., La. R.S. 40:1097 (2000); Ohio Rev. Code Ann. § 2317.54 (West 2000); Ala. Code § 26-1-3 (West 2000); Ariz. Rev. Stat. Ann. § 44-134 (West 2000); Ark. Code Ann. § 20-27-301 (West 2000); Cal. Fam. Code §§ 25.5 and 6920 (West 2000); Fla. Stat. Ann. § 743.06 (West 2000); Ga. Code Ann. § 44-5-89 (West 2000); Miss. Code Ann. § 41-41-15 (West 2000). See also 21 C.F.R. §§ 640.1-640.6, particularly 640.3 (2000) (suitability of donor).

61. However, Alabama and Wisconsin have passed legislation regulating bone marrow donation by minors. See Ala. Code § 22-8-9 (West 2000) ("Any minor who is 14 years of age or older, or has graduated from high school, or is married, or having been married is divorced or is pregnant, may give effective consent to the donation of his or her bone marrow for the purpose of bone marrow transplantation. A parent or legal guardian may consent to such bone marrow donation on behalf of any other minor."); Wis. Stat. Ann. § 146.34 (West 2000) (establishing strict requirements whereby minors under 12 years of age with parental consent may donate their bone marrow to a sibling and also establishing strict requirements whereby minors 12 years of age or over may consent to donate their bone marrow to a sibling without the need for parental consent).

62. See *City Bank Farmers Trust Co. v. McGowan*, 323 U.S. 594, 599, 655 S. Ct. 496, 498 (1945); Lynn E. Lebit, *Compelled Medical Procedures Involving Minors And Incompetents And Misapplication Of The Substituted Judgments Doctrine*, 7 J.L. & Health 107, 112-19 (1993) [hereinafter Lebit]; Robbenolt et al., *supra* note 8, at 221-22. The substituted judgment standard was conceived in an early English case, *Ex parte Whitebread*, 35 Eng. Rep. 878 (1816). *Ex parte Whitebread* did not involve a medical question, but concerned the dilemma of how to justify making provisions for needy siblings from the estate of an incompetent. The standard was created to authorize the equity court's exercise of power. The *Whitebread* court stated: "[T]he court will not refuse to do, for the benefit of the Lunatic, that which it is probable the Lunatic himself would have done." *Id.* at 879. A New York court was the first in the United States to follow this standard. See *In re Willoughby*, 11 Paige Ch. 257 (N.Y. Ch. 1844) (involving a petition for an allowance from an incompetent's estate). See also *infra* notes 67 and 68.

63. See discussion in *supra* note 62.

64. See discussion in *supra* note 62.

order to ascertain the proper course of action.⁶⁵ Accordingly, the best interests standard is an objective standard that utilizes logic and reason in reaching decisions for the incompetent; the personal preferences of the incompetent are not considered.⁶⁶

While both the substituted judgment and best interests standard are useful judicial standards, they are flawed when applied in the context of living organ or tissue donation by minors. Because minors lack any period of legal competency, there are no intentional acts from which to draw a personal preference to donate. Accordingly, the substituted judgment standard cannot be properly applied to adjudicate the disposition of a living organ or tissue donation by a minor.⁶⁷ Moreover, because the best interests standard in its purest form fails to consider the reasonable wishes of the donating minor, it is also inherently flawed when applied to adjudicate the disposition of a living organ or tissue donation by a minor. The personal autonomy of the donating minor should be accorded fair respect by at least factoring in the minor's reasonable wishes. Thus, when a minor, particularly one near majority, desires to donate his organ or tissue to another, such as his sibling, the reasonable wishes of the minor should be heard and considered but should not be determinative.⁶⁸

65. See Korins, *supra* note 44, at 506-09 ("In theory, the best interest of the donor test provides a stricter approach because it focuses purely on the objective benefit to the individual donor."); Daniel B. Griffith, *The Best Interests Standard: A Comparison Of The State's Parens Patriae Authority And Judicial Oversight In Best Interests Determinations For Children And Incompetent Patients*, 7 *Issues L. & Med.* 283 (1991). See also authorities cited at *infra* notes 67 and 68. The best interests standard is prevalent throughout family law in varying forms. In Louisiana, see La. Civ. Code arts. 131, 134. The first significant expression of the best interests standard is found in the late nineteenth century case of *Chapsky v. Wood*, 26 Kan. 650, 654 (Kan. 1881) ("Above all things, the paramount consideration is, what will promote the welfare of the child?").

66. See discussion in *supra* note 65.

67. See Lebit, *supra* note 62, at 110-11 ("Substituted judgment is a subjective standard, and therefore can only apply to persons who have been competent at one time. The best interests standard, however, is to be applied to the minor or incompetent who has never been competent and is, therefore, entitled to more protection under the law."); David S. Lockmeyer, *At What Cost Will The Court Impose A Duty To Preserve The Life Of A Child?*, 39 *Clev. St. L. Rev.* 577, 586 (1991) ("In the case of a minor donor, there is no period of competency upon which to base a determination of the donor's altruism. Therefore, in applying the substituted judgment doctrine in a case involving a minor, a court is simply applying a form of the best interest test. The court is making a decision based upon its perception of what a reasonable person would do if he were in the minor's position."); Robbenolt et al., *supra* note 8, at 226.

68. See Robbenolt et al., *supra* note 8, at 226-27 ("[T]he best interests standard is itself unsatisfactory in that it fails to capture the nature of the decision to donate bone marrow and, accordingly, does not further a respect for the personhood of the children involved. Even very young children facing bone marrow harvests are often able to understand what is happening and why, at least on an elementary level."); Rachel M. Dufault, *Bone Marrow Donations By Children: Rethinking The Legal Framework In Light Of Curran v. Bosze*, 24 *Conn. L. Rev.* 211, 244 (1991) [hereinafter Dufault]. See also La. Civ. Code art. 134, wherein "[t]he reasonable preference of the child, if the court deems the child to be of sufficient age to express a preference[,] may be considered in awarding custody of the child and La. Civ. Code art. 136, wherein "[t]he preference of the child[,] if he is determined to be of sufficient maturity to express a preference[,] may be considered in awarding visitation rights.

Despite claims of adherence to one particular standard, many courts adjudicating the propriety of a living organ or tissue donation by a minor have, in fact, responded to the flaws inherent in sole application of one of the judicial standards by incorporating particular aspects of both standards to create a hybrid standard.⁶⁹ While the application of a hybrid standard may resolve many of the problems presented by the sole application of either standard, it suffers, as does any judicial standard, from a lacking ability to regulate the disposition of donations not before the court. Furthermore, not all courts apply a hybrid standard or apply it in the same manner. Finally, the courts adjudicating the propriety of a living organ or tissue donation by a minor have committed themselves to a unitary legal analysis that fails to distinguish between the various types of organ and tissue donations. There are, however, important distinctions in organ and tissue donations, such as regeneration, which necessitate the application of differing legal analysis.

IV. NATIONAL JURISPRUDENCE INVOLVING LIVING ORGAN AND TISSUE DONATIONS BY MINORS

UNOS data reveal that there were ninety-six reported living kidney donations by minors between 1989 and 1998, with donor age ranging from less than one to seventeen-years-old.⁷⁰ The total annual number of reported living kidney donations by minors has been on the rise since 1995 and has doubled in number from the previous year in 1998, rising from fifteen reported donations in 1997 to thirty-three reported donations in 1998.⁷¹ Preliminary data from 1999 also demonstrates a similar rate of growth for living kidney donation by minors.⁷² No data exist on the number of bone marrow donations by minors. However, many hospitals and clinics, without judicial approval, permit a minor to donate bone marrow under established guidelines.⁷³

Despite the increase in living organ and tissue donations by minors, there is a dearth of jurisprudence to assist a court in adjudicating the propriety of a donation. The lack of jurisprudence is due to the fact that many cases are not reported and many donations are never challenged.⁷⁴ All of the reported cases

69. See, e.g., *Hart v. Brown*, 289 A.2d 386 (Conn. Super. Ct. 1972) and *Little v. Little*, 576 S.W.2d 493 (Tex. Civ. App. 1979), discussed at *infra* Section IV.A.

70. See UNOS's website, *supra* note 2.

71. *Id.*

72. See *supra* note 6.

73. This information was acquired through contacting several hospitals and clinics throughout Louisiana.

74. "Challenges" to donations occur usually because hospitals and physicians want judicial authorization to protect them from subsequent lawsuits. See *Korins*, *supra* note 44, at 500 n.5 (stating that very few cases are reported and many donations are not "challenged"); Jennifer S. Bard, *The Diagnosis Is Anencephaly And The Parents Ask About Organ Donation: Now What? A Guide For Hospital Counsel And Ethics Committees*, 21 W. New Eng. L. Rev. 49, 72 (1999) [hereinafter Bard] ("As a practical matter, donations between family members usually take place without legal intervention. Although sometimes hospital attorneys seek a declaratory judgment from the court before

involving a living organ or tissue donation by a minor are discussed below.⁷⁵ Analogous cases involving a living organ or tissue donation by an incompetent who is not a minor are also discussed.

Courts adjudicating the propriety of a living organ or tissue donation by an incompetent have not applied a uniform standard; however, many courts tend to focus on certain core facts. For instance, such facts as the age and mental competency of the donor are of particular importance. Many of the adjudicating courts have also placed emphasis on the fact that the incompetent donor was represented by an attorney who opposed the donation. Presumably, such representation furthers the interests of the incompetent because the propriety of the donation is fully explored in an adversarial proceeding. However, because the courts have been without legislative guidance in deciding cases involving living organ or tissue donation by a minor, many of the decisions appear to be decided somewhat arbitrarily and weakly reasoned.⁷⁶ Furthermore, as the following case analysis illustrates, the jurisprudential standard that each court claimed it was applying and the standard it actually applied are not always consistent. This inconsistency has not only added to the confusion surrounding the proper application of the substituted judgment and best interests standards, but it has also created uncertainty about what facts are pertinent to a determination of whether a donation should be permitted.

A. Purported Application of the Substituted Judgment Standard

In *Strunk v. Strunk*,⁷⁷ the Kentucky Supreme Court held that Jerry Strunk, a twenty-seven-year-old mental incompetent with the mental capacity of a six-

the procedure takes place, these opinions are often not reported decisions. When both parents give their consent to an intra-family donation, court intervention is rare."); Robbenolt et al., *supra* note 8, at 218; Jenn Swenson Bregman, *Conceiving To Abort And Donate Fetal Tissue: New Ethical Strains In The Transplantation Field—A Survey Of Existing Law And A Proposal For Change*, 36 UCLA L. Rev. 1167, 1185 (1989) [hereinafter Bregman]. See also Thomas R. Trenkner, *Tort Liability Of Physician Or Hospital In Connection With Organ Or Tissue Transplant Procedures*, 76 A.L.R.3d 890 (1977).

75. While there are very few reported cases which address the propriety of a living organ or tissue donation by a minor, there are several unreported cases. For example, an annotated statute from Ohio (Ohio Rev. Code Ann. § 2317.54 (West 2000)) lists an unpublished opinion and states:

In determining whether to grant an order authorizing parents to consent to their child's organ donation surgery, a court must independently balance and evaluate the facts of the case in light of the following criteria: (1) the prospective donor's desire to proceed with the surgery, (2) the prospective donor's level of maturity and understanding, (3) the risks and benefits of the transplant surgery, (4) the good faith and reasonableness of the parents' consent, and (5) whether the minor's interests have been adequately represented. In re Guardianship of Ingram, 11 OBR 570 (CP, Ottawa 1983).

Id.

76. Contrast *In re Richardson*, 284 So. 2d 185 (La. App. 4th Cir.), *writ denied*, 284 So. 2d 338 (La. 1973), a three-page opinion, ten-line legal analysis, *from Curran v. Bosze*, 566 N.E.2d 1319 (Ill. 1990), a twenty-six page opinion in which the court set out three factors to consider in adjudicating cases involving a bone marrow donation by a minor.

77. 445 S.W.2d 145 (Ky. 1969).

year-old, could donate a kidney to his twenty-eight-year-old brother, Tommy, who was dying from a kidney disease. The entire family, including a number of collateral relatives, was tested and found to be medically incompatible to donate. Jerry's mother acting as committee,⁷⁸ petitioned the court to permit the donation. Jerry's father also supported the donation; however, a guardian ad litem, appointed to represent Jerry's interests, opposed the donation.⁷⁹

The *Strunk* court justified the donation by applying what it perceived to be the substituted judgment standard: "The right to act for the incompetent in all cases has become recognized in this country as the doctrine of substituted judgment and is broad enough not only to cover property but also to cover all matters touching on the well-being of the ward."⁸⁰ While the *Strunk* court embraced the substituted judgment standard, the court failed to discuss what Jerry would do if he was competent and instead, focused on the county court's findings.⁸¹ The county court found that the operation was necessary and would be beneficial not only to Tommy, but also to Jerry. The court also found that Jerry was "greatly dependent upon Tommy, emotionally and psychologically, and that his well-being would be jeopardized more severely by the loss of his brother than by the removal of a kidney."⁸² Furthermore, the court noted that testimony in the county court included the ward's psychiatrist who opined that the death of Jerry's brother would have an extremely traumatic effect upon Jerry. The court also to notice of the Department of Mental Health recommendation that the operation take place. Jerry's appointed guardian ad litem, throughout the legal proceedings, continually questioned the power of the state to authorize the removal of Jerry's kidney.⁸³

Improper application of the substituted judgment standard is also illustrated in the case of *Hart v. Brown*.⁸⁴ This case underscores the current ambiguity as to what facts are relevant to a determination of whether a donation should be permitted. In

78. A "committee" is similar to a "curator" in Louisiana. See La. Civ. Code art. 389.1.

79. See Hawkins, *supra* note 33, at 2106 ("Legal counsel for minors usually falls into two formal categories: guardians ad litem and attorneys. Typically, a guardian ad litem advocates the child's best interests while an attorney advocates the child's expressed wishes. Very few states, however, clearly differentiate between the two.").

80. *Strunk*, 445 S.W.2d at 148.

81. See Louise Harmon, *Falling Off The Vine: Legal Fictions And The Doctrine Of Substituted Judgment*, 100 Yale L.J. 1, 34-35 (1990), wherein the author points out that, prior to *Strunk*, the doctrine of substituted judgment had never been used for anything other than making allowances or gifts from a lunatic's surplus income. The author also notes that the doctrine had been used only in cases of insanity, in which the court could look to an incompetent's former intentional states. Moreover, the author states that since the "mentally retarded" donor in *Strunk* always lacked the capacity to make gifts, there was no prior acts from which to draw an inference of probable donative intent, thus giving the judge "unfettered discretion" in making a substituted judgment.

82. *Strunk*, 445 S.W.2d at 146.

83. However, in a strong dissenting opinion, one judge stated that "[t]he ability to fully understand and consent is a prerequisite to the donation of a part of the human body" and that "[t]o 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." *Id.* at 150-51 (Steinfeld, J., dissenting).

84. 289 A.2d 386 (Conn. Super. Ct. 1972).

Hart, the Connecticut court held that seven-year-old Margaret Hart could donate a kidney to her identical twin sister, Kathleen, who was suffering from a kidney disease. The twins' parents, Peter and Eleanor, were tested and excluded as donors because of medical incompatibility. Thereafter, Mr. and Mrs. Hart brought the action to declare their power to consent to the proposed operation. A guardian ad litem was appointed for each twin; both supported the donation. Moreover, a clergy person testified that the parents were making a morally and ethically sound decision.

Relying on *Strunk v. Strunk*,⁸⁵ *Bonner v. Moran*,⁸⁶ and three unreported Massachusetts cases,⁸⁷ the *Hart* court concluded it had the power to adjudicate the issue before it and claimed to apply the substituted judgment standard. However, the court did not explore what Margaret would do if she were competent. Instead, the court determined that Mr. and Mrs. Hart could substitute their consent for Margaret after a close, independent, and objective investigation of their motivation and reasoning.

The *Hart* court reviewed the medical testimony which indicated that the twins were medically compatible. Moreover, the court noted that a psychiatrist examined Margaret and found her to have a strong identification with her twin sister. The court also noted that the psychiatrist testified "that if the expected successful results are achieved they would be of immense benefit to the donor in that the donor would

85. 445 S.W.2d 145 (Ky. 1969).

86. 126 F.2d 121 (D.C. Cir. 1941). In *Bonner*, a physician was sued for damages based on an alleged assault and battery committed when he performed operations on a fifteen-year-old boy to provide the boy's cousin, who had been severely burned, with flesh for a skin graft. Although the boy consented to the procedures at the request of his aunt, the boy's mother neither knew of the nature of the operations nor consented to them. The court found that the circumstances involved in the case were inadequate to create an exception to the general requirement of valid consent because the operations were not performed for the child's benefit. The court noted that, in fact, the operations involved sacrifice on the part of the boy of two months of schooling, in addition to serious physical pain and possible results affecting his future life, including at least some permanent marks of disfigurement. The court also noted that the techniques of the operations were so involved as to require a mature mind to understand precisely what the donor was offering to give. Therefore, the court held that notwithstanding the boy's consent, the trial court erred in refusing to charge the jury that the physician should have obtained the consent of the boy's parents before performing the operations.

87. See Korins, *supra* note 44, at 509-10, which discusses these cases. *Masden v. Harrison*, No. 68651, Eq. Mass. Sup. Jud. Ct. (June 12, 1957), involved an authorized kidney transplant between nineteen-year-old twins (the age of majority was twenty-one-years-old). The donor and his mother were fully informed about, and consented to, the procedure; in addition, the court heard evidence from a psychiatrist stating that the donor would suffer "a grave emotional impact" if his brother died. In reaching its decision, the court emphasized both the nineteen-year-old donor's consent and the potential emotional harm to him if the donee-recipient died. The other two cases involved twins who were fourteen-years-old. In each case, the court made a finding that the donor fully understood the procedure (i.e., a kidney transplant) and consented to it. In *Huskey v. Harrison*, No. 68666, Eq. Mass. Sup. Jud. Ct. (Aug. 30, 1957), the court found the fact that both the donor and parent consented determinative and, thus, the transplant was authorized. In *Foster v. Harrison*, No. 68674, Eq. Mass. Sup. Jud. Ct. (Nov. 20, 1957), the court found that the donor was of "good understanding and intelligence" and "fully informed of . . . the nature of the operation and its possible risks and consequences." For a complete discussion of the early Massachusetts cases, see Charles H. Baron, et. al., *Live Organ And Tissue Transplants From Minor Donors In Massachusetts*, 55 B.U. L. Rev. 159 (1975) [hereinafter Baron et al.].

be better off in a family that was happy than in a family that was distressed and in that it would be a very great loss to the donor if the donee were to die from her illness."⁸⁸ However, the court considered the testimony of the psychiatrist to be of limited value because of the age of the twins.

The *Hart* court found that the testimony of the parents demonstrated that they reached their decision to consent only after many hours of agonizing consideration. Additionally, the court thought it notable that Margaret was informed of the operation and, insofar as she was capable of understanding, she desired to donate her kidney. The court also stated:

To prohibit the natural parents and the guardians ad litem of the minor children the right to give their consent under these circumstances, where there is supervision by this court and other persons in examining their judgment, would be most unjust, inequitable and injudicious. Therefore, natural parents of a minor should have the right to give their consent to an isograft kidney transplantation procedure when their motivation and reasoning are favorably reviewed by a community representation which includes a court of equity.⁸⁹

In *Little v. Little*,⁹⁰ the Texas court, although aware of the improper application of the substituted judgment standard by prior courts, provided little guidance for future cases because it failed to delineate what facts are relevant in determining whether a donation should be permitted. In *Little*, the court held that Anne Little, a fourteen-year-old incompetent suffering from Down's Syndrome, could donate a kidney to her younger brother, Stephen, who was diagnosed with end-stage renal disease. Both of Anne's parents supported the donation after alternative donors were excluded due to medical incompatibility. An attorney ad litem, appointed to represent Ann's interests, opposed the donation.

The court in *Little* purported to apply the substituted judgment standard, but admittedly noted:

It is clear in transplant cases that courts, whether they use the term "substituted judgment" or not, will consider the benefits to the donor as a basis for permitting an incompetent to donate an organ. Although in *Strunk* the Kentucky Court discussed the substituted judgment doctrine in some detail, the conclusion of the majority there was based on the benefits that the incompetent donor would derive, rather than on the theory that the incompetent would have consented to the transplant if he were competent. We adopt this approach.⁹¹

The *Little* court found that Anne and Stephen had a close relationship and that each had a genuine concern for the welfare of the other. The court also found that Anne

88. *Hart*, 289 A.2d at 389.

89. *Id.* at 391.

90. 576 S.W.2d 493 (Tex. Civ. App. 1979).

91. *Id.* at 498.

had an awareness of the nature of Stephen's plight and an awareness that she could ameliorate Stephen's burden. Moreover, the court concluded that Anne had the cognitive ability to understand the concept of absence and thus would suffer psychologically from Stephen's death. The court also stated:

Studies of persons who have donated kidneys reveal resulting positive benefits such as heightened self-esteem, enhanced status in the family, renewed meaning in life, and other positive feelings including transcendental or peak experiences flowing from their gift of life to another. The record before us indicates that Anne is capable of experiencing such an increase in personal welfare from donating her kidney.⁹²

The court further stated that there was strong evidence showing that Anne would receive substantial psychological benefits from the participation. Therefore, the court found that the "minimal" risks, pain, and discomfort associated with the donation were outweighed by the benefits flowing from it.

B. Purported Application of the Best Interests Standard

In *In re Richardson*,⁹³ a Louisiana court held, with little explanation, that Roy Allen Richardson, a seventeen-year-old "mental retardate" with a mental age of three or four years, could not donate a kidney to his thirty-two-year-old sister, Beverly Jean, who was suffering from a kidney disease.⁹⁴ Medical testing revealed that Roy Allen would be the most acceptable donor of all the family members tested. The advising physicians estimated that a transplant using one of Roy Allen's kidneys presented a four to five percent probability of rejection over a period of three to five years, while the probability of rejection using one of the other family members' kidneys was between twenty and thirty percent. The court recognized the benefits that the procedure could provide to Beverly Jean, but stated that "neither a kidney transplant, nor particularly a transplanted kidney from Roy, is an absolute immediate necessity in order to preserve Beverly's life."⁹⁵

In reaching its decision, the *Richardson* court rejected the legal analysis applied in *Strunk v. Strunk*⁹⁶ because it found the procedural and substantive aspects of the majority opinion not in accord with Louisiana law. In search of legal guidance, the court analogized organ donation to property donation and noted that an unmarried minor in Louisiana may not make any inter vivos donation of his

92. *Id.* at 499 (citations omitted).

93. 284 So. 2d 185 (La. App. 4th Cir.), *writ denied*, 284 So. 2d 338 (1973).

94. The suit was filed by Charles W. Richardson against his wife, Madeline Cecelia Richardson; however, at all times, Mrs. Richardson consented to the proposed kidney donation. The action was filed against Mrs. Richardson merely as a procedural vehicle for placing before the court the propriety of removing and transplanting Roy Allen's kidney.

95. *Id.* at 187. This statement by the court seems to refer to the possibility that Beverly Jean could have received a kidney from another relative or from a cadaver or be maintained by dialysis three times a week for six hours a day. *Id.* at 186-87.

96. 445 S.W.2d 145 (Ky. 1969).

property. Moreover, a minor's tutor is forbidden from making such a donation as well. The court then adopted the best interests standard and stated:

Since our law affords this unqualified protection against intrusion [sic] into a comparatively mere property right, it is inconceivable to us that it affords 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.⁹⁷

The court concluded that the proposed kidney donation was not in the best interests of Roy Allen. In fact, the court specifically rejected Mr. and Mrs. Richardson's argument that the transplant was in Roy Allen's best interests because his sister could care for him after they died. The court dismissed this argument as "not only highly speculative but, in view of all the facts, highly unlikely."⁹⁸

In *In re Pescinski*,⁹⁹ the Supreme Court of Wisconsin held that Richard Pescinski, a thirty-nine-year-old incompetent classified as "a schizophrenic, chronic, catatonic type" with the mental capacity of a twelve-year-old, could not donate a kidney to his thirty-eight-year-old sister, Elaine, suffering from a kidney disease. All other members of the Pescinski family were purportedly ruled out as potential donors due to age or health. Janice Pescinski Lausier, Richard's guardian and sister, petitioned the court to permit the donation. A guardian ad litem, appointed to represent the interests of Richard, opposed the donation.¹⁰⁰

97. *In re Richardson*, 284 So. 2d at 187. *In re Richardson* is widely misunderstood. The confusion is probably a result of the court's concluding sentence, which states: "Our conclusion is that neither his parents nor the courts can authorize surgical intrusion on Roy for the purpose of donating one of his kidneys to his sister, Beverly." *Id.* at 187. Extracted from the court's opinion, this sentence can reasonably be interpreted to mean that a Louisiana court is without the power to authorize living kidney donations by minors. In fact, *In re Richardson* is mistakenly cited by writers for this proposition. See, e.g., Hal Daniel Friedman, *The Greatest Gift, But At What Cost?—Objections To Court Compelled Organ Donation In Aid Of A Family Member*, 30 J. Fam. L. 605, 612 (1991) [hereinafter Hal Friedman] ("In *In re Richardson*, a Louisiana court of chancery was forced to decide if it had the authority to order an operation to remove a kidney of an incompetent ward and transfer it to the ward's sister In affirming the lower court's opinion, the appellate court held that it had no power to order such a procedure."). However, a close reading of the case reveals that this assertion is incorrect. Moreover, the concurring opinion clarifies the ambiguity found in the majority opinion. See *In re Richardson*, 284 So. 2d at 188 (Gulotta, J., concurring) ("The majority, in my opinion, rightfully assumes that the court is empowered to authorize the transplant of the kidney from the minor, provided certain standards are met, i.e., the best interests of the minor."). The concurring judge also states:

I am of the opinion that before the court might exercise its awesome authority in such an instance and before it considers the question of the best interests of the child, certain requirements must be met. I am of the opinion that it must be clearly established that the surgical intrusion is urgent, that there are no reasonable alternatives, and that the contingencies are minimal.

Id. at 188.

98. *Id.* at 187. This statement by the court presumably pertains to the health status of Roy Allen's sister. The court seems to have thought that Beverly Jean was not likely to live very long even if the donation was permitted.

99. 226 N.W.2d 180 (Wis. 1975).

100. *Id.* at 180. *In re Pescinski* is a rather unique factual situation insofar as the incompetent was

The court in *In re Pescinski* discussed the substituted judgment standard approved by the court in *Strunk v. Strunk*,¹⁰¹ but declined to adopt the standard, stating:

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.¹⁰²

The *In re Pescinski* court emphasized the lack of benefit to Richard, thereby indicating that it was applying the best interests standard. But the court also highlighted the lack of consent, stating: "No evidence in the record indicates that Richard consented to the transplant. Absent that consent, there is no question that the trial court's conclusion that it had no power to approve the operation must be sustained."¹⁰³ Therefore, what standard the court was using is somewhat questionable.

In *In re Doe*,¹⁰⁴ the New York court held, in a brief, two-page, per curiam opinion, that John Doe, a severely mentally retarded forty-three-year-old with the mentality of a two-year-old, could donate bone marrow to his thirty-six-year-old brother who suffered from chronic myelogenous leukemia. The brother petitioned the court to permit the donation. A guardian ad litem, appointed to represent John's interests, opposed the donation.

The *In re Doe* court stated that the source of any power a court may have to authorize an incompetent's participation in a surgical procedure to save the life of another is confined to its *parens patriae* power and, thus, authorization may only be given if it is in the incompetent's best interests. The court found that the bone marrow transplant would be of minimal risk to John and was the only reasonable medical alternative to save his brother's life. Moreover, the court noted that

represented by two guardian ad litem; one proposing and the other opposing the donation.

101. 445 S.W.2d 145 (Ky. 1969).

102. *In re Pescinski*, 226 N.W.2d 180, 182 (Wis. 1975).

103. *Id.* at 181. However, in a dissenting opinion, one judge stated that authorization to proceed should be granted if certain criteria are met, such as a showing that: the donee-recipient stands to suffer death in the absence of the transplant; reasonable steps have been taken to find another source for the organ; the incompetent is closely related by blood to the donee-recipient; the donor would most likely donate due to normal family ties, if he were competent; the donor is in good health; the operation poses little threat to the donor. *Id.* at 183 (Day, J., dissenting). Moreover, the holding from *In re Pescinski* was clarified by *In re Eberhardy*, 307 N.W.2d 881, 893 n.13 (Wis. 1981). In *In re Eberhardy*, the Wisconsin Supreme Court held that Wisconsin courts have constitutional and statutory jurisdiction to decide petitions seeking court authorization for guardians to give consent to sterilization of incompetent wards. Therein the court discussed its decision in *In re Pescinski* and explained that the case "should not be read as a ruling of want of jurisdiction" on the part of the court to authorize a kidney transplant. The court stated that *In re Pescinski* instead represented the "exercise of judicial restraint under particular circumstances," noting that in *In re Pescinski* those circumstances included the lack of consent by the guardian ad litem, no showing of benefit to the ward, and an absence of legislative guidance. *Id.* at 893 n.13.

104. 481 N.Y.S.2d 932 (N.Y. App. Div. 1984).

without the donation, Jerry's brother would probably die within the next five years and the use of any other donor may significantly reduce the potential for a successful transplant. The court then concluded by stating:

The evidence was neither loose, equivocal nor contradictory. We agree that the benefits to the incompetent if his brother lives outweigh the physiological and psychological risks, so long as the conditions imposed in the order are complied with. The petitioner is the sole family member to have become involved in placement and treatment decisions for the incompetent in the past and will likely continue to do so. Regardless of the standard of proof that should be required in cases of this type, the record before us demonstrates by clear and convincing evidence that the procedure is in the incompetent donor's best interests.¹⁰⁵

Finally, *Curran v. Bosze*¹⁰⁶ perhaps provides the best analysis of any case concerning the propriety of a donation by a minor. In *Curran*, the Supreme Court of Illinois held that three-year-old twins, Allison and James Curran, could not be compelled to submit to a blood test to determine medical compatibility for a bone marrow harvesting procedure over the objections of their primary caretaker, the twins' mother, Nancy Curran. The donation was sought by Tamas Bosze, the twins' father, after all other available family members had been tested and rejected as possible donors. The donation was for Mr. Bosze's son, the twins' half-brother, Jean Pierre, with whom the twins did not have an existing, close relationship. Jean Pierre suffered from leukemia. The parents of the twins had never married, and their relationship was strained by earlier litigation wherein Ms. Curran established Mr. Bosze's paternity of the twins.

The court in *Curran* rejected the substituted judgment standard, stating:

Neither justice nor reality is served by ordering a 3 ½-year-old child to submit to a bone marrow harvesting procedure for the benefit of another by a purported application of the doctrine of substituted judgment. Since it is not possible to discover that which does not exist, specifically, whether the 3 ½-year-old twins would consent or refuse to consent to the proposed bone marrow harvesting procedure if they were competent, the doctrine of substituted judgement is not relevant and may not be applied in this case.¹⁰⁷

The court followed with a thorough exposition of the law pertaining to kidney and bone marrow donations by incompetents, including minors, and stated that a parent or guardian may give consent on behalf of and for a minor to donate bone marrow to a sibling only when doing so is in the minor's best interests. The court identified three factors which must be satisfied to ensure that it is in the best interest of the child to donate bone marrow to a sibling: (1) the parent who consents on behalf of the child must be informed of the risks and benefits inherent in the bone marrow

105. *Id.* at 933.

106. 566 N.E.2d 1319 (Ill. 1990).

107. *Id.* at 1326.

harvesting procedure to the child; (2) there must be emotional support available to the child from the person or persons who take care of the child; (3) there must be an existing, close relationship between the donor and recipient.¹⁰⁸

The court found that the twins' mother was aware that the risks involved in donating bone marrow and undergoing general anesthesia were small, but the court noted she was also aware that such risks were life-threatening. The court stated that it would not be in the best interests of the twins if they were required to undergo a bone marrow harvesting procedure without the constant reassurance and support of a familiar adult known and trusted by the children. The court then pointed out that the twins' mother, who objected to the procedure, was the only caretaker that the twins had ever known. Additionally, the court thought that Mr. Bosze would be unable to substitute his support because his involvement in the children's lives was limited to periodic visitation. The court further stated that although the twins and their half-brother shared the same biological father, there was no evidence to indicate they were known to each other as family. Therefore, the court concluded that under the circumstances presented, it would neither be proper under existing law nor would it be in the twins' best interests to participate in the bone marrow harvesting procedure.

As the foregoing case analysis illustrates, there is a great deal of confusion surrounding the proper application of the substituted judgment and best interests standards. The confusion has created uncertainty about what facts are pertinent to a determination of whether a donation should be permitted. To resolve this confusion, the legislative standards discussed in the following section are proposed.

V. THE PROPOSED LEGISLATIVE STANDARDS FOR REGULATING LIVING ORGAN AND TISSUE DONATIONS BY MINORS

In developing a legislative standard for regulating living organ and tissue donations by minors, the first issue which must be addressed is whether such donations should be permitted at all. Many countries have legislation banning living organ and tissue donations by minors.¹⁰⁹ However, the organ and tissue donation legislation of these countries should not serve as model legislation for the United States. The countries which have banned living organ and tissue donations by minors usually have done so because of religious beliefs or a lack in advancement of medical science.¹¹⁰ Generally, neither of these reasons stand as an

108. *Id.* at 1343.

109. *See supra* note 58.

110. *See* Morelli, *supra* note 58, at 921-22 (stating that certain religious beliefs prevent living and cadaveric organ donations and that some nations lack the technology necessary for transplantation); John Gillman, *Religious Perspectives On Organ Donation*, *Critical Care Nursing Quarterly*, Nov. 1999, at 19. However, most religions with large followings accept organ donation. Buddhists believe organ donation is a personal decision that should be left to an individual's conscience. Because donation is a noble act, Buddhism honors those people who donate their bodies, including organs, to advance medical science and save lives. Catholics view organ donation as an act of charity, self-sacrifice and

obstacle to living organ or tissue donations by minors in the United States.¹¹¹ Moreover, while there exists a fair amount of sentiment in the United States that there ought to be a ban on living organ and tissue donations by minors,¹¹² the general consensus seems to support such donations under limited circumstances.¹¹³ Therefore, because the medical risks associated with living organ and tissue donations by minors are relatively low and the appreciable societal benefits are great, the legislation proposed below permits living organ and tissue donations by minors.

Assuming that living organ and tissue donations by minors should be permitted, one question that must be addressed is how such donations should be regulated. Who decides whether a minor may donate? Under what circumstances should minors be permitted to donate? These questions are difficult to answer and often invoke passionate opinions.¹¹⁴ Undoubtedly, the decision of whether a living minor donates an organ or tissue should first rest with the minor and his parents. A minor should not and probably could not be required to donate an organ or tissue when he expressly states a desire not to donate.¹¹⁵ Moreover, a minor should not and

love for others. Judaism teaches that saving a life takes precedence over maintaining the sanctity of the human body; although the dead should not be "mutilated" or their burial deferred, exceptions are made for organ donation. Finally, Protestants encourage and endorse organ donation; the Protestant faith respects individual choice and a person's right to make decisions regarding his own body. See Jennifer M. Krueger, *Life Coming Bravely Out Of Death: Organ Donation Legislation Across European Countries*, 18 Wis. Int'l L.J. 321, 336-37 (2000).

111. *Id.*

112. See *supra* note 8.

113. See Lainie Friedman Ross, *Moral Grounding for the Participation of Children as Organ Donors*, 21 J.L. Med. & Ethics 251 (1993) (stating that living children should be permitted to donate organs to their family members alone and that the consent of a parent for donations with no or minimal risk should be sufficient regardless of the child's opinion while risky procedures should be limited to the child's consent); Caplan, *supra* note 8, at 1196 and the numerous authorities cited in note 6 therein. See also Ala. Code § 22-8-9 (West 2000) and Wis. Stat. Ann. § 146.34 (West 2000).

114. See *Altruism By Proxy: Volunteering Children For Bone Marrow Donation*, 312 British Medical Journal 240 (1996) for a provocative discussion by various professionals answering such queries as: "Should children ever be allowed to donate bone marrow to help treat their sisters or brothers?" and "Can their parents give informed consent to an invasive procedure that is not in the child's own best interests?"

115. See *McFall v. Shimp*, 10 Pa. D. & C.3d 90 (Pa. 1978), wherein the court held that it had no authority to compel a relative of a person suffering from a rare bone marrow disease to submit to a bone marrow transplant, even though the prognosis for survival was dim in the absence of a transplant from the particular defendant. The court stated:

For a society which respects the rights of one individual, to sink its teeth into the jugular vein or neck of one of its members and suck from it sustenance for another member, is revolting to our hard-wrought concepts of jurisprudence. Forceable [sic] extraction of living body tissue causes revulsion to the judicial mind. Such would raise the specter [sic] of the swastika and the Inquisition, reminiscent of the horrors this portends.

Id. Hal Friedman, *supra* note 96, at 621. Friedman states:

[T]he state may not violate an individual's bodily integrity for the purpose of pursuing the state's interest in the preservation of life. This rule covers a situation in which either the individual is unable to consent on his or her own behalf, as in the case of a minor or incompetent, or in which the individual has openly refused to consent to such procedures.

probably could not be required to donate an organ or tissue over the objection of the minor's parents.¹¹⁶ The legislation proposed below is predicated upon the assumption that no minor is under a duty to donate an organ or tissue. Furthermore, difficult medical decisions, such as whether a living minor should donate an organ or tissue, are and should be made in consultation with medical professionals. Medical professionals can provide clarity to the clouded thinking of parents fraught with the emotional difficulty of having to decide whether to permit their minor child to donate. The legislation proposed below should not serve as a replacement for consultation with a medical professional.

The presumption that parents will act in the best interests of their minor children is not always reasonable. This is especially true when the presumption is raised in the context of a proposed sibling-to-sibling living organ or tissue donation. Parents face an inherent conflict of interest when they must decide whether to risk the health of one child in order to save the life of another.¹¹⁷ The desperation of parents faced with this conflict is best illustrated by reports of parents who have conceived a child for the purpose of donating that child's bone marrow to a sibling, a phenomena termed "parity for donation."¹¹⁸ And while medical consultation may

Id. Robert W. Griner, *Live Organ Donations Between Siblings And The Best Interest Standard: Time For Stricter Judicial Intervention*, 10 Ga. St. U. L. Rev. 589, 600 (1994) [hereinafter Griner]. See also Ross Povenmire, *Do Parents Have The Legal Authority To Consent To The Surgical Amputation Of Normal, Healthy Tissue From Their Infant Children?: The Practice Of Circumcision In The United States*, 7 Am. U.J. Gender Soc. Pol'y & L. 87, 102 (1999), stating:

Thus, there is a biological limit, determined by psychological and intellectual development factors, to the ability of minors to grant effective consent. In other words, at a certain age, the minor is too young to say "yes." Nevertheless, it does not necessarily follow that the minor is too young to say "no."

116. In *Bonner v. Moran*, 126 F.2d 121 (D.C. Cir. 1941), the court suggested that doctors must always secure parental consent before proceeding with a nontherapeutic medical procedure on a minor. See also Griner, *supra* note 115, at 610. In *Curran v. Bosze*, 566 N.E.2d 1319 (Ill. 1990), discussed *supra* Section IV.B, the court implicitly held that parental consent by at least one parent is required before the donation may proceed. Because much of the law in this area is unsettled, the above statements are conditioned—"probably could not." Until the courts articulate the relative weight of a parent's consent and a child's consent, it is unclear how they would resolve these issues.

117. See Korins, *supra* note 44, at 503, stating:

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

Griner, *supra* note 115, at 602-03 ("There is also an unavoidable conflict of interest for the parents who, no matter how much one may protest to the contrary, cannot divorce the extreme need of one child from the interests of the healthy child."); Dufault, *supra* note 68, at 238-39 ("A parent experiences tremendous stress and emotional pain when her child is dying. Insofar as desperate times call for desperate measures, the parent may be incapable of behaving rationally on behalf of either child.")

118. See Griner, *supra* note 115, at 604-05, which discusses the report of a California couple who, after a fruitless search for a compatible bone marrow donor for their seventeen-year-old daughter dying of leukemia, decided to conceive a child specifically for the purpose of donation. The father underwent a vasectomy reversal to conceive the child. Prenatal testing indicated that the fetal tissue was a suitable

provide some clarity to the decision-making process, the medical professional providing the advice may be the donee-recipient's physician; thus, the advising physician may also face a conflict of interest because he must seek to aid his patient but also provide accurate medical advice.¹¹⁹ Moreover, the prospect of performing innovative transplantations may be luring to medical professionals and thus color the information they provide.¹²⁰ The legislation proposed below is a prophylactic measure which protects minors from discriminatory or abusive treatment by requiring court review of all living organ and tissue donations by minors not regulated by other legislation.¹²¹ Judicial oversight of all living organ and tissue donations by minors provides reassurance that the parties involved have carefully considered the relevant factors with central focus on the welfare of the potential donating minor.¹²²

match for their leukemic daughter, so when the infant reached the age of thirteen months, a successful bone marrow transplant was performed. It has been claimed that this is a common event: "While no registry keeps records of this practice, a reported phone survey indicates at least forty attempted cases of parity for donation between 1984 and 1989. In eight of these cases, the infant subsequently served as a donor." *Id.* at 605. See also Dufault, *supra* note 68, at 238 n.132 (citing an article which discusses the California parity donation case); Bard, *supra* note 74, at 72-73 (discussing parity donations); Bregman, *supra* note 74.

119. See Caplan, *supra* note 8, at 1199-1200, stating:

Transplant centers and other transplant personnel may face problems in providing 'objective' information to prospective donors because those involved in seeking donors have an inherent conflict of interest. They cannot both advocate for the best interests of patients who need transplants and simultaneously protect the best interests of prospective donors. Those involved in innovative forms of live donation may be so eager to proceed that their enthusiasm may color the extent or kind of information made available to prospective donors. This is especially so when the same physician or health care team is treating both the prospective donor and would-be recipient.

Id. Kallich & Merz, *supra* note 8, 143-44, stating:

Whether to undergo a surgical procedure with its attendant risks is a highly complex decision. The potential recipient, family members, and even physicians or other health care providers (e.g., procurement coordinators) may exert subtle (and not so subtle) pressures on a potential donor. One could argue, as have Fox and Swazey, that by communicating to the potential recipient and donor that living organs (especially from biologically related donors) have a better prognosis than a cadaveric organ, physicians are engaging in a powerful form of pressure to donate.

120. See discussion in *supra* note 119.

121. Donations regulated by other legislation include post mortem organ and tissue donations and blood donations. In Louisiana, see La. R.S. 17:2351 (2000) (Uniform Anatomical Gift Act) and La. R.S. 40:1097 (2000) (blood donation statute).

122. Even those who criticize judicial review of family decisions recognize the possible benefits of such review. See Korins, *supra* note 44, at 520-21, stating:

[I]f a judicial or administrative proceeding increases the accuracy of determining a child's best interest, the intrusion might be justified. For example, if a formal judicial setting helps parents to better understand and appreciate the seriousness of their decision and more carefully reflect on the issues, then all parties would benefit from judicial review. This process would encourage parents and doctors to consider carefully the question of donor benefit. In addition, if doctors were aware that their recommendations could be subjected to judicial review, their institutional biases in favor of treatment would be offset.

Furthermore, as the jurisprudence discussed in Section IV underscores, legislation is needed to provide substantive guidance to courts adjudicating the disposition of a living organ or tissue donation by a minor. A legislative standard would indeed counter any inferences that the adjudicating courts may be drawing from the jurisprudence. Because nearly all of the reported cases (i.e., appealed cases) involve a "questionable donation," such as a living kidney donation by a "mentally retarded" minor, the adjudicating courts may be erroneously inferring that other donations involving distinguishable facts are always permissible. The fact that only two of the seven reported cases (i.e., appealed cases) discussed above involved a living donation by a mentally competent minor gives rise to a fair assumption that such donations are usually approved—possibly "rubber stamped" by district courts—and, thus, the cases are never appealed.¹²³ A legislative standard ensures that every living organ or tissue donation by a minor, whether a "questionable donation" or not, is reviewed on its own merits, rather than through case law analysis. Individual evaluation of each proposed donation will become more important as the number of per year living organ and tissue donations continues to rise and courts are concomitantly faced with cases involving a myriad of distinguishable facts.¹²⁴

The legislation proposed below encompasses two legislative standards, which, due to the associated medical risks and gravamen of abuse, vary somewhat according to the type of donation sought. The first proposed legislative standard regulates: living organ and nonregenerative tissue donations; living partial organ donations even if the portion of the organ donated is regenerative (e.g. partial liver donation); and transplantable nonregenerative tissues (e.g. lung lobe).

The second proposed legislative standard regulates living regenerative tissue donations including bone marrow donations. However, blood donation is not within the scope of this standard.¹²⁵

123. Only *Hart v. Brown*, 289 A.2d 386 (Conn. Super. Ct. 1972) and *Curran v. Bosze*, 566 N.E.2d 1319 (Ill. 1990) involved mental incompetents. See *supra* Section IV. Some writers have, in fact, suggested that mental status affects treatment of donors. See Griner, *supra* note 115, at 603 (stating that there is evidence indicating different treatment of donors depending on mental status and pointing out that there are no reported cases in which permission was sought to transplant tissue from a mentally competent sibling to a mentally incompetent sibling).

124. See *Little v. Little*, 576 S.W.2d 493, 500 (Tex. Civ. App. 1979), noting:

We consider it proper and judicious to suggest that the problem of organ donations by incompetents can be more effectively addressed by the legislature, whose members can promulgate standards based on expert medical, psychiatric and psychological information, as well as testimony and experience of social workers which is not readily available to the judiciary. While we believe that the limited nature of our decision in this case will prevent the exploitation of minors and mental incompetents, we acknowledge that legislators are better qualified to conduct the necessary investigations which will yield a system of rules to adequately protect minors and other incompetents from exploitation without denying them such benefits as competent adults may derive from the organ-donating experience.

See also Bregman, *supra* note 74, at 1185.

125. Because issues dealing with the family tend to be resolved on the state level, the legislation proposed below should be implemented by state governments rather than the federal government. In Louisiana, these statutes would be placed in the Children's Code. This article is not the first in which

A. A Proposed Legislative Standard for Regulating Living Organ and Nonregenerative Tissue Donations by Minors

The following legislative standard is proposed for regulating living organ and nonregenerative tissue donations by minors:

A. No organ or nonregenerative tissue shall be removed from the body of a minor child for transplantation unless a court declares the donation to be in the best interests of the donating minor.

B. Upon the filing of a petition seeking the approval of an organ or nonregenerative tissue donation by a minor, an attorney shall be appointed to represent the interests of the donating minor. Insofar as feasible, but without unduly burdening efficient judicial functioning, the proceedings before the court shall be adversarial.

C. The court shall consider all relevant factors in determining whether the donation is in the best interests of the donating minor. Those factors may include:

(1) Urgency and immediacy of the donee-recipient's medical need for the donation.

(2) Risks the donating minor may be exposed to because of the donation.

(3) Benefits the donating minor may derive from the donation.

(4) The quality and length of the relationship between the donating minor and donee-recipient, including closeness in consanguinity or affinity.

(5) Emotional support available to the donating minor.

(6) Reasonable wishes of the donating minor.

D. This Section does not preclude donations regulated by R.S. 17:2352, R.S. 40:1097, or any other law.

a legislative standard has been proposed for regulating living organ and tissue donations by minors. See Morelli, *supra* note 58, at 949-50, wherein the following proposal for revision of Principle 4 of the WHO Guiding Principles on Human Organ Transplantation, discussed in *supra* note 58, is presented:

No organ or regenerative tissue should be removed from the body of a living minor for the purpose of transplantation. Exceptions may be made if the minor is the brother or sister of the intended recipient. In that case, the organ or regenerative tissue may be removed only with the consent of the person's legal representative and after authorization has been given by the court based on its determination of the best interests of the child after hearing testimony by the minor's physician, the intended recipient's physician (who may not be the same physician attending to the minor donor), and the minor's psychologist/social worker. If the child is over age seven, then the child's viewpoints must enter into the court's decision. If the minor unequivocally refuses donation, then the minor's wishes shall be respected. Violations of this provision shall be punishable by fine or imprisonment subject to national law.

See also *Living Organ Donor Act*, 18 J. Corp. L. 561 (1993), Sheldon F. Kurtz & Michael J. Saks, *Forward*, 18 J. Corp. L. 523 (1993), and *Living Organ Donor Act*, 18 J. Corp. L. 583 (1993), wherein a proposed "Living Organ Donor Act" is discussed.

1. *The Best Interests Standard Modified*

The proposed legislative standard clearly establishes that a living minor may not donate an organ or nonregenerative tissue unless the donation is in the best interests of the donating minor. This declaration is in accord with the jurisprudence discussed above.¹²⁶ Moreover, the notion that a minor should not be exposed to risks without benefits is firmly embedded in the law.¹²⁷

The proposed legislative standard also clarifies that judicial approval is an *a priori* requirement to living organ and nonregenerative tissue donations by minors. Neither a minor nor the minor's parents may proceed with the donation without judicial approval. However, the proposed legislative standard goes beyond the pure objective best interests standard because it expressly requires consideration of the reasonable wishes of the donating minor. Thus, the proposed legislative standard accepts the premise of the best interests standard, but modifies the range of factors to consider and provides a procedure for determining the best interests of the donating minor.

2. *The Appointed Attorney*

The proposed legislative standard provides that an attorney shall be appointed to represent the interests of the donating minor upon the filing of a petition seeking the approval of an organ or nonregenerative tissue donation by that minor. The proposed legislative standard also provides that the proceedings before the court shall be adversarial. Thus, the appointed attorney, acting as an adversary to the petitioner(s) seeking the donation, must attempt to prevent the donation. Evidence should be presented by both petitioner(s) and the appointed attorney to establish the best interests of the donating minor, in particular evidence concerning the risks and benefits of the donation. However, the requirement of adversarial proceedings should not frustrate efficient judicial functioning. For example, the appointed attorney should not needlessly compel testimony. These procedural steps have been embraced by several courts and are likely to further the interests of the donating minor because the propriety of the donation is fully explored in an adversarial manner.¹²⁸

126. See *supra* Section IV.

127. See *supra* note 65 and accompanying text.

128. See *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 318, 110 S. Ct. 2841, 2872 (1990) (Brennan, J., dissenting) ("An adversarial proceeding is of particular importance when one side has a strong personal interest which needs to be counterbalanced to assure the court that the questions will be fully explored."); Martin Guggenheim, *The Right To Be Represented But Not Heard: Reflections On Legal Representation For Children*, 59 N.Y.U. L. Rev. 76, 147-54 (1984):

[T]here are cases where counsel is essential if the child's legitimate interests are to be protected. This is so in cases where parents wish to do something to their child that, as a matter of federal constitutional or state law, requires judicial approval. In these cases, unlike those we have already discussed, the presence of an adult party opposing the parents'

3. *The Factors*

The proposed legislative standard requires the court to consider all relevant factors in determining whether the donation is in the best interests of the donating minor. Several nonexclusive factors are listed in nonhierarchical order; each factor must be considered if relevant. Some of these factors have been considered by every court that has adjudicated the propriety of a living organ or tissue donation by a minor, such as the risks and benefits of the donation.¹²⁹ Other factors have been considered by only a limited number of courts, such as the emotional support available to the donating minor.¹³⁰ However, all of these factors are potentially important in evaluating the donating minor's best interests and, thus, should be considered if relevant. Moreover, the listing of factors is an attempt to control judicial discretion. By legislatively providing a listing of factors to consider, the judge's decision is more likely to be grounded upon relevant considerations.¹³¹

a. Urgency and Immediacy of the Donee-Recipient's Medical Need for the Donation

This factor directs the court's attention to the donee-recipient. By focusing on the donee-recipient, particularly the urgency and immediacy of the donee-recipient's medical need, the court is able to evaluate the context in which the donation is sought. The court should consider whether the donation is needed or if alternative solutions can effectively ameliorate the donee-recipient's condition. Moreover, the court should consider whether the donation is needed now or if alternative solutions can be explored without medical harm to the donee-recipient. Thus, this factor will require the presentation of oral or documentary medical testimony by a physician, preferably the donee-recipient's physician. As medical science advances and new, effective alternative solutions become available, this factor will grow in importance.¹³²

position is unlikely. Examples of such cases [include] . . . court approval for surgery on a healthy child to allow his organs or tissue to be transplanted into a sibling To ensure the legal validity of the parents' position in such cases, the attorney for the child should vigorously oppose the relief sought.

See also Baron et al., *supra* note 87, at 193 ("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."). See also discussion in *supra* Section IV.

129. See discussion in *supra* Section IV.

130. See Curran v. Bosze, 566 N.E.2d 1319 (Ill. 1990), discussed in *supra* Section IV.B.

131. See, e.g., La. Civ. Code arts. 131-134 and La. R.S. 9:335 (2000) (child custody articles), wherein the legislature limits judicial discretion.

132. It is entirely possible that physicians will one day be able to successfully transplant organs of other species into human bodies as replacement parts, a procedure referred to as xenotransplantation. If alternative solutions, such as xenotransplantation, are effective, the need for living organ and tissue donations should decrease. See Jack M. Kress, *Xenotransplantation: Ethics And Economics*, 53 Food & Drug L.J. 353 (1998) (discussing the ethical implications of xenotransplantation).

b. Risks the Donating Minor May Be Exposed to Because of the Donation

This factor has been considered by all courts having adjudicated the propriety of a living organ or tissue donation by a minor.¹³³ Because the risks of living organ and tissue donations are real and potentially fatal,¹³⁴ the court should carefully consider the physiological risks associated with the proposed donation. Moreover, the court should also weigh the potential psychological risks associated with the proposed donation.¹³⁵ Therefore, this factor will require the presentation of oral or documentary testimony from a physician and mental health professional, both of which should be independent of the donee-recipient. The expert testimony should specifically review the risks of the donation according to the particular characteristics of the donating minor, accounting for the minor's age and health condition, rather than broadly review the risks associated with such a donation for the general population.

c. Benefits the Donating Minor May Derive from the Donation

This factor has also been considered by all courts having adjudicated the propriety of a living organ or tissue donation by a minor.¹³⁶ However, many of the adjudicating courts have used a narrow definition of "benefits." This narrow definition should be abandoned for a broader definition.

It is supported in the social science literature that a minor can derive psychological benefits from a living organ or tissue donation.¹³⁷ Therefore, oral or documentary testimony from an experienced psychiatrist, psychologist, social worker, or other mental health professional, who has evaluated the child to determine the child's capacity to benefit psychologically from the donation, should be presented to the court. Moreover, the court should consider the accrual of future, not merely immediate benefits. For example, the court should consider whether the donee-recipient, through a prolonging of life attributable to the donation, can provide future financial or emotional support to the donating minor.¹³⁸

133. See discussion in *supra* Section IV.

134. See *supra* Section I, which discusses the medical implications of living organ and tissue donations by minors.

135. *Id.* See also authorities cited at *infra* note 136.

136. See discussion in *supra* Section IV.

137. See Mary Ellen Smith, *Facing Death: Donor And Recipient Responses To The Gift Of Life*, *Holistic Nursing Practice*, Oct. 1998, at 32; Robert M. House & Troy L. Thompson II, *Psychiatric Aspects Of Organ Transplantation*, 260 *JAMA* 535 (1988); Robbennolt et al., *supra* note 8, at 223 n.56 (citing authority). See also discussion *supra* Section IV.

138. See *In re Richardson*, 284 So. 2d 185 (La. App. 4th Cir.), *writ denied*, 284 So. 2d 338 (1973), discussed in *supra* Section IV.B, wherein the court considered the potential for future benefits but found no such benefits. See also *In re Doe*, 481 N.Y.S.2d 932 (N.Y. App. Div. 1984), discussed in *supra* Section IV.B, wherein the court found that the donor was likely to benefit from the donee-recipient's continued care in the future.

d. The Quality and Length of the Relationship between the Donating Minor and Donee-Recipient, Including Closeness in Consanguinity or Affinity

The donating minor is more likely to obtain benefits from the living organ or nonregenerative tissue donation if the minor has a close relationship with the donee-recipient. If a close relationship is lacking between the two, the benefits which flow from the donation may be too attenuated and thus outweighed by the risks. This probability stems from reality. Since the greatest benefit derived from living organ or tissue donation by a minor is a psychological benefit, strong emotional and psychological ties are probably needed between the donating minor and donee-recipient to foster an appreciable benefit. However, the proposed legislative standard does not restrict such donations merely to siblings. Many minors have the capacity to psychologically benefit from a pure altruistic act of giving.¹³⁹ Therefore, while the court should evaluate the quality and length of the relationship between the donating minor and donee-recipient, particularly examining the closeness in consanguinity or affinity between the two, it should be receptive to permitting more than merely sibling-to-sibling donations.

e. Emotional Support Available to the Donating Minor

The medical procedure which a donating minor must undergo to remove an organ or tissue may be frightening for the minor, despite the minor's willingness to donate. A donating minor will be prodded and stuck by unfamiliar hospital or clinical staff while undergoing the procedure which he may not fully understand. Therefore, this factor reflects the importance of having an individual, preferably a trusted parent, who can provide the needed emotional support to allay any possible fear or concern the donating minor may have. This factor is particularly important for younger donating minors.¹⁴⁰

f. Reasonable Wishes of the Donating Minor

Since the personal autonomy of the donating minor is at stake, the minor should have the opportunity to express his wishes pertaining to the donation. This factor permits the court to consider these wishes, but only if they are reasonable. The minor's wishes may be unreasonable under two circumstances. First, the minor may be too young to make reasoned decisions. In such a case, the minor's wishes should not even be sought by the court. Second, the minor's wishes may be unreasonable, such as when a minor seeks approval for an unreasonably dangerous donation. Under this situation, the minor's unreasonable wishes should be disregarded by the court.

139. See Robbenmolt et al., *supra* note 8 and authorities cited in *supra* note 136.

140. See *Curran v. Bosze*, 566 N.E.2d 1319, 1343 (Ill. 1990) (discussing the importance of having emotional support available for a minor bone marrow donor), discussed in *supra* Section IV.B.

4. *The Limited Scope*

The scope of the proposed legislative standard is set out in subsection (D), which clarifies that neither Louisiana Revised Statutes 17:2352 (the Uniform Anatomical Gift Act),¹⁴¹ 40:1097 (the blood donation statute),¹⁴² nor any other law pertaining to donations of any sort, by minors or majors, is precluded.

B. The Proposed Legislative Standard for Regulating Living Regenerative Tissue Donations by Minors

The following legislative standard is proposed for regulating living regenerative tissue donations by minors:

- A. No regenerative tissue shall be removed from the body of a minor child for transplantation unless a court declares the donation to be in the best interests of the donating minor.
- B. If the parents of a mentally competent minor child provide informed consent to the donation of that minor's regenerative tissue, there shall be a rebuttable presumption that the donation is in the best interests of the donating minor; however, if the donation is shown by clear and convincing evidence not to be in the best interests of the donating minor, the court shall not approve the donation.
- C. Upon the filing of a petition seeking the approval of a regenerative tissue donation by a minor, an attorney shall be appointed to represent the interests of the donating minor. Insofar as feasible, but without unduly burdening efficient judicial functioning, the proceedings before the court shall be adversarial.
- D. The court shall consider all relevant factors in determining whether the donation is in the best interests of the donating minor. Those factors may include:
 - (1) Urgency and immediacy of the donee-recipient's medical need for the donation.
 - (2) Risks the donating minor may be exposed to because of the donation.
 - (3) Benefits the donating minor may derive from the donation.
 - (4) The quality and length of the relationship between the donating minor and donee-recipient, including closeness in consanguinity or affinity.
 - (5) Emotional support available to the donating minor.
 - (6) Reasonable wishes of the donating minor.
- E. This Section does not preclude donations regulated by R.S. 17:2352, R.S. 40:1097, or any other law.

141. See La. R.S. 17:2352 (2000) (governs consent to postmortem organ donations).

142. See La. R.S. 40:1097 (2000) (seventeen-year-old minor may consent to donation of blood).

1. *The Rebuttable Presumption*

The proposed legislative standard for living regenerative tissue donations by minors accords greater deference to parental authority than the standard for living organ and nonregenerative tissue donations by minors. This deference to parental authority, implemented in the form of a rebuttable presumption, is justified because the state's interest in protecting the health of minor children is less threatened by the low risks associated with this type of donation. Consequently, parental authority tips the scale.¹⁴³

However, the proposed legislative standard for living regenerative tissue donations by minors does not accord absolute deference to parental authority. The rebuttable presumption is conditioned upon two prerequisites. First, the rebuttable presumption only arises in the context of a living regenerative tissue donation by a "mentally competent" minor. The proposed legislative standard does not define the concept of mental competency, but instead, purposefully leaves the term open for interpretation. By providing flexibility in defining this term, the courts have greater power to protect mentally incompetent minors from potential discriminatory abuse.¹⁴⁴ If the donating minor is not mentally competent, the court should proceed to adjudicate the best interests of the minor without a presumption in favor of parental choice.

Second, the donating minor's parents must be informed of the medical risks associated with the living regenerative tissue donation before a rebuttable presumption may arise. This is a prerequisite that, hopefully, all parents will fulfill before even considering that their minor child donate regenerative tissue. The prerequisite of informed parental consent should rarely stand as an obstacle to the rebuttable presumption and can be easily accomplished through consultation with a physician and completion of a release form which explains the associated risks.¹⁴⁵ However, parental disagreement over whether the minor should donate is more likely to occur, especially in cases involving unmarried parents. If there is parental disagreement, the court should proceed to adjudicate the best interests of the minor without a presumption in favor of either parent's choice.¹⁴⁶

Parental authority is also tempered by a clear and convincing burden of proof.¹⁴⁷ If the proposed living regenerative tissue donation is shown by clear and

143. See *supra* Section II, discussing the constitutional implications of living organ and tissue donations by minors. See also La. R.S. 40:1097 (2000) (seventeen-year-old minor may consent to donation of blood), wherein the state has legislatively declared that its interest in protecting the health of minors is low with respect to blood donation.

144. See Griner, *supra* note 115, at 603 (discussing reports of different treatment of donors depending on mental competency).

145. In Louisiana, see La. R.S. 40:1299.40 (2000) and *Hondroulis v. Schuhmacher*, 553 So. 2d 398 (La. 1988).

146. See *Curran v. Bosze*, 566 N.E.2d 1319 (Ill. 1990), discussed in *supra* Section IV.B.

147. See *Chatelain v. State Dept. of Transp. and Dev.*, 586 So. 2d 1373, 1378 (La. 1991) ("The burden of proof by clear and convincing evidence requires a party to persuade the trier of fact that the fact or causation sought to be proved is highly probable, i.e. much more probable than its non-existence."); *Louisiana State Bar Ass'n v. Edwards*, 329 So. 2d 437, 442 (La. 1976) ("The standard

convincing evidence not to be in the best interests of the mentally competent donating minor, then the court should not approve the donation. While this burden of proof should rarely be overcome, it provides a means by which to prevent donations that are not in the best interests of the donating minor.¹⁴⁸

CONCLUSION

As the shortage in transplantable organs and tissues increases over the next few years, the number of per year living organ and tissue donations by minors will likely continue its concomitant increase. The proposed legislation presented in this article provides a framework for safely regulating these donations. While allowing living organ and tissue donations by minors, the proposed legislation ensures that the best interests of the donating minor are protected by requiring judicial approval of such donations. However, recognizing the pragmatic distinctions inherent in living organ and tissue donations, two legislative standards have been proposed which differ in the amount of deference accorded parental authority. This proposed legislation strikes a balance between the state's right to protect the welfare of minor children and parental authority.

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requires that the existence of the disputed fact be highly probable, that is, much more probable than its non-existence." See also Joseph Sanders, *The Anatomy Of Proof In Civil Actions*, 28 La. L. Rev. 297, 304 (1968).

¹⁴⁸ For example, this burden of proof probably could be overcome in cases involving parity donations. Because these types of donations involve donors of a very young age (usually less than a year old), the court may find the donation not to be in the best interests of the donating minor by clear and convincing evidence. See *supra* note 118 and accompanying text, discussing parity donations.

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