

TESTING THE BOUNDARIES OF FAMILY PRIVACY: THE SPECIAL CASE OF PEDIATRIC SIBLING TRANSPLANTS

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A six-year-old girl suffers third-degree burns over eighty percent of her body. Her chance of survival with minimal scarring is said to depend on her identical twin sister's availability as an organ source.¹ There are other transplant options—including the parents—but because the twins' skin is "equivalent," a "sibling transplant" is likely to result in a better medical and aesthetic outcome for the burned twin.² Her doctor thus proposes to harvest her healthy sister's skin on "her backside from her bra line down to the bottom of her buttocks or possibly her thighs." This procedure would be repeated up to three times in as many weeks. It would cause "permanent discoloration," and would feel like "a severe sunburn with blisters" for "3–5 days with return to normality with[in] 10–12 days."³

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¹ Samuel J. Tilden, *Ethical and Legal Aspects of Using an Identical Twin as a Skin Transplant Donor for a Severely Burned Minor*, 31 AM. J.L. & MED. 87 (2005).

² Verified Petition for Declaratory Judgment, *In re S.C.*, No. 180564, at 3 (Ala. Prob. Ct. Jan. 2, 2003) [hereinafter Verified Petition] (on file with author). Although the girls' full names have been published elsewhere, throughout this Article I have used only their initials.

³ Guardian ad Litem Report to the Court, *In re S.C.*, Nos. 180564 & 180565, at 2 (Ala. Prob. Ct. Jan. 6, 2003) [hereinafter Guardian ad Litem Report] (on file with author). This report was filed by S.C.'s guardian ad litem (GAL) who opposed her use as a skin source. The Verified Petition described the surgery similarly:

Harvesting the necessary skin from [S.C.] would entail removing a thin layer of skin from [S.C.]'s scalp, the backs of her legs in the thigh area, and possibly from her

Concerned about the legal implications of harvesting skin from a healthy minor child, the hospital consults with outside advisors, including at the local juvenile court, who suggest that the procedure might constitute child abuse. Anxious to proceed, the parents thus choose to bypass that forum and file an action in probate to establish their right to use their healthy daughter's skin to benefit her injured sister.⁴ There, they argue that the grafts are in the healthy child's best interests, presumably because of the sisters' close relationship.⁵ Her guardian ad litem argues otherwise: "[U]nder no circumstances will this 'well-child' . . . escape these surgeries without immediate physical pain and trauma in addition to life-long physical skin damage appearance issues that create probable severe psychological and emotional damage."⁶ The court, which goes to extraordinary lengths to establish its equitable jurisdiction,⁷ finds that, on balance, given the risks and benefits to both sisters, the parents have the right to authorize the surgeries.⁸

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back. In order to complete the process several harvestings may be necessary and would be spaced approximately seven to ten days apart.

Verified Petition, *supra* note 2, at 3.

⁴ Tilden, *supra* note 1, at 97.

⁵ Verified Petition, *supra* note 2, at 5.

⁶ Guardian ad Litem Report, *supra* note 3, at 4.

⁷ See Order on Petition for Declaratory Judgment, *In re S.C.*, Nos. 180564 & 180565, at 2 (Ala. Prob. Ct. Jan. 6, 2003) [hereinafter Order on Petition] (on file with author); see also *infra* notes 140–59 and accompanying text (discussing this analysis).

⁸ Order on Petition, *supra* note 7, at 3.

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INTRODUCTION

Parents hurt their children all the time. They hurt their children's bodies, their feelings, their development, and their chances for happiness and success as adults, for reasons that include maliciousness, indifference, momentary or longer-term lapses of attention, competing priorities, a desire for their progeny's success, religion, culture, psychological dysfunction, and outright incapacity. Indeed, childhood is marked in part by parentally-inflicted injuries, although some of us are luckier than others with respect to the degree to which we suffer or cause harm.

Precisely for this reason, but also because of ideology, the government mostly does not get involved. As a practical matter, even if there were some way for the government to know each time a child is hurt by her parents, there simply are not enough public resources allocated to taking care of children for it to intervene and then to have a net positive effect in every case.⁹ Even if money were no object, however, this extent of state incursion into the family would be anathema in a political system and society that is premised on limited government, that privileges individual privacy in both its decisional and physical forms, and that not only protects but also celebrates its ideological, cultural, and religious diversity.¹⁰ Family privacy¹¹ and the

⁹ See Doriane Lambelet Coleman, *Storming the Castle to Save the Children: The Ironic Costs of a Child Welfare Exception to the Fourth Amendment*, 47 WM. & MARY L. REV. 413 (2005); Michael Wald, *State Intervention on Behalf of "Neglected" Children: A Search for Realistic Standards*, 27 STAN. L. REV. 985, 987 (1975).

¹⁰ Martha Albertson Fineman, *What Place for Family Privacy?*, 67 GEO. WASH. L. REV. 1207, 1212 n.31, 1223 (1999).

¹¹ Family privacy can mean different things. See, e.g., *id.* at 1207 (family privacy means the right to freedom from state interference that belongs to the family as a unit or entity, rather than to its included individuals); Kenneth L. Karst, *The Freedom of Intimate Association*, 89 YALE L.J. 624, 634 (1980) (family privacy means freedom from state intervention in "intimate associations" among individuals); Barbara Bennett Woodhouse, *The Dark Side of Family Privacy*, 67 GEO. WASH. L. REV. 1247, 1254 (1999) (family privacy is essentially the same thing as parental autonomy since, "[w]hen we adopt a theoretical framework that endows any 'unit' of persons with 'autonomy,' or a 'right' to be free of state intervention, in practice, we are conferring unregulated authority on the dominant member within this closed community of persons."). In this Article I mean for family privacy to signify the sphere of family life and parental decisions about family life that are free from state interference.

substantially overlapping doctrine of parental autonomy¹² are the constitutional embodiments of this idea.¹³

Of course, like other rights in this liberal democratic scheme, family privacy and parental autonomy are limited by the principle of ordered liberty, which “provides for freedom within assumed societal goals and values as opposed to freedom from assumed goals and values.”¹⁴ Based on this principle, the government will intervene in the family when parents harm their children in ways that transgress prevailing social norms and aspirations as these are expressed in the law.¹⁵ To use a cartographic metaphor that is prevalent in this context, prevailing social norms and aspirations are the tools that are used to set the outer boundaries of family privacy and thus also of parental authority to cause children harm.¹⁶ And particular harms are permitted or prohibited according to where they fall on the map thus drawn.¹⁷

¹² See Doriane Lambelet Coleman, *The Legal Ethics of Pediatric Research*, 57 DUKE L.J. 517, 545–49 (2007); Woodhouse, *supra* note 11, at 1254.

¹³ Anne C. Dailey, *Constitutional Privacy and the Just Family*, 67 TUL. L. REV. 955, 959 (1993) (“[T]he family acts as an important institutional check on the power of the state to mold citizens in its own image.”); *id.* at 996 (“[P]arental authority . . . is necessary for the development of responsible individuals who have been raised with a sense of belonging to distinct and diverse moral traditions.”); Fineman, *supra* note 10, at 1214 (concluding that “[t]his ideology of state non-intervention is rooted in idealization, but also references the perceived pragmatics of family relationships and the acknowledged limitations of legal, particularly judicial, systems as substitutes for family decision-making.”).

¹⁴ Doriane Lambelet Coleman, *The Seattle Compromise: Multicultural Sensitivity and Americanization*, 47 DUKE L.J. 717, 718 (1998).

¹⁵ *Id.* at 719; see also Dailey, *supra* note 13, at 959, 992 (noting that “the family’s role in initiating children into political life suggests that there must be some constitutional limits to the degree of family diversity a liberal democracy may tolerate” and that “[t]he settled boundaries of parental authority inject a strong normative vision of the ‘good citizen’ into family life”); Fineman, *supra* note 10, at 1224 (noting that “[e]ntity privacy . . . denote[s] a line of non-intervention drawn around on-going functioning relationships”); Lee E. Teitelbaum, *The Family as a System: A Preliminary Sketch*, 1996 UTAH L. REV. 537, 548, 556 (noting that “[t]he institutional idea [of the family] has normative content precisely because it grounds expectations about conduct,” and that “[a]t the most general level, family relations exist in a setting that includes legal and social norms that strongly influence the institutional idea of the family, the way families define the arrangements available to them, and the ways family members live their lives together”).

¹⁶ See, e.g., Dailey, *supra* note 13, at 965 (noting the historical construction of the family as “a little commonwealth”); Elizabeth S. Scott & Robert E. Scott, *Parents as Fiduciaries*, 81 VA. L. REV. 2401, 2453 (1995) (noting that “[e]xplicit legal commands [regulating the parent-child relationship] are limited largely to a series of preemptive rules that define the boundaries of parental discretion”); Teitelbaum, *supra* note 15, at 542 (recalling colonial history which described the family as “distinct from that other entity, the state, [which] must be given some decisional space” and describing a married couple as “form[ing] a precinct that stands apart from and is ordinarily closed to state authority”); *id.* at 546 (rejecting the conventional idea of “the family . . . as an island or refuge”); Barbara Bennett Woodhouse, “Who Owns the Child?": *Meyer and Pierce and the Child As Property*, 33 WM. & MARY L. REV. 995, 1051 (1992) (describing state incursions on family privacy and parental autonomy using language such as

Because prevailing social norms and aspirations are used to define the boundaries of family privacy and parental authority, as social norms and aspirations change, so do these boundaries. Thus, when society conceives of the child as being one with her parent,¹⁸ or in an implicit contractual relationship with her parent in which “the infant ‘agrees’ to obey the parent in exchange for the parent’s forbearance from allowing the helpless infant to perish,”¹⁹ or—like slaves or even a treasured object—as the property of her parents,²⁰ or as the property of god whose fiduciary is her parent,²¹ the parent has quite a lot of freedom to hurt her child. Barbara Bennett Woodhouse has summarized some of the implications of the boundaries established according to these property-related norms:

Under Roman law, fathers possessed the power of life or death over their children. Even in the American Colonies, laws in many places provided capital punishment for a child who struck or cursed his parent, although there is no record of such sentences being carried out. Well into the nineteenth century, a father could enroll his male children in the army and collect the enrollment bounty, betroth his

“patriarchal governance was being challenged in skirmishes on many fronts”; “patriarchy fought to maintain its ground”; “the boundaries of its kingdom were blurring”; “[p]rogressive reforms . . . pushed at the borders of the domestic realm”).

¹⁷ Doriane Lambelet Coleman, *The Role of the Law in Relationships Within Immigrant Families: Traditional Parenting Practices in Conflict with American Concepts of Maltreatment*, in IMMIGRANT FAMILIES IN CONTEMPORARY SOCIETY 287, 290 (Jennifer E. Lansford et al. eds., 2007) (explaining that governments develop “their definitions of [maltreatment] in the same way that they develop other values-based legislation . . . [i.e., using a combination of] prevailing (majoritarian) norms and sometimes also the recommendations of experts in the field about what is needed to achieve public policy goals”); *id.* (explaining that the Supreme Court has for the most part accepted the states’ maltreatment rules as also setting the outer boundaries of parental authority to cause children harm); *see also* Coleman, *supra* note 12, at 545–99 (further elaborating on the relationship between state maltreatment rules and the constitutional doctrine of parental autonomy).

¹⁸ *See* Barbara Bennett Woodhouse, *From Property to Personhood: A Child-Centered Perspective on Parents’ Rights*, 5 GEORGETOWN J. ON FIGHTING POVERTY 313, 313 (1998) (describing this identity relationship as a source of the view of the child as property, i.e., “[f]lesh of their father’s flesh, children rightly belonged to the patriarch, to be worked, traded, and given in marriage in exchange for money”); *id.* (describing Aristotle as another source of this same view, i.e., “[t]here cannot be injustice towards that which is one’s own; and a chattel, or a child, until it is of a certain age and has attained independence, is as it were a part of oneself; and nobody chooses to injure himself (hence there can be no injustice towards oneself) and so neither can there be any conduct towards them that is politically just or unjust”).

¹⁹ *Id.* at 314 (describing Thomas Hobbes’s view of parental authority).

²⁰ *See id.* at 313 (describing the property theory of parental authority over children as an aspect of “[t]he concept of human property, of which slavery was the most notorious vestige,” and as imagining “parental rights as being virtually absolute and an end in themselves, rather than as an outgrowth of parents’ responsibilities and a means to secure the well-being of their children”).

²¹ *See id.* at 314 (describing John Locke’s view that “God was the true owner of children. God created children and gave them into their parents’ care: thus parental powers were a form of trusteeship of the Creator’s property”).

minor female children to persons of his choice, put his children to work as day laborers on farms or factories and collect their wage packets. As recently as in 1920 a parent who killed a child in the course of punishment could claim a legal excuse for homicide in no fewer than nine states. A father had the power to decide where and with whom his child would reside, and to transfer his children by testamentary disposition to someone other than their mother.²²

However, when society rejects these property-related norms and reconceives the child as a “collective resource,”²³ or as an individual worthy of respect in her own right who belongs ultimately to herself and whose parent is her fiduciary during the period of her infancy,²⁴ the parent has quite a lot less freedom to hurt her child. In such a society, the parent is presumed to be her child’s fiduciary—her primary or “‘first best’ caretaker[.]”²⁵—because she is naturally inclined to protect her child’s survival and success and otherwise to act in her best interests.²⁶ Within this scheme, the state in its twin *parens patriae* and police power roles is viewed mostly as a “junior partner,” assisting the parent to raise her child up to be a healthy and responsible member of society, but also as a last check on the parent who might violate her fiduciary obligations by causing harm to the child that transgresses the boundaries of family privacy.²⁷

This last, most progressive, concept of the child and her relationship to her parent and the state is still largely aspirational. Nevertheless, it is expressed in modern law and also to a great degree in

²² *Id.*; see also Emily Buss, *What the Law Should (and Should Not) Learn from Child Development Research*, 38 HOFSTRA L. REV. 13 (2009).

²³ Woodhouse, *supra* note 16, at 1051–52, 1054 (introducing the idea of the child as a “collective resource” whose “highest duty was no longer obedience to parents, but preparation for citizenship” and who was “not [the] private property of his parent, nor of himself, but . . . belonging to the community, the collective family”; and positing that this shift away from the view of the child as the property of her parents was in part responsible for the development beginning in the late nineteenth century of child welfare, child labor, and mandatory school attendance laws).

²⁴ See Katharine T. Bartlett, *Re-Expressing Parenthood*, 98 YALE L.J. 293, 294 (1988) (arguing that the law should express a view of parenthood “based upon notions of benevolence and responsibility” rather than “in notions of exchange and individual rights”); Gregory A. Loken, *Gratitude and the Map of Moral Duties Toward Children*, 31 ARIZ. ST. L.J. 1121, 1149 (1999) (citing Immanuel Kant on the child, her relationship with her parents, and their obligations to her); Scott & Scott, *supra* note 16, *passim* (demonstrating how the law’s structuring of the parent-child relationship is consistent with a fiduciary model); Woodhouse, *supra* note 16, *passim* (beginning her development of a “trusteeship” model of the parent-child relationship); see also PAUL RAMSEY, *THE PATIENT AS PERSON: EXPLORATIONS IN MEDICAL ETHICS* 14, 24–26 (2d ed. 2002) (describing a fiduciary theory of the parent-child relationship in the medical and research settings).

²⁵ SAMUEL M. DAVIS ET AL., *CHILDREN IN THE LEGAL SYSTEM* 1 (4th ed. 2009) (using this expression).

²⁶ See *Parham v. J. R.*, 442 U.S. 584, 602 (1979).

²⁷ See *Prince v. Massachusetts*, 321 U.S. 158, 163–68 (1944); Coleman, *supra* note 12, at 548–49, 616 (describing this relationship).

the informal social norms that complement its terms. Thus, in contrast with earlier periods, a parent's legal and cultural obligations today include not only assuring her child the basic necessities of life—food, shelter, and medical care—but also (among other things) a childhood free of labor and maltreatment, an education, and in cases of intra-family conflict, focused attention on her physical, educational, emotional, and developmental best interests.²⁸

The goal of this Article is to situate the parenting practice described in the introductory illustration—the use of minor children as an organ source²⁹ for their ill siblings, or “pediatric sibling transplants”—within this historical and theoretical context, with an emphasis on understanding how it is or can be justified in the current period. In the process, I hope to develop a more complete picture of the modern boundaries of family privacy. Sibling transplants are particularly, maybe even uniquely, illuminating of these boundaries because unlike most all other parenting practices they appear to have broad (albeit mostly tacit) societal support at the same time that the surgeries involved violate the strongest and least controversial of the norms at the core of the modern concept of the child and her relationship with her parents: The requirement that parents protect their children from unnecessary serious physical harm.³⁰ In at least many instances, they also appear to violate parents' obligation to do right by their children's emotional and developmental wellbeing; although this latter obligation does not have the same normative or doctrinal weight as its physical counterpart, it is still a significant aspect of the progressive concept of the child and her relationships with her parents and the state. As a result, the use of healthy minor children as organ sources for their ill siblings is a puzzle that both tests the boundaries of parental authority and provides the basis for the development of important details about their contours.

Specifically, the practice of using healthy minor children as organ sources presents as one of three possibilities: First, it presents most

²⁸ See Coleman, *supra* note 12, at 614–19.

²⁹ Throughout this Article I refer to healthy children from whom organs are harvested as organ “sources” rather than as “donors.” Although the latter term is more common, I use the former because I agree with the Council on Ethical and Judicial Affairs of the American Medical Association that “donation” is not only a misnomer but also disingenuous in this context since “minors generally cannot give valid consent to donation,” and since (because of their age or the circumstances) they may not even be asked for or capable of giving their assent. COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, AM. MED. ASS'N, THE USE OF MINORS AS ORGAN AND TISSUE DONORS: REPORT 3-I-93, at 1 (1993).

³⁰ This practice is one of a number of medically unnecessary surgeries that include cosmetic and gender re-assignment surgeries, and male circumcision. All are alike in that they are generally (if only tacitly) accepted at the same time that they violate the prohibition against physical abuse of a child. See Coleman, *supra* note 12, at 553–59 (describing *de facto* exceptions to child maltreatment law). The use of healthy children as organ donors for their ill siblings is most probative of the boundaries of family privacy, however, the case is more difficult to make here than it is in these other contexts that the surgery is in the donor child's best interests.

easily but also most unsatisfactorily as an important relic of the historical concepts of the child as property and of parents as sovereigns of the kingdom that is the family. Second, it may reflect a particularly strong set of traditional and still-vital countervailing norms, in this case about family unity or interdependence, that manage in certain special circumstances to trump our commitment to a progressive sense of the child. Third, to the extent that a real commitment to the child as an individual requires recognition of the fact that her first nuclear family—including in its composition and culture—is a necessary if not inevitable part of what constitutes her as a person, the practice may be seen as perfectly consonant with a most progressive sense of the child. Developing the latter two possibilities in particular allows for the establishment of grounded views not only about the practice itself but also, and most importantly, about the boundaries that they either transgress or amplify.

The Article proceeds as follows: Part I describes the relatively sparse legal history of pediatric sibling transplants beginning with the first cases decided by the Massachusetts Supreme Judicial Court sitting in equity in 1957 through the extraordinary 2003 *In re S.E.* decision, featured in the introductory illustration. In contrast with previous summary renditions of this history,³¹ it provides a thorough analysis of the cases that makes clear that—contrary to the generally-held view—they can no longer be considered the basis for parental or judicial authority to use healthy children as organ sources for their ill or injured siblings. Specifically, it situates the cases in a period of procedural flux in American law during which the state courts' equity jurisdiction became increasingly narrow and thus decreasingly available to parents seeking authorization to proceed with pediatric sibling transplants. The procedural gymnastics engaged by the parties and legal actors in *In re S.C.* exemplify these difficulties in the modern era. They also exemplify the conundrum that the pediatric sibling transplant cases pose for the law: What is it about the practice of using healthy minor children as organ sources that causes it to remain not only sub rosa but also probably *ultra vires*, even as all of the relevant parties *including lawyers and judges* seem willing to pursue the option in particular circumstances?

³¹ This line of cases has been described previously; however, because the commentators apparently did not have access to the original case files, or because they did not appreciate the significance of the cases' foundations in the courts' historic but now largely diminished equity jurisdiction, they are incomplete or incorrect in important respects. See Robert J. Pristave & Katie L. Watson, *Kidney Donation by Children and the Mentally Handicapped: Evolution of Precedent*, in LEGAL AND ETHICAL CONCERNS IN TREATING KIDNEY FAILURE 7, 8–11 (Eli A. Friedman ed., 2000); Jennifer K. Robbennolt et al., *Advancing the Rights of Children and Adolescents to Be Altruistic: Bone Marrow Donation by Minors*, 9 J.L. & HEALTH 213 (1994).

Part II attempts to answer this question. It first elaborates on the principles that underlie modern law's inevitable rejection of the practice, focusing on fiduciary theory and its doctrinal application in the states' battery, consent, and maltreatment laws. It then develops the arguments from family unit and interdependence and obligation theories in support of the right of parents to use their healthy minor children as organ sources for needy family members. It closes with an analysis of the practical and normative implications of the awkward status quo for children who would be used as organ sources, and for the law's capacity to draw the boundaries of family privacy.

Part III argues that the boundaries of family privacy should and will continue to be drawn according to fiduciary theory and its associated norms and aspirations; competing norms and aspirations about the child as property and the family as a unit are practically and ethically weak by comparison and also unlikely to gain sufficient currency in the modern context. It joins scholars who respect fiduciary theory's privileging of the child's physical integrity but who also have urged a commitment to the child's emotional and developmental interests: Doing so is controversial for many of the same reasons that explain the law's reluctance generally to recognize emotional harms, and yet it is necessary to assure that the fiduciary enterprise is meaningful. Finally, it applies these principles to the special case of pediatric sibling transplants, arguing that the law must take an express stand on the practice to assure that the healthy child who would be used as an organ source is adequately protected—nonbinding medical protocols are insufficient for this purpose—and that the protections developed should bar transplants unless they are shown by clear and convincing evidence to be in the healthy child's multiple interests.

The Article concludes that resolving the issues raised by pediatric sibling transplants according to fiduciary theory will serve to clarify the boundaries of family privacy, and also to assure that they remain set to protect children against parentally-inflicted harm that cannot be justified according to their interests. Although parents will always have competing interests to consider, including their own and those of their other children, the state ought to be permitted to intervene in the family and its decisionmaking to protect the child who would be seriously injured as a result.

I. A LEGAL HISTORY OF PEDIATRIC SIBLING TRANSPLANTS

Neither the medical practice of using living minor children as an organ source for their ill siblings nor the legal practice of allowing or disallowing the surgeries is well documented, at least not publicly. For example, online histories of transplantation abound, including those

involving living donors, but these histories typically omit or obscure references to living pediatric donors;³² courts that have been asked to authorize parents to consent to the transplants typically have not written or published their opinions and have impounded or sealed the accompanying records;³³ and although the federal government publishes detailed annual data on living donations, it appears likely that underreporting of pediatric donations is the norm.³⁴ Nevertheless, despite its sub rosa nature, it is possible to understand something of the history and scope of the practice from a combination of the clinical possibilities, related writing in the medical and legal literature, and available (albeit mostly unpublished) case law. From these sources, we can assume that, with the exception of surgeries whose short and/or long term negative physical consequences for the prospective donor cannot be ignored, the use of living minor children as organ sources has probably tracked the use of living adult donors.³⁵

³² See, e.g., *Donation & Transplantation History*, UNITED NETWORK FOR ORGAN SHARING (UNOS), <http://www.unos.org/donation/index.php?%20topic=history> (last visited Mar. 14, 2014) (noting that the “[f]irst successful living donor liver transplant [was] performed” in 1989, but that it was not until 1998 that the “[f]irst successful adult-to-adult living donor liver transplant [was] performed,” and otherwise omitting references to pediatric transplantation). A clear exception is the proliferation, particularly in the last several years, of details and commentary about children donating bone marrow and stem cells. See, e.g., Comm. on Bioethics, Am. Acad. of Pediatrics, *Children as Hematopoietic Stem Cell Donors*, 125 PEDIATRICS 392 (2010) [hereinafter AAP Policy Statement]; Rebecca D. Pentz et al., *The Ethical Justification for Minor Sibling Bone Marrow Donation: A Case Study*, 13 ONCOLOGIST 148 (2008); Michael A. Pulsipher, *A Donor’s a Person, No Matter How Small*, 119 BLOOD 2705 (2012); Lainie Friedman Ross, *In Defense of the American Academy of Pediatrics Policy Statement—Children as Hematopoietic Stem Cell Donors*, 56 PEDIATRIC BLOOD & CANCER 520 (2011); Jan Styczynski et al., *Risk of Complications During Hematopoietic Stem Cell Collection in Pediatric Sibling Donors: A Prospective European Group for Blood and Marrow Transplantation Pediatric Diseases Working Party Study*, 119 BLOOD 2935 (2012); see also *infra* notes 79–80, 124–125 (discussing this further).

³³ See, e.g., Pristave & Watson, *supra* note 31, at 10–11; John A. Robertson, *Organ Donations by Incompetents and the Substituted Judgment Doctrine*, 76 COLUM. L. REV. 48, 53 n.26 (1976).

³⁴ Compare Organ Procurement & Transplantation Network, *Living Donors Recovered in the U.S. by Donor Age*, U.S. DEPARTMENT HEALTH & HUM. SERVICES, <http://optn.transplant.hrsa.gov/latestData/step2.asp> (Step 1: “Choose Category” select “Donor” and “Choose Organ” select “All”; Step 2: follow “Living Donors by Donor Age” hyperlink) (including detailed numbers for all organ transplants from 1988 to 2012) (last visited Mar. 19, 2014), with *infra* notes 124–25 and accompanying text (discussing prevalence of pediatric sibling transplants in the current period). Cf. Mary E. Olbrisch et al., *Children as Living Organ Donors: Current Views and Practice in the United States*, 15 CURRENT OPINION ORGAN TRANSPLANTATION 241, 242 & tbl.1 (2010) (providing some data but noting that it may not be complete); Lainie Friedman Ross & J. Richard Thistlethwaite, Jr., *Minors as Living Solid-Organ Donors*, 122 PEDIATRICS 454, 456 (2008) [hereinafter AAP Clinical Report] (same).

³⁵ I do not mean to suggest that the numbers of healthy children used as organ sources track the numbers of adult donors; because of the administrative and procedural hurdles in the way of the former, if not also because of a continuing squeamishness about the practice, it is likely that the numbers are not at all the same. See, e.g., AAP Clinical Report, *supra* note 34, at 454–55 (suggesting that “[a]lthough rare, children do serve as [solid-organ] donors” and

A. *The Early Equity Decisions*

Although it is likely that skin grafts were taken from healthy minor children to benefit their injured siblings earlier in the twentieth century,³⁶ the first documented uses of minor children as organ donors appear to have involved kidney and bone marrow transplants between identical twins starting in the late 1950s.³⁷ Professor William Curran of Boston University was the first to describe the origins of the kidney cases in the legal literature, in an article published in 1959:

The first successful homotransplantation of a kidney in identical twins was performed at the Peter Bent Brigham Hospital in Boston in 1954.³⁸ In this case the twins were adults.

In 1956 the same hospital was confronted with [three] requests for similar procedures on identical twins who were minors. In each of the cases, one of the twins was suffering from chronic renal disease which would soon prove fatal if a kidney was not transferred from the healthy twin. For the hospital staff and its board of trustees the request raised, among many problems, a puzzling legal question. For every medical and surgical procedure performed in a hospital a consent is obtained to avoid the act being found a battery (and an assault, if the patient is conscious at the time). For minors, all hospitals obtain the consent of the parents or guardians. The question here was whether the consent, in fact, the request, of the parents was sufficient to warrant the hospital in proceeding. In most cases of minors, of course, parental consent is controlling in regard to medical treatment. However, in such cases the treatment is always potentially *beneficial* to the child. In homotransplantation of a kidney from a healthy twin to save the life of the sibling, there is a potential

providing as examples that “at least 60 children younger than 18 years served as living kidney donors between 1987 and 2000, during which time approximately 40[,]000 live kidney donations occurred” and that “[a]t least 4 minors in the United States have served as living liver donors since 1989”); Olbrisch et al., *supra* note 34, at 242 (suggesting that the numbers of healthy children used as organ sources is actually on the decline as a result of increased attention to children’s “rights and protections” and “policies that advantage [children] in the allocation of organs from deceased donors”).

³⁶ Homologous skin transplantation using adult donors was a reality before the kidney cases. See *Bonner v. Moran*, 126 F.2d 121 (D.C. Cir. 1941) (suggesting that a parent probably could consent to the use of her child as a skin donor for a needy cousin); *Organ Transplantation*, WIKIPEDIA, http://en.wikipedia.org/wiki/Organ_transplantation (last modified Mar. 9, 2014) (summarizing the history of organ transplantation).

³⁷ *History of Transplantation*, FRED HUTCHINSON CANCER RES. CENTER, <http://www.fhcr.org/en/treatment/long-term-follow-up/FAQs/transplantation.html> (last visited Mar. 14, 2014).

³⁸ For a discussion of this pioneering surgery see M.J. Friedrich, *Joseph Murray, MD—Transplantation Pioneer*, 292 J. AM. MED. ASS’N 2957 (2004), available at <http://jama.jamanetwork.com/article.aspx?articleid=200049> (noting that Dr. Murray received the Nobel Prize for Physiology or Medicine in 1990 for his development of the living kidney transplant procedure).

benefit for the sick twin, but what of the healthy donor? He will lose one of his two kidneys. At some time in the future such a loss could be highly detrimental should his remaining kidney be threatened.

There being no law on the subject in Massachusetts or elsewhere the hospital trustees and the surgical staff were advised to seek a declaratory judgment.³⁹

Because the resulting three decisions—*Masden v. Harrison*,⁴⁰ *Huskey v. Harrison*,⁴¹ and *Foster v. Harrison*⁴²—were never published and were apparently under seal, Professor Curran’s account has long been the basis for further discussion of their particulars by courts and legal commentators.⁴³ I describe this trilogy in additional detail below based on files I was able to obtain from the state’s archives.

The decisions were rendered by the state’s Supreme Judicial Court⁴⁴ sitting in equity in a single justice session.⁴⁵ Consistent with the legal advice given to the Brigham Hospital and its surgical team, at the time, the courts’ equity jurisdiction was invoked when an injunctive remedy was sought or when there was an absence of law on the subject of the suit.⁴⁶ Both of these doors to equity were open to the petitioners.

³⁹ William J. Curran, *A Problem of Consent: Kidney Transplantation in Minors*, 34 N.Y.U. L. REV. 891, 892 (1959) (footnote omitted); see also Pristave & Watson, *supra* note 31, at 9 (“Declaratory judgment is a procedural mechanism that allows parties . . . to go to court and receive a ruling on whether what they propose to do is legal.”).

⁴⁰ No. 68651 (Mass. Eq. June 12, 1957) (decision on file with author).

⁴¹ No. 68666 (Mass. Eq. Aug. 30, 1957) (decision on file with author).

⁴² No. 68674 (Mass. Eq. Nov. 20, 1957) (decision on file with author).

⁴³ See, e.g., Pristave & Watson, *supra* note 31, at 9 n.3 (indicating that their account is based on the Curran article); Robertson, *supra* note 33, at 78 n.26 (same).

⁴⁴ Massachusetts calls its supreme or highest court the Supreme Judicial Court. See Neal Quenzer & Francis X. Spina, *Supreme Judicial Court*, in 1 MASS. CONTINUING LEGAL EDUC., APPELLATE PRACTICE IN MASSACHUSETTS ch. 1 (3d ed. 2011) (summarizing the history and institutional role of this court). At least two previous authors commenting on the trilogy have misunderstood this point, suggesting erroneously that the cases were decided by lower level trial courts. See Pristave & Watson, *supra* note 31, at 9–10. Pristave and Watson critique the decisions for failing to set a clear standard that could provide guidance to parties and courts in the future. *Id.* at 10. It is likely they did not understand or notice the fact that the decisions were rendered by the court exercising its equity jurisdiction, which was (at least relative to law) intentionally standardless. See *infra* note 46 and accompanying text (discussing the use of equity in this context and the history of equity jurisdiction generally).

⁴⁵ Single justice sessions are used mostly in cases in which time is of the essence. See, e.g., Karen Hennessey et al., *Interlocutory Relief in Child Welfare Cases*, in 1 MASS. CONTINUING LEGAL EDUC., CHILD WELFARE PRACTICE IN MASSACHUSETTS ch. 12, § 12.2.1 (1st ed. Supp. 2012) (noting the use of such sessions in child custody cases); see also Quenzer & Spina, *supra* note 44 (describing the court’s single justice session in general).

⁴⁶ Historically, equity was “[a] system of jurisprudence collateral to, and in some respects independent of, ‘law’; the object of which [wa]s to render the administration of justice more complete, by affording relief where the courts of law [we]re incompetent to give it.” BLACK’S LAW DICTIONARY 540 (6th ed. 1990); see also JACK H. FRIEDENTHAL ET AL., CIVIL PROCEDURE: CASES AND MATERIALS 22–23 (10th ed. 2009) (setting out the history of the equity courts); Thomas O. Main, *Traditional Equity and Contemporary Procedure*, 78 WASH. L. REV. 429, *passim* (2003) (providing a particularly detailed account of the historical division between law

That is, they all sought a declaration of the parties' legal rights, and none of the three areas of the law implicated by the facts had directly applicable rules.⁴⁷ Thus, the tort of battery and its consent defense as these apply to minors had not developed doctrine specifically on the issue of nontherapeutic procedures.⁴⁸ The state's child maltreatment law

and equity and their procedural merger). Law was considered "incompetent" or "inadequate" in this context because it did not speak to the issue at hand, because the kind of relief or remedy sought, for example a declaratory judgment, an injunction, or specific performance, could not be awarded by a law court which could only award monetary damages, or because law's then-cumbersome procedures made relief inaccessible to the petitioner. KEVIN M. CLERMONT, *PRINCIPLES OF CIVIL PROCEDURE* 24–25 (2d ed. 2009). Thus, the equity courts assumed jurisdiction of cases—opened their doors to the petitioner—when one or more of these factors was at issue. When equity jurisdiction attached in this earlier period, the judge's discretion was guided by (i.e., the standard for making the decision was) "fairness as contrasted with the strictly formulated rules of common law." BLACK'S LAW DICTIONARY, *supra*. Fairness was in the eye of the beholder, however; and thus this guidance was subject to the criticism that it was effectively standardless. As one early commentator described it, "Equity is a Roguish thing; for Law we have a measure, know what to trust to; Equity is according to the Conscience of him that is Chancellor, and as that is larger or narrower, so is Equity." CLERMONT, *supra*, at 25. Judicial reforms involving simplification of procedural rules beginning in the 1800s resulted in the merger of law and equity courts so that today, in almost all states, the same judges "sit" both in law and in equity, and the combined courts (now usually called civil courts) are entitled to award both legal and equitable remedies. See FRIEDENTHAL ET AL., *supra*, at 541–45; Main, *supra*, at 464–76. The standard for deciding cases that were equitable in nature also evolved significantly, initially as a result of the critique against the standardlessness of the historical fairness and justice test, but then because law itself had become increasingly pervasive; areas of human interaction previously untouched or "inadequately" addressed were now dealt with in meticulous detail either by statute or by operation of the common law. See, e.g., *infra* notes 51–59 and accompanying text (discussing the seminal pediatric sibling transplant case *Masden v. Harrison*, in which the court sitting in equity adopted a version of the law's "best interests" standard to decide the case); *infra* notes 113–22 and accompanying text (discussing the increased statutory regulation of the court's probate jurisdiction). Thus, where a court in an action seeking an equitable remedy previously could examine the substantive issues involved according to their inherent equities, today the rules of decision are typically detailed in the states' and/or the federal government's statutory and case law; and certainly, where their law is on point, a court cannot ignore its applicability. See, e.g., Marc E. Tarlock, *Voluntary Departure and the Right to Reopen Removal Proceedings on the Merits*, 2007 U. CHI. LEGAL F. 613, 635 n.125 (citing *Ngarurih v. Ashcroft*, 371 F.3d 182, 194 (4th Cir. 2004) ("Having concluded, however, that [the statutory provision] precludes judicial review . . . we cannot evade this statutory directive by resort to equity.")).

⁴⁷ Given that the medical procedure was novel and that the law generally evolves to address real controversies, this is not surprising. See *Pristave & Watson*, *supra* note 31, at 8.

⁴⁸ The closest precedent was an out-of-jurisdiction (thus not binding) case, *Bonner v. Moran*, 126 F.2d 121 (D.C. Cir. 1941), which suggested in dicta (which is also not binding) that a parent probably could consent to the use of her child as a skin donor for a needy cousin. On the facts, although the child himself had apparently consented to be used as an organ source for his cousin, his mother was not informed of the transplant before it took place, and thus the doctor at issue was found liable in battery. The case is typically understood to stand for the legally non-controversial proposition that parental consent is required before a non-emergency surgical procedure can be performed on a minor. See, e.g., *Kozup v. Georgetown Univ.*, 851 F.2d 437, 439 (D.C. Cir. 1988) (citing *Bonner* for the rule that "[i]n the case of a minor patient, the relevant consent is that of the parents").

was primarily focused on neglect.⁴⁹ And the law's overarching, individual-child-centered "best interests" standard had not been applied in an obviously analogous situation. This legal backdrop imposed some, but not particularly constraining, boundaries on the justices who were otherwise free to operate according to equity's first principles of fairness and justice.⁵⁰ That is, the justices clearly believed that they could not permit the parties to proceed in the absence of consent; and they apparently believed that it was a good idea, if not even required, that they find the surgery to be (also) in the interests of the healthy child. But their hands were not otherwise tied.

The seminal case in the trilogy is *Masden v. Harrison*, decided in June of 1957.⁵¹ The parties in *Masden*, including the children, sought to establish the right of twin nineteen-year-old boys and their mother to consent to the removal of a kidney from the healthy twin (Leonard) to benefit his brother (Leon) whose own kidneys had failed; indeed, Leon was described as "fast approaching a terminal condition and the only hope of saving his life is to perform a kidney transplant operation."⁵² Because the surgery would obviously not result in any physical benefit to the healthy twin, the parties developed the two-pronged argument that the surgery was in his psychological best interest as it would allow him to do what he could to save the life of his treasured sibling, and that his psychological welfare was of overwhelming developmental significance. Specifically, they argued that

if this operation is not performed and Leon dies... a grave emotional impact on Leonard would result... [which] would be further aggravated by the realization that it was within his power to have saved the life of his brother had this operation been performed.⁵³

Lacking even a single close precedent to support the proposition that surgery could proceed on the basis of these non-physical interests, the parties, and ultimately the Massachusetts Supreme Judicial Court, chose to rest the argument and decision on the United States Supreme Court's then-recent, seemingly inapposite decision in *Brown v. Board of*

⁴⁹ See MASS. GEN. LAWS ANN. ch. 119, § 24 (West 1954) (defining the maltreated child as one "without necessary and proper physical, educational or moral care and discipline, or... growing up under conditions or circumstances damaging to [his] sound character development, or who lacks proper attention of parent, guardian with care and custody, or custodian, and whose parents or guardian are unwilling, incompetent or unavailable to provide such care"); see also *id.* (West 1957) (same).

⁵⁰ See *supra* note 46 (describing the history of equity jurisdiction and its standards).

⁵¹ *Masden v. Harrison*, No. 68651 (Mass. Eq. June 12, 1957) (decision on file with author).

⁵² *Id.* at 2.

⁵³ *Id.*

Education.⁵⁴ In particular, to support its finding that “[s]uch emotional disturbance could well affect the health and physical well-being of Leonard for the remainder of his life”⁵⁵ and thus that “this operation is [also] necessary for the continued good health and future well-being of Leonard,”⁵⁶ the opinion in *Masden* cites the latter part of *Brown* in which the Court describes the developmental and lifelong impact of the social stigma and psychological injuries suffered by black children as a result of school segregation.⁵⁷ *Masden* does not otherwise discuss *Brown*; however, the point implied by the citation appears to be that sometimes, psychological and developmental benefit (at least if these can be said also to implicate the individual’s future physical welfare) can justify enormous social and jurisprudential upheaval, such as that which was involved in desegregating the public schools and in allowing a parent to consent to the cutting open of a healthy child to remove an organ for someone else’s benefit.⁵⁸ Ultimately, *Masden* held that “it is proper for the [surgeons] with the assistance of [the hospital] to perform the operation herein described with the consent of all the plaintiffs without incurring any civil liability to Leonard or any criminal prosecution.”⁵⁹

The second and third cases in the trilogy were *Huskey v. Harrison*⁶⁰ and *Foster v. Harrison*,⁶¹ decided by different justices just several months later, in August 1957 and November 1957, respectively. These cases apparently cemented both the declaratory judgment procedure as the vehicle to obtain lawful consent to perform pediatric sibling transplants and (at least in Massachusetts) the substantive right of

⁵⁴ 347 U.S. 483 (1954). The *Masden* court did cite two other cases but neither was sufficiently helpful. See *Masden*, No. 68651, at 3 (citing *Bonner v. Moran*, 126 F.2d 121 (D.C. Cir. 1941) (suggesting that a parent might be able to consent to the use of her child as a skin donor); *Reddington v. Clayman*, 134 N.E.2d 920 (Mass. 1956) (concerning an unconsented-to blood transfusion)).

⁵⁵ *Masden*, No. 68651, at 4.

⁵⁶ *Id.* Specifically, the court noted that “in performing the operation the defendants are conferring a benefit upon Leonard as well as upon Leon.” *Id.*

⁵⁷ *Brown*, 347 U.S. at 494 (noting that for young “negro” children, race-based segregation “generates a feeling of inferiority as to their status in the community that may affect their hearts and minds in a way unlikely ever to be undone” and that “this finding is amply supported by modern [psychological] authority”).

⁵⁸ *Brown* is often described as the first (or at least the first notable) decision to accept that psychological and developmental harm could have such far-reaching legal implications. See, e.g., *Pristave & Watson*, *supra* note 31, at 10 n.4; Carroll Seron, *Foreword*, 44 LAW & SOC’Y REV. 419, 420–21 (2010). Given the concerns raised by commentators and judges in later pediatric sibling transplant cases about the value of psychological harm evidence, it is interesting that the Supreme Court’s reliance on this argument in *Brown* was also controversial from the start. See, e.g., John Hart Ely, *If at First You Don’t Succeed, Ignore the Question Next Time? Group Harm in Brown v. Board of Education and Loving v. Virginia*, 15 CONST. COMMENT. 215 (1998).

⁵⁹ *Masden*, No. 68651, at 4.

⁶⁰ *Huskey v. Harrison*, No. 68666 (Mass. Eq. Aug. 30, 1957) (decision on file with author).

⁶¹ *Foster v. Harrison*, No. 68674 (Mass. Eq. Nov. 20, 1957) (decision on file with author).

parents and physicians to use healthy minor children as organ sources for their ill siblings so long as judicial authorization was obtained in advance. The cases also appear to have cemented the factual prerequisites for judicial authorization in this early period, including an urgent need for a transplant, the likelihood that the transplant would be successful in saving the life of the ill sibling, a close genetic and personal relationship between the siblings, the likelihood that because of this relationship the healthy child would suffer grave emotional and developmental harm if she were not permitted to donate an organ, and the consent (in the colloquial sense of that word) of everyone involved including the children. Notably, neither the *Masden* nor the *Huskey* decision mentions the harms and risks inherent in the surgery on the healthy child;⁶² the requirement that these be relatively minimal only emerged in *Foster*, the final case in the trilogy.⁶³

Huskey involved a joint request by Dolores and Doris, who were almost fifteen, and their parents. Dolores was described as being within hours or days of death should she not receive a transplant, and the transplant itself was described as likely to succeed given that the girls were identical twins.⁶⁴ In contrast with the *Masden* opinion, the *Huskey* opinion is short and cursory: It notes that everyone involved had consented to the surgeries, including Doris; that the surgeons and the hospital would not proceed in the absence of court approval because they had been warned that without such approval they “may be subject to civil liability and criminal prosecution”; that “if this operation is not performed and Dolores dies, there is the risk of grave emotional impact on Doris”; and thus that “this operation is necessary for the future well-being of Doris and that in this respect performance of the operation will confer a benefit upon Doris as well as upon Dolores.”⁶⁵ And it concludes as *Masden* did, that the operations could proceed without the surgeons or the hospital incurring any civil or criminal liability.⁶⁶ Throughout, *Masden* is the only precedent cited by the Court. *Masden*’s own meager scaffolding, *Brown v. Board of Education*, thus disappears (forever, as it turns out) as a legal foundation for the right of courts to authorize parents to consent to the use of their minor children as organ sources for their ill siblings. Also gone without any comment is *Masden*’s suggestion—possibly also based in *Brown* and the evidence presented in that case⁶⁷—that averting eventual *physical* harm (as a consequence or

⁶² Neither opinion or order references these harms and risks.

⁶³ See *infra* note 71 and accompanying text (finally noting these inherent harms and risks).

⁶⁴ *Huskey*, No. 68666, at 1–2.

⁶⁵ *Id.* at 1–2.

⁶⁶ *Id.* at 3.

⁶⁷ For example, in its famous “Footnote 11” in *Brown*, 347 U.S. 483, 494 n.11 (1954), the Court cited GUNNAR MYRDAL WITH THE ASSISTANCE OF RICHARD STERNER & ARNOLD ROSE, AN AMERICAN DILEMMA: THE NEGRO PROBLEM AND MODERN DEMOCRACY (1944), available at

manifestation of grave emotional suffering) is important to offset the physical injury that is organ retrieval surgery; from *Huskey* forward, there has been no mention of this equation in the available decisions.

Foster v. Harrison involved a request by the children's mother for authorization to consent to the use of her fourteen-year-old son Carl as an organ donor for his ill sibling Clyde, who was also fourteen.⁶⁸ In contrast to the *Masden* and *Huskey* opinions, the *Foster* opinion appears to be both procedurally distinct in some of its aspects and also richer and more nuanced in terms of the analysis, particularly in its attention to matters of concern to Carl. Thus, it appears that the case was brought by the boys' mother alone; at least the court did not emphasize the fact of their status as parties.⁶⁹ The court noted that "[p]reliminary tests indicate that Carl and Clyde are identical twins";⁷⁰ that "Carl appears to be in good health and medical opinion is that no unusual risks are involved to Carl beyond the inevitable risk of a major surgical operation and the hazards incident to having only one kidney in the event of later injury to that one kidney";⁷¹ that Clyde was in declining health and would die "in a relatively short period" unless he could get a kidney from his twin—that "[s]uch an operation is the only hope of saving Clyde's life";⁷² and that "[a]lthough the operation could be postponed for a time, it has a greater chance of success in saving Clyde if performed before Clyde's condition reaches an emergency state."⁷³ Notably, the *Foster* court also undertook to document the basis for finding that Carl had consented:

[Carl] is a boy of fourteen with good understanding and intelligence. He has been fully informed of, and understands the nature of the operation and its possible risks and consequences. He has talked with a donor of a kidney in a similar operation. . . . Carl and his mother

<https://archive.org/download/AmericanDilemmaTheNegroProblemAndModernDemocracy/AmericanDelemmaVersion2.pdf>. Among other things, Myrdal details the extraordinary extent of discrimination in education in the Jim Crow South, MYRDAL, *supra*, at 337–44, and then writes

[m]ortality in all age groups is much higher among Negroes than among whites. Negroes suffer more from nearly all sorts of illnesses. We have shown that at least the major part of these differentials is not due to greater susceptibility on the part of Negroes but to the impact of economic, educational, and cultural handicaps, directly or indirectly imposed upon Negroes by discrimination.

Id. at 344 (footnotes omitted). It is this portion of the *Brown* decision upon which the *Masden* court originally relied.

⁶⁸ *Foster v. Harrison*, No. 68674, at 1–2 (Mass. Eq. Nov. 20, 1957) (decision on file with author).

⁶⁹ *Id.* at 1.

⁷⁰ *Id.* at 2.

⁷¹ *Id.*

⁷² *Id.*

⁷³ *Id.*

desire that the operation take place and Carl's consent to it is the result of his own decision, free from pressure or coercion, made with admirable courage, generosity, and appreciation of the factors involved.⁷⁴

And, perhaps because the likelihood of saving the ill patient's life, and thus the payoff from the transplant, is not always as clear as it had been portrayed in *Masden* and *Huskey*,⁷⁵ the *Foster* court also described in detail the benefits of the surgeries to Carl:

I also find . . . (1) that if this operation is not performed and Clyde dies, there is danger of serious emotional impact upon Carl, and (2) that, because the risk of emotional disturbance will be reduced and because of the probability that Carl will be enabled by the operation to have the continued companionship of his twin brother, Carl will receive a benefit from the operation, and (3) that the operation, if the doctors decide to perform it, is necessary to Carl's future welfare and happiness.⁷⁶

Foster's contribution is subtle, but it is real: It does not obviously add new factors to those established in *Masden*—indeed, in its own citations only to *Masden* and *Huskey* it cements the trilogy as the only foundation for the right of parents to use their healthy minor children as organ sources for their ill siblings. However, in its evaluation of those factors, it does suggest that the nature of the transaction is more ambiguous than it appeared at least in the written decisions in the first two cases. It also suggests that it is important to acknowledge that ambiguity, and thus to focus attention on the physical and psychological implications for the healthy child, including particularly his mental capacity and stated desires.

In the fourteen years between late 1957 and 1972, when the next publicly available decision was rendered, there is some legal activity on a related point—whether a court can authorize the transfer of a kidney from an adult incompetent to his adult brother⁷⁷—but none that I could

⁷⁴ *Id.* at 2–3.

⁷⁵ See *Pristave & Watson*, *supra* note 31, at 11 (noting that both Dolores Huskey and Clyde Foster died within months of the transplants).

⁷⁶ *Foster*, No. 68674, at 3.

⁷⁷ See *Strunk v. Strunk*, 445 S.W.2d 145 (Ky. Ct. App. 1969) (case in equity in which chancery court decided that it had authority to manage and to make distributions from the personal assets and estate of an adult incompetent; that an adult incompetent's kidneys are among the assets over which it has control; that the doctrine of substituted judgment, applied using best interests principles since the individual had never previously been competent, was the governing standard; and that as applied in the case it was in the psychological best interests of the adult incompetent to donate a kidney to his brother because they were so close). *Strunk* becomes relevant to the modern cases because it provides the roadmap for getting into equity through the probate courts after it is abolished in other contexts. See *supra* note 46 and accompanying text (discussing the history and evolution of equity jurisdiction); *infra* notes 129–36 and accompanying text (discussing this probate strategy).

find involving minors.⁷⁸ Nevertheless, one can reasonably suppose that as medical transplant capability developed to include non-identical siblings and organs other than skin and kidneys, most notably bone marrow,⁷⁹ minors were sometimes sought out as organ sources⁸⁰ and courts were sometimes if not always asked either for pre-authorization or to ratify existing consents.⁸¹ In other words, the dearth of published or available judicial decisions is not a sign of inactivity either by surgeons or by courts given that lower level state courts rarely draft opinions to accompany their decisions, perhaps particularly when they are rendered in emergent circumstances; moreover, there is a documented inclination to seal the records in these cases in particular.⁸²

The 1972 case *Hart v. Brown*, decided by a Connecticut state court also sitting in equity,⁸³ considered whether to permit the parent petitioners to consent to a sibling kidney transplant from their healthy seven-year-old daughter Margaret to her twin Kathleen.⁸⁴ Consistent with the pattern established in the Massachusetts transplant trilogy, the girls' parents offered psychiatric testimony focusing on Margaret's best interests, suggesting that

the donor has a strong identification with her twin sister. . . . that if the expected successful results are achieved they would be of immense benefit to the donor in that the donor would be better off in a family that was happy than in a family that was distressed

⁷⁸ The literature does reference some additional but apparently still unavailable decisions. See, e.g., Pristave & Watson, *supra* note 31, at 10 n.5 (“[B]etween 1970 and 1973, the Massachusetts courts decided more than seven additional cases of incompetent kidney donors in unpublished opinions.” (citing Charles H. Baron et al., *Live Organ and Tissue Transplants from Minor Donors in Massachusetts*, 55 B.U. L. REV. 159 (1975))).

⁷⁹ The first successful transfer of kidneys between fraternal twins and non-twin siblings, respectively, dates to 1959 and 1960. A *Timeline of Kidney Transplantation*, MED. U. S.C., <http://waring.library.musc.edu/exhibits/kidney/Transplantation.php> (last visited Mar. 14, 2014). The first successful transfer of bone marrow between non-identical minor twins dates to 1968. *History of Transplantation*, *supra* note 37; Kendra D. MacLeod et al., *Pediatric Sibling Donors of Successful and Unsuccessful Hematopoietic Stem Cell Transplants (HSCT): A Qualitative Study of Their Psychosocial Experience*, 28 J. PEDIATRIC PSYCHOL. 223 (2003); see also AAP Policy Statement, *supra* note 32 (describing this history and analyzing the ethical implications of the practice generally).

⁸⁰ As a group of medical commentators noted in the context of bone marrow and stem cell transplantation, because “[a] sibling is more likely to be a compatible donor than parents, relatives, or strangers,” as transplants “increase in number, so does the number of pediatric sibling donors.” MacLeod et al., *supra* note 79, at 223.

⁸¹ Both the available medical and legal literatures strongly encouraged this ex ante judicial review. See, e.g., Baron et al., *supra* note 78, at 161–62; Pristave & Watson, *supra* note 31, at 15.

⁸² See *supra* note 33 and accompanying text (noting this point and providing references).

⁸³ 289 A.2d 386, 387–88 (Conn. Super. Ct. 1972) (discussing its decision to proceed in equity, and emphasizing the courts' historical authority to invoke equity in the interests of legally incompetent persons and the sibling transplant precedents including the Massachusetts trilogy which were also based in equity).

⁸⁴ *Id.* at 386.

and . . . that it would be a very great loss to the donor if the donee were to die from her illness.⁸⁵

Parting ways with the Massachusetts Supreme Judicial Court, the *Hart* court found only “limited value” in this testimony given “the ages of the minors.”⁸⁶ Instead, the court chose to focus its attentions very differently, on “whether it should abandon the donee to a brief medically complicated life and eventual death or permit the natural parents to take some action based on reason and medical probability in order to keep both children alive.”⁸⁷ In analyzing this question the court “balanc[ed] . . . the rights of the natural parents . . . to keep both children alive” against “the rights of the donor child,”⁸⁸ and ultimately affirmed the right of the girls’ parents to use Margaret as an organ source for Kathleen:

[T]he operation on the donee is a necessity for her continued life; . . . there are negligible risks involved to both donor and donee; . . . to subject the donee to a parental homograft may be cruel and inhuman because of the possible side effects of the immunosuppressive drugs; . . . the prognosis for good health and long life to both children is excellent; . . . there is no known opposition to having the operations performed; . . . it will be most beneficial to the donee; and . . . it will be of some benefit to the donor.⁸⁹

With respect to Margaret in particular, the court noted that she was “informed of the operation and insofar as she may be capable of understanding she desires to donate her kidney so that her sister may return to her,”⁹⁰ but otherwise gave little weight (as it said it would) to the psychiatric testimony. It also apparently ignored (or was never provided evidence detailing) the threshold injury that was the surgical intrusion itself. Instead, it emphasized only the likely physical implications of that surgery in the short and long term:

Of 3000 recorded kidney operations of live donors, there is reported only one death of a donor, and even this death may have been from causes unrelated to the procedure. The short-range risk to a donor is negligible. The operating surgeon testified that the surgical risk is no more than the risk of the anesthesia. The operative procedure would last about two and one-half hours. There would be some minor postoperative pain but no more than in any other surgical procedure. The donor would be hospitalized for about eight days and would be

⁸⁵ *Id.* at 389.

⁸⁶ *Id.* at 390.

⁸⁷ *Id.*

⁸⁸ *Id.*

⁸⁹ *Id.* at 391.

⁹⁰ *Id.* at 389.

able to resume normal activities in thirty days. Assuming an uneventful recovery, the donor would thereafter be restricted only from violent contact sports. She would be able to engage in all of the normal life activities of an active young girl. Medical testimony indicated that the risk to the donor is such that life insurance actuaries do not rate such individuals higher than those with two kidneys. The only real risk would be trauma to the one remaining kidney, but testimony indicated that such trauma is extremely rare in civilian life.⁹¹

Hart is mostly cited for being the only published decision out of any court to authorize the use of a healthy minor child as an organ donor.⁹² However, the case is ultimately most notable for its rejection of the Massachusetts court's emphasis on the psychological best interests of the donee and its adoption instead of a balancing test that takes into account not only the interests of the healthy sibling but also those of her sister (in a chance at life) and her parents (in saving their ill child). It is also notable for its appointment of guardians ad litem (GALs) to represent the separate interests of each of the girls in this balancing process, and for its focus on community ethical norms (as described by a member of the clergy and evaluated independently by the court itself)⁹³ as the foundation for its overarching approach. With respect to the latter, it is significant that, in a concluding paragraph, the *Hart* court returned to the fact that it was sitting in equity:

Justice will be accomplished in this case. . . . 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.⁹⁴

Two years later, in the 1974 bone marrow case *Nathan v. Farinelli*,⁹⁵ the Massachusetts Supreme Judicial Court itself adopted a version of the *Hart* court's balancing test.⁹⁶ Still sitting in equity,

⁹¹ *Id.*

⁹² The Texas Court of Civil Appeal's 1979 decision in *Little v. Little*, 576 S.W.2d 493 (Tex. Civ. App. 1979), involved a fourteen-year-old prospective donor; however, because the mother's lawyer's legal strategy involved having the child declared an "incompetent" so that they could get into probate court and avail themselves of the more favorable legal climate in that context, her status as a child was irrelevant to the decision. See *infra* notes 129-39 and accompanying text (discussing this strategy and its consequences).

⁹³ *Hart*, 289 A.2d at 389-90.

⁹⁴ *Id.* at 391.

⁹⁵ *Nathan v. Farinelli*, No. 74-87 (Mass. Eq. July 3, 1974) (on file with author).

⁹⁶ There is some evidence that the Massachusetts Supreme Judicial Court actually adopted this standard earlier in the same year. The *Farinelli* opinion and order references a case, *Camitta v. Schillinger*, No. 74-18 (Mass. Eq. Jan. 31, 1974 and Mar. 8, 1974), which it says also used this standard. *Farinelli*, No. 74-87, at 6-7. I have not been able to confirm this.

perhaps for the last time,⁹⁷ the court rejected its prior position that “a finding of benefit to the donor is essential, or that the absence of such a finding is fatal, to the allowance of such a transplant.”⁹⁸ Indeed, it found that “[t]o require a finding of benefit to the donor, and particularly to accept a psychological benefit as sufficient, often seems to invite testimony conjured to satisfy the requirement by words but not by substance.”⁹⁹ Not surprisingly, the petition to allow the transplant was deficient in this regard—“the evidence does not permit a finding that the procedure will be of any benefit to Toni”¹⁰⁰—as the psychiatrist in the case had testified that “it can be hoped that serving as the donor may confer some psychological benefit upon Toni in later years but that it would be indulging in speculation to attempt to predict now whether that hope would be realized.”¹⁰¹ Thus, the *Farinelli* court found that

a better approach . . . is to consider that the primary right and responsibility for deciding the delicate question of whether bone marrow should be taken from [six-year-old] Toni and transplanted in [ten-year-old] William is that of the parents with reference to both children. However, because of the possibility of a conflict between their responsibility for the care and custody of William and their similar responsibility for Toni, their decision to grant consent for the transplantation . . . is subject to review by a court under its broad equity powers.¹⁰²

Specifically, the court described its role as being to determine “whether the parents’ decision . . . is fair and reasonable in the . . . circumstances” and this is done by “weigh[ing] and balanc[ing] the individual interests of the two children.”¹⁰³ Thus,

[o]n the one hand the court must consider the nature and urgency of William’s physical condition, his need for the transplant, the probable benefit to him from the transplant, the probable risks or consequences to him if the transplantation is withheld, and the availability and efficacy of alternative methods of treatment for his condition; and on the other hand it must consider Toni’s physical condition, the nature and extent of her physical participation in the

⁹⁷ In its decision the court noted that the “bill in equity” is “now called a ‘civil action’ under the Massachusetts Rules of Civil Procedure which took effect on July 1, 1974,” that is, post-filing but immediately before the hearing. *Farinelli*, No. 74-87, at 2.

⁹⁸ *Id.* at 6.

⁹⁹ *Id.* at 7. Citing the dissent in *Strunk v. Strunk*, 445 S.W.2d 145 (Ky. 1969), and Curran’s 1959 Article, *supra* note 39, the court added, “I prefer the approach of the psychiatrist who testified in this case that she would be speculating if she ventured any opinion about the psychological effect of either allowing or preventing the intended donor from furnishing the bone marrow which is to be transplanted.” *Farinelli*, No. 74-87, at 7.

¹⁰⁰ *Farinelli*, No. 74-87, at 3.

¹⁰¹ *Id.*

¹⁰² *Id.* at 10.

¹⁰³ *Id.* at 11.

transplant, and the probable and possible risks and consequences to her by reason of her participation.¹⁰⁴

In this case, the parents' decision to subject Toni to surgery to remove her bone marrow for William's benefit was determined to be "fair and reasonable as to Toni" because the risks inherent in that procedure were outweighed by the benefits that would inure to William from the transplant.¹⁰⁵ Specifically, the risks as to Toni were described as "minimal. . . consist[ing] of possible adverse reactions to general anesthesia, and possible infection."¹⁰⁶ (As was the case in *Hart*, the *Farinelli* court did not address the physical harms inherent in the procedure itself.)¹⁰⁷ On the other hand, William was suffering from aplastic anemia, which was likely to be fatal unless he could get a bone marrow transplant; such transplants were not a cure, but at the time they were said to be of benefit in fifty percent of the cases. Toni was the only bone marrow match they could find.¹⁰⁸ Although not directly on point, the court also inferred that "it will be a source of comfort, satisfaction and psychological benefit to the parents to know that a transplant is performed for William whose chances of survival without it are dubious at best."¹⁰⁹

Farinelli is particularly notable both for following the *Hart* court's substantive approach to deciding these cases using a combination of parental rights and responsibilities principles and a balancing test involving consideration of the two children's independent interests; for rejecting psychological best interests testimony as speculative, at least on facts involving prospective donors who are not yet adolescents; and for its procedural history, including especially its expansion of the role of the healthy child's GAL. Although the *Hart* court also used GALs, *Farinelli* appears to have been the first case in which the healthy child's GAL appeared as a party with full adversarial capacities. Thus, for example, Toni's GAL—Garrick Cole—filed both cross- and counter-claims, requesting, among other things, that the court order the hospital to obtain and pay for insurance to cover any additional harms Toni might suffer as a consequence of the procedure should it be authorized.¹¹⁰ Cole was also considered by the hospital to be an eventual proxy for consent purposes should the court decide the parents were incapable of providing lawful consent.¹¹¹ It is probably not a coincidence

¹⁰⁴ *Id.*

¹⁰⁵ *Id.*

¹⁰⁶ *Id.* at 3.

¹⁰⁷ See *supra* note 91 and accompanying text (discussing this omission in *Hart*).

¹⁰⁸ *Farinelli*, No. 74-87, at 1.

¹⁰⁹ *Id.* at 3.

¹¹⁰ *Id.* at 12.

¹¹¹ *Id.* at 2.

that Cole subsequently co-authored an Article about the role of GALs in this context.¹¹² This Article remains an important template for academics and practitioners considering the issue how best to protect the interests of the healthy child in sibling transplant cases.

B. *The Later Decisions in Probate*

In the period around the time *Farinelli* was decided, a few related developments were beginning to influence the way courts could treat requests for authorization to use of minors as organ sources for their ill siblings. First, as harked in *Farinelli* itself,¹¹³ state legislatures were continuing to reduce the scope of the judiciary's equity jurisdiction. This happened in different states at different times, but of particular note here, at some point the courts' substantive equity powers were no longer automatically triggered by a petition seeking a declaratory judgment, and even where the courts' equity powers were still at issue, their authority to decide cases simply on the basis of fairness and justice principles was fading fast.¹¹⁴ As I have already explained, this happened in part because these principles had long been considered standardless, allowing individual judges to decide cases essentially on the basis of their personal inclinations, but also because the principal justification for resorting to equity—the absence of applicable law—was mostly no longer available.¹¹⁵ Indeed, by this time in American legal history, applicable law had developed in most areas including in the area of parental rights and the things parents could and could not do to their children. Thus, the states' maltreatment laws had been redrawn beginning in the early-to-mid-1960s to shift the focus of the inquiry away from parents' rights and motives to the right of the individual child to be free from parentally-inflicted serious (primarily physical) harm.¹¹⁶ (This shift was itself a product of developments in pediatric medicine¹¹⁷ and in the social movements of the civil rights era.)¹¹⁸ In doing so, the states began specifically to define unlawful "abuse" to include "non-accidental physical injury to a child," and to include in that category such injuries as cuts, bruises, burns, and the like, which

¹¹² Baron et al., *supra* note 78.

¹¹³ See *supra* note 97 and accompanying text (noting that the *Farinelli* court acknowledged the shift in the midst of its consideration of that case).

¹¹⁴ See *supra* note 46 and accompanying text (discussing the history of equity jurisdiction).

¹¹⁵ *Id.*

¹¹⁶ Coleman, *supra* note 12, at 550.

¹¹⁷ See C. Henry Kempe et al., *The Battered-Child Syndrome*, 181 J. AM. MED. ASS'N 17 (1962); Jessica R. Givelber, Note, *Imposing Duties on Witnesses to Child Sexual Abuse: A Futile Response to Bystander Indifference*, 67 FORDHAM L. REV. 3169 (1999).

¹¹⁸ See, e.g., Joel F. Handler, *Continuing Relationships and the Administrative Process: Social Welfare*, 1985 WIS. L. REV. 687, 694 (situating children's rights movement in this context).

were not justified by an offsetting benefit to the child herself.¹¹⁹ Notably, apart from lawful corporal punishment, the states did not find, and to date have not found, psychological and developmental benefits to be sufficiently offsetting—even if these could be proven non-speculative and thus established to a court’s satisfaction.¹²⁰ These developments made it increasingly difficult to obtain judicial ratification of parental consents to pediatric sibling transplants according to the procedures and standards established in the Massachusetts transplant trilogy and adapted in *Hart* and *Farinelli*. Thus, the question “whether this court can [authorize such a transplant] in the exercise of its equity powers”¹²¹ increasingly had to be answered in the negative. In this landscape it is not surprising that proponents of the right to use minor children as sources of bone marrow for their ill relatives turned to state legislatures for statutory authorization; this alternative was successful, but only in two states, and only for bone marrow.¹²²

So what did parents, doctors, hospitals, and their lawyers do? The answer is not clear. That is, although the older medical literature consistently advised doctors and hospitals to get judicial authorization in advance of a transplant procedure involving a minor donor,¹²³ I have found nothing in either the medical or the legal literature that explains

¹¹⁹ See Coleman, *supra* note 12, at 549–52; Doriane Lambelet Coleman et al., *Where and How to Draw the Line Between Reasonable Corporal Punishment and Abuse*, 73 LAW & CONTEMP. PROBS. 107, 115–16 (2010).

¹²⁰ See Coleman, *supra* note 12, at 569–70.

¹²¹ *Nathan v. Farinelli*, No. 74-87, at 4–5 (Mass. Eq. July 3, 1974) (on file with author).

¹²² See ALA. CODE § 22-8-9 (1975) (permitting some adolescent minors to consent to a bone marrow donation so long as this is “for the purpose of bone marrow transplantation”; and providing that a “parent or legal guardian may consent to such bone marrow donation on behalf of any other minor.”); WIS. STAT. ANN § 146.34 (West 2014) (permitting the parent, guardian, or legal custodian of a child under twelve to use a minor child as a bone marrow source for an ill sibling so long as certain conditions are met; and permitting a child who is twelve or older himself under certain circumstances to consent to a pediatric sibling transplant). That Alabama should be one of the states providing unrestricted authority for minors fourteen years of age and older to consent to donate their bone marrow (including to non-family members and for research) is not surprising given that it is also one of the few states that authorizes children beginning at this age to consent to general medical treatment. See Doriane Lambelet Coleman & Philip M. Rosoff, *The Legal Authority of Mature Minors to Consent to General Medical Treatment*, 131 PEDIATRICS 786 (2013) (discussing ALA. CODE § 22-8-9 (2014)).

¹²³ See, e.g., Pristave & Watson, *supra* note 31, at 15. This admonition makes even more sense in the current legal landscape than it did at the time the Brigham defendants originally adopted the strategy. That is, the concern today is not merely that parents of a child who is ill or injured to the point of needing a transplant have an inherent conflict of interest that may void their consent to any use of a different child as an organ source, it is also that the law clearly defines as abuse an intentional, unnecessary (to the individual herself) cut of the sort involved in these surgeries. Thus, even if one could imagine the conflict away, there is still another important barrier that requires consideration. The potential for legal liability in circumstances where the donor child would complain is thus more salient. Given this, it is troublesome that the American Academy of Pediatrics would adopt the position that authorization from a court is no longer necessary. See *infra* notes 177–78 and accompanying text (discussing this move).

how such authorizations could be obtained or that discusses the metaphorical brick walls that are the legal doctrines that now stand in their way. Thus, although it is likely that hospital general counsels and their outside lawyers know what works on the ground in their particular locales, the broader story must be pieced together from a combination of the few cases that have seen the light of day since *Hart* and what we know of some hospitals' internal procedures and experiences.

As a threshold matter, although there is some indication that the numbers may be in decline, it is clear that minors continue to be used as organ sources for their ill siblings.¹²⁴ It is likely that healthy children are most often used as bone marrow sources given how relatively acceptable this procedure seems to be.¹²⁵ It is also probably true that healthy children continue to be used as kidney sources for their ill siblings;¹²⁶ indeed, one can reasonably surmise that the number of kidney harvesting procedures involving pediatric patients likely increased after the surgery became laparoscopic and thus less medically intrusive and risky for the donor in the operative and post-operative periods.¹²⁷ Finally, one can speculate that healthy children already have been or (because the medical possibilities are there) likely will be used as sources for other organs that are presently harvested from living adult donors; according to the federal government's Organ Procurement and Transplantation Network these include livers, lungs, pancreases, intestines, and hearts.¹²⁸

¹²⁴ See Olbrisch et al., *supra* note 34, at 242 (providing data on the numbers of healthy children used as organ sources in the current period and also claiming that these numbers may be on the decline); see also *supra* notes 34–35 and accompanying text (providing additional references).

¹²⁵ See AAP Policy Statement, *supra* note 32, at 392 (“Children often serve as hematopoietic stem cell donors, most commonly for their siblings.”).

¹²⁶ See generally Olbrisch et al., *supra* note 34, at 242 (providing some available data on kidney harvesting); Pristave & Watson, *supra* note 31, *passim* (discussing the ethics and law involved in this procedure and giving guidance to medical providers engaged in the practice).

¹²⁷ Michael D. Fabrizio et al., *Laparoscopic Live Donor Nephrectomy*, JOHNS HOPKINS BRADY UROLOGICAL INST., http://urology.jhu.edu/surgical_techniques/nephrectomy/index.html (last visited Mar. 21, 2014) (describing the benefits of laparoscopic kidney harvesting from the donor's perspective).

¹²⁸ *Organ and Tissue Donation from Living Donors*, U.S. DEPARTMENT HEALTH & HUM. SERVICES, <http://www.organdonor.gov/about/livedonation.html> (last visited Mar. 14, 2014) (“Living individuals can donate one of the two kidneys . . . one of two lobes of their liver. . . . a lung or part of a lung, part of the pancreas, or part of the intestines. . . . Surprisingly, it is also possible for a living person to donate a heart, but only if he or she is receiving a replacement heart.”). Notably, the Network's online information includes the aside that “[g]enerally, living donors *should* be . . . between the ages of 18 and 60.” *Id.* (emphasis added). The Network's transplantation data reveals that from 1988–2013, minors (seventeen years old or younger) made living donations of two hearts and fifteen livers. *Living Donors Recovered in the U.S. by Donor Age*, U.S. DEPARTMENT HEALTH & HUM. SERVICES, <http://optn.transplant.hrsa.gov/latestData/step2.asp> (last visited Mar. 14, 2014) (Step 1: “Choose Category” select “Donor” and “Choose Organ” select “All”; Step 2: follow “Living Donors by Donor Age” hyperlink; “Add Field to Report:” select “Organ (6 items)”). The Network's references to living heart donors,

It is also clear that motivated lawyers with the right facts can be quite creative in their use of the judiciary's remaining equity jurisdiction. The 1979 decision in *Little v. Little*¹²⁹ out of the Texas Court of Civil Appeals is exemplary in this respect. The petitioner in *Little* was the mother of two children, fourteen-year-old Anne and her younger brother Stephen. Stephen was suffering from end-stage-renal disease and needed a kidney transplant. Anne, who had Down syndrome, was apparently a match. A week before their mother petitioned for authorization to use Anne as an organ donor, she petitioned the probate court to have Anne declared "of unsound mind" and to have herself appointed as Anne's guardian. This was done.¹³⁰ Although it is not unusual for a parent of a mentally disabled child to seek such declarations, unless the child has separate assets it is not obviously important to do so until she reaches the age of majority since, before then, her parents are already the "natural guardian[] of [her] person."¹³¹ Thus, Anne's mother did not need to be appointed "guardian" to make all decisions for her including the decision "to consent to surgical intrusions upon [her] person."¹³² The problem, however, was that the right of "natural guardians" (parents) in the latter respect are "limited to the power to consent to medical 'treatment.'"¹³³ And the *Little* court was clear that

[e]ven ascribing to the word "treatment" its broadest definition, it is, nevertheless, limited to "the steps taken to effect a cure of an injury or disease . . . including examination and diagnosis as well as application of remedies."

We cannot accept the guardian's argument that a donor nephrectomy constitutes medical treatment for the donor. In this case the ward's mental incompetency results from the fact that she suffers from Down's Syndrome . . . [and] the guardian does not contend that removal of a kidney is a medically acceptable method of curing or treating Down's Syndrome We think it is clear that the

and to the inclusion of children among those donors, is likely unrelated to the pediatric sibling transplant context. That is, it is likely that the donor children in these cases were also in need of medical need, and that harvesting their heart was necessary to address that need. *See also* AAP Clinical Report, *supra* note 34, at 454 (noting that "[l]iving donors have also provided segments of livers and, less frequently, lungs, pancreases, intestines, and skin for transplantation" and that "[a]lthough minors are more likely to be organ recipients than living donors, minors have served as living donors").

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

¹³⁰ *Id.* at 494.

¹³¹ TEX. PROB. CODE ANN. § 676(b) (West 2013) (repealed 2014) ("If the parents live together, both parents are the natural guardians of the person of the minor children by the marriage, and one of the parents is entitled to be appointed guardian of the children's estates.").

¹³² *Little*, 576 S.W.2d at 495; *see also* Parham v. J.R., 442 U.S. 584, 602-03 (1979); Coleman, *supra* note 12, at 545-49; Coleman & Rosoff, *supra* note 122.

¹³³ *Little*, 576 S.W.2d at 495.

medical procedure authorized by the probate court in this case constitutes “treatment” of the ward’s brother, Stephen, and that the proposed medical procedure has as its purpose curing, remedying or ameliorating the condition of the proposed donee of the ward’s kidney.¹³⁴

What was apparently not so limited was the power of a “guardian” (who might in that state be a parent appointed as guardian) to “distribute” her ward’s “estate” according to equitable principles. That is, using the 1969 Kentucky Court of Appeals decision in *Strunk v. Strunk* as a model,¹³⁵ Little’s legal strategy was apparently to get access to a court that would agree to imagine that a kidney was not part of a child’s “person” but rather a part of her “estate” so that it could be harvested from her body and “distributed” or “gifted” in ways that the law (which spoke only to “treatment”) otherwise would not allow. (The intellectual gymnastics really are quite astounding.) Of course *Strunk* itself involved an adult incompetent as donor, not a minor;¹³⁶ however, this distinction was irrelevant to the *Little* court since it had based its jurisdiction in the first instance on the erasure of Anne’s status as a child.

In any event, Little’s strategy was successful. Applying a hybrid of probate law’s traditional best interests and substituted judgment tests,¹³⁷ the court found that because Anne was close to and cared about Stephen, because she both missed him when he was away and knew she could help him, and because she would be happy if he lived and sad if he died, she would derive “substantial psychological benefits” from being a donor and she likely would have agreed to the donation had she been competent.¹³⁸ Finally, perhaps in response to the analysis in *Farinelli*, the court added that although psychological prognostications can sometimes be speculative, the best interests test often governs legal outcomes and evidence of psychological benefit should not be ignored in that context.¹³⁹

The next and final available decision authorizing a pediatric sibling transplant is the 2003 decision in *In re S.C.*, which is featured in the introductory illustration. In my view, it represents the pinnacle of creative lawyering in this area. Indeed, the petitioners’ jurisdictional and

¹³⁴ *Id.* (second alteration in original) (citation omitted) (quoting BLACK’S LAW DICTIONARY 1673 (4th ed. 1968)).

¹³⁵ 445 S.W.2d 145 (Ky. 1969); see *supra* note 77 and accompanying text (placing the *Strunk* decision in the chronology of sibling transplant cases).

¹³⁶ *Strunk*, 445 S.W.2d at 145.

¹³⁷ Probate law has traditionally used best interests analysis in cases where incompetents have never been competent; substituted judgment analysis is used where incompetents have previously been competent and thus where there is evidence of how they would decide the issue themselves. See, e.g., *Little*, 576 S.W.2d at 497–98.

¹³⁸ *Id.* at 498–500.

¹³⁹ *Id.* at 498–99.

related procedural arguments, adopted wholesale by the Alabama probate judge in the case, arguably crossed both ethical and legal lines. Recall that the case involved a six-year-old girl, J.C., who had been badly injured in an accidental fire at her family's home.¹⁴⁰ At the time J.C.'s surgeon began contemplating skin transplants from her identical twin sister S.C., the third-degree burns, which covered eighty percent of J.C.'s body, were considered life threatening.¹⁴¹ According to Professor Samuel Tilden's superbly detailed account of the case,

[a]fter the hospital administration was informed of the proposed harvesting, the hospital medical director obtained a "curbside" consultation from a pediatric ethicist in Ohio, who opined that performance of the harvesting in Sydney would be tantamount to child abuse. Thus, the hospital administration's initial information cautioned against going forward with the harvesting procedures. . . . After the [hospital's own] ethics committee's [contrary, positive] recommendation, the hospital's attorneys proposed seeking judicial determination in juvenile court, but later reported that "feedback" for petitioning in juvenile court would not be greeted enthusiastically by the judiciary. . . . [M]aybe the concept of child abuse and neglect had not been fully put to rest.¹⁴²

In fact, the lawyers' inquiry to the juvenile court made perfect sense since, by 2003 when the matter was being evaluated, Alabama, like other states, had already prohibited parentally-inflicted, non-accidental physical injury to a child; this law was administered by the juvenile courts (or the equivalent in states with different nomenclatures).¹⁴³ In

¹⁴⁰ See *supra* notes 1–8 and accompanying text (introductory illustration); see also Tilden, *supra* note 1, at 88 (describing the accident).

¹⁴¹ Tilden, *supra* note 1, at 88 (explaining that "only her head, hands, and intertriginous areas were spared. Doctors estimated that [she] had a 30–50% chance of survival."). Tilden emphasizes, however, that by the time the procedures were performed, J.C.'s life was likely no longer in jeopardy. *Id.* at 87–88, 107–09.

¹⁴² *Id.* at 97. Professor Tilden's Article is an excellent summary of the facts of the case and an analysis of the ethics and law on the subject of pediatric sibling transplants generally.

¹⁴³ ALA. CODE § 26-14-1(1) (1975) (defining abuse as "[h]arm or threatened harm to a child's health or welfare," and explaining that "[h]arm or threatened harm to a child's health or welfare can occur through nonaccidental physical or mental injury, sexual abuse or attempted sexual abuse, or sexual exploitation or attempted sexual exploitation"). Section 26-14-3(a) provides explicitly that hospitals and related medical providers are required to report suspected abuse to the authorities in circumstances where it is suspected, including when they are "called upon to render aid or medical assistance to any child." *Id.* § 26-14-3(a). Professor Tilden suggests that "[a]s much of the case law applicable here derived from probate or circuit court decisions, a recommendation to petition the juvenile court to hear this case seemed misplaced." Tilden, *supra* note 1, at 97. As I explain above, this is incorrect since, by 2003 the equitable basis for the prior sibling transplant decisions (both those rendered in probate and in the circuit courts) had diminished so substantially that it was formally unavailable. Turning to the juvenile court was by then the right thing to do. See *supra* notes 113–22 and accompanying text. That the court had to engage in extraordinary contortions to establish its jurisdiction illustrates this point particularly well.

any event, concerned about the welfare of his patient but bound by the hospital's decision to proceed only if "specific court approval of the harvesting procedures" was obtained in advance,¹⁴⁴ J.C.'s "surgeon was seeking his own advice on the matter from a long-term acquaintance and judge in Louisiana, whose opinion was that, with [J.C.]'s life at risk, no court would hold against the parents' wishes and the physician's recommendation for the harvesting procedures."¹⁴⁵

The conflicting legal opinions obtained by the hospital's lawyers and J.C.'s surgeon likely reflected the parties' different orientations to the problem: The lawyers and their client, the hospital's administration, were concerned about liability, and as with most hospital counsels, they were likely risk-averse; thus, they were properly focused on the applicable law which included not only traditional battery and consent doctrines but also child abuse rules since parents cannot provide lawful consent to batteries that transcend abuse standards.¹⁴⁶ The surgeon and his clients, J.C. and her parents, were concerned about the medical promise afforded by the transplants; thus, they were focused on ensuring they could somehow make the law work for them.¹⁴⁷

The problem was that the governing law was no longer friendly to petitioners in pediatric sibling transplant cases. Citing the 1969 Kentucky state court's decision in *Strunk* and the 1972 Connecticut court's decision in *Hart*, Professor Tilden argues that a judge "could have found subject matter jurisdiction in the inherent powers of a court of equity, as other courts have done."¹⁴⁸ But this is wrong: These inherent powers had long since been abrogated by legislatures both in statutes carefully delineating the terms under which the courts' remaining equity jurisdiction could be exercised, and in other legislation that mapped in increasing detail the state law boundaries of parental

¹⁴⁴ Tilden, *supra* note 1, at 95.

¹⁴⁵ *Id.* at 97. Tilden describes J.C.'s surgeon as being "frustrated" by "the hospital's legal approach," which "prompt[ed] him to recommend to the parents that they retain their own counsel. . . . [T]he surgeon felt that the hospital was more concerned with the potential long-term liability from performance of the procedures than with the pressing needs of a severely burned child." *Id.* Of course, long-term legal liability would attach if the procedures were performed in contravention of the state's battery and related maltreatment laws (and the healthy child's rights under those laws), and thus one could view the hospital's trepidation as rights protective.

¹⁴⁶ See Coleman, *supra* note 12, at 545-59 (describing the boundaries of parents' medical consent authority). Notably, modern abuse standards do not allow for consideration of parental motivation except in the context of reasonable corporal punishment and medical treatment for the child herself. See *supra* note 119; *infra* notes 193-97.

¹⁴⁷ I do not assume that the surgeon had no thoughts about S.C. Rather, I assume that, as he told the court, because the risks inherent in the medical aspects of the procedures were negligible in relation to the enormous benefits that would inure to J.C.—either life or significantly ameliorated physical aesthetics—he believed it made sense to focus on J.C. Of course, it was also his fiduciary obligation to his patient to be so focused.

¹⁴⁸ Tilden, *supra* note 1, at 114 n.191.

authority. The Texas court's 1979 decision in *Little* had already provided a sense of these new restrictions and the procedural moves that would henceforth be required to come within the bounds of equity.¹⁴⁹ In Alabama, the applicable statute in 2003 was again the probate code,¹⁵⁰ but unlike the Texas code, this version contained an important (and apparently immutable) legal obstacle: It was explicit that children who have parents "with custodial rights" could not be the subject of the court's probate jurisdiction;¹⁵¹ indeed, the purpose of the relevant provisions was to facilitate the appointment of guardians for children whose parents were unavailable because of incapacity, relinquishment, abandonment, or death.¹⁵² S.C. and J.C.'s parents were alive and well, and their physical and legal custody of their children was not in doubt—they were a "normal" intact family in these respects. Thus, although the surgeon's judicial acquaintance in Louisiana may have been correct to tell him that with a child's life in the balance, "no court would hold against the parents' wishes and the physician's recommendation for the harvesting procedures,"¹⁵³ the matter of figuring out how legally to accomplish this result remained a serious one. Indeed, a routine analysis of the relevant provisions would suggest that for the girls' parents, the door to probate and thus to equity was sealed shut.

What appears to have happened next is thus truly extraordinary:¹⁵⁴ The parents filed a petition in probate court on Thursday, January 2, 2003, alleging jurisdiction under the probate code; describing the code's remaining equity powers and suggesting that these permitted the court to "stretch forth its arm in whatever direction its aid . . . may be

¹⁴⁹ See *supra* notes 129–39 and accompanying text (discussing the procedural wrangling in that case).

¹⁵⁰ ALA. CODE § 26-2A-31 cmt. (1975) ("The 'court' referred to in this section is the probate court.").

¹⁵¹ The statute initially defines the jurisdiction of the state's probate courts broadly to include "all subject matter relating to estates of protected persons and protection of minors and incapacitated persons." *Id.* § 26-2A-31(a). However, the official comment associated with this section is explicit that "[t]he subject matter jurisdiction described in this section affects the jurisdiction of the probate court only insofar as it applies to proceedings under this chapter and it does not purport to otherwise expand the jurisdiction of probate courts as established in other law." *Id.* § 26-2A-31 cmt. (emphasis added). The only proceedings that relate to the protection of minors who are not also "incapacitated" are guardianship proceedings, and those provisions are clear that they do not apply to children whose parents have custodial rights. See *id.* § 26-2A-73(a) ("The court may appoint a guardian for an unmarried minor if all parental rights have been terminated or suspended by circumstances or prior order of a court having jurisdiction . . ."); *id.* § 26-2A-73 cmt. ("The court is not authorized to appoint a guardian for one for whom a parent has custodial rights . . .").

¹⁵² See ALA. CODE § 26-2A-73 cmt. (discussing these circumstances generally).

¹⁵³ Tilden, *supra* note 1, at 97.

¹⁵⁴ Given the limitations inherent in the probate code, it is my opinion that this explanation of the case's procedural history is the only way to understand the court's assumption of jurisdiction. It can be pieced together from a careful review of the filings, the court's order, and the relevant provisions of the code. It is also discussed in Tilden, *supra* note 1, at 113–15.

needed;” and arguing that in this instance its aid was needed to authorize them to consent to the skin harvesting procedures because it was in S.C.’s best interests to support J.C.¹⁵⁵ Four days later, on Monday, January 6, the court determined that the conflict of interest faced by the parents—having to choose between their burned daughter’s life and/or circumstances and their healthy daughter’s welfare and physical integrity—made it impossible for them to be proper parents to and to make decisions in the best interests of either daughter, and thus, the girls effectively had no “parents.”¹⁵⁶ This first determination unsealed the door to probate. The next step was to appoint “guardians” for the girls who could act and make decisions in their best interests.¹⁵⁷ In a second, but this time truly inexplicable contortion, the court on the same day, January 6, named as “guardians” these very same individuals who had just been declared incapable of conflict-free, best interests decisionmaking.¹⁵⁸ Thus, the girls whose parents were unavailable to the point that they could be said to have no “parents” had their parents as “guardians.” The papers contain no discussion of how this transformation in name managed also to restore their on-the-ground fiduciary capacities.

Presumably, concern over the parents’ actual (as opposed to legal) capacities was never the point. The Verified Petition makes clear that they were purposeful and directed throughout the legal proceedings, and that their goal—to get legally effective signatures on the hospital’s consent forms so that they could proceed with the transplant—would be accomplished however they had to describe themselves in the process. Indeed, S.C.’s GAL characterized them as being “hugely in favor” of the harvesting the day after the petition was filed, which he found to be “understandable by anyone” given that they had been told that it would result in a “substantial mortality reduction for J.C.”¹⁵⁹ The fact that the court made them guardians on the same day it declared them to be too conflicted to function as parents also makes clear that it never doubted their capacities, notwithstanding that finding otherwise was necessary to establishing its jurisdiction.

The substantive aspects of the case are not nearly so tricky although they are notable. The petition for declaratory judgment filed by the girls’ parents acting in their capacity as guardians alleged that:

¹⁵⁵ Verified Petition, *supra* note 2, at 1–2, 4 (citing *Hart v. Brown*, 289 A.2d 386, 387 (Conn. Super. Ct. 1972)).

¹⁵⁶ Tilden, *supra* note 1, at 114.

¹⁵⁷ Letters of Guardianship, *In re S.C.*, No. 180564 (Ala. Prob. Ct. Jan. 6, 2003) (on file with author).

¹⁵⁸ Tilden, *supra* note 1, at 114.

¹⁵⁹ Guardian ad Litem Report, *supra* note 3, at 2.

S.C., [J.C.]’s identical twin sister, is the best available source of skin for the skin grafting procedures necessary to save [J.C.]’s life. . . . [A] successful graft from [S.C.] would reduce the probability of [J.C.] dying from her wounds and attendant complications (i.e. infection) from approximately sixty percent (60%) to approximately ten percent (10%). . . . [J.C.’s surgeon] is of the opinion that the harvesting of the necessary skin from [S.C.] presents minimal risk to S.C. as the donor and is the last best hope for establishing permanent skin covering on [J.C.]’s wounds.¹⁶⁰

The petition cited as precedents *Hart*, *Strunk*, and *Little*, which together reflect all of the possible legal approaches to authorizing the parents to proceed—namely that it is in the source’s psychological best interests, that the harms and risks to the source are outweighed by the benefits to the recipient, and that it is within parents’ rights and responsibilities to make decisions for their children.¹⁶¹ Finally, the petition requested that the court find that “serving as a donor and undergoing the said procedures is in the best interest of the minor child, [S.C.]”¹⁶²

GALs were appointed to represent the two girls on Friday, January 3.¹⁶³ S.C.’s GAL performed his adversarial role admirably.¹⁶⁴ He spent most of that day with J.C.’s GAL at the hospital meeting separately with the surgeons, the girls, their parents, a clinical psychologist on staff at the hospital, and a pediatrician who was also the medical director.¹⁶⁵ His report to the court was drafted in the period between when he left the hospital on Friday afternoon and when he filed it with the court on Monday morning, January 6. It notes “[f]or the record” that he “does not contest the right or authority of th[e] court to issue . . . an order” in the case, suggesting that he may have been aware of but decided not to engage the jurisdictional controversy; it sets out the fact that he “strongly contest[ed] and oppose[d] the order . . . as not being in the best interest and welfare of the ‘well child’, [S.C.]”; and it distinguishes the three precedents cited by her parents on the grounds that two (*Strunk* and *Little*) involved true incompetents, not children, and the one that did involve a child (*Hart*) was not comparable because unlike kidney harvesting, “skin grafting surgery . . . has vastly different long-term implications with physical body disfigurement or discoloration

¹⁶⁰ Verified Petition, *supra* note 2, at 3.

¹⁶¹ *Id.* at 4.

¹⁶² *Id.* at 5.

¹⁶³ See Appointment of Guardian ad Litem in the Matter of a Minor, *In re* S.C., Nos. 180564 & 180565 (Ala. Prob. Ct. Jan. 6, 2003) (on file with author).

¹⁶⁴ Although the court rejected the GAL’s analysis and conclusion, its order notes specifically that the GALs both exhibited “outstanding due diligence” and that S.C.’s GAL in particular was to be commended for his “specific opposition to [the] petition.” Order on Petition, *supra* note 7, at 2.

¹⁶⁵ See Guardian ad Litem Report, *supra* note 3, at 1.

damage that is open and visible for all to observe as well as probable psychological damage to the minor ‘well child’, both in her childhood and as an adult.”¹⁶⁶ The GAL focused on this last point over two-and-a-half single-spaced typed pages of his report, which included the following submissions:

It is proposed that [the same doctor] would be the surgeon for [S.C.], the minor donor and also for [J.C.], the minor donee. With all due respect to [this doctor], who seems to be totally committed to saving [J.C.]’s life, it is this GAL’s opinion that [he] has a direct conflict and cannot simultaneously serve in dual capacities representing that he is looking out for the best interest of [J.C.] and at the same time, looking out for the best interest of [S.C.]. This GAL submits . . . that if the “well child” had a separate surgeon, [she] . . . could not in all good conscience, verbalize that the proposed 2 or 3 skin removal surgeries on [S.C.] would be or even could be in her best interest. How could that happen when the short term effect on [S.C.] would be pretty severe pain and more importantly, the long term damage would be physical body permanent damage to the surgical areas that would have far-reaching psychological damage, both in childhood and even into adulthood—creating probable lifelong emotional issues including self-esteem issues, feeling different or less than because of the physical damage and barriers to intimacy with others.¹⁶⁷

The GAL did take J.C.’s injuries into account, but he was not willing to accept that they outweighed the harms and risks to S.C. simply because, as he understood the medical facts, “there [were] other reasonable options available” to J.C.’s parents that “d[id] not impose life-long physical and emotional scars to [S.C.]”¹⁶⁸ He concluded that “the relief sought . . . is not equitable under the given circumstances.”¹⁶⁹ Nevertheless, on the same day the GAL submitted his report, the court signed an order permitting S.C.’s use as a skin source for her sister that was in its relevant parts a verbatim transcription of the parents’ original petition.¹⁷⁰

¹⁶⁶ *Id.* at 2.

¹⁶⁷ *Id.* at 2–3. Others have noted the ethical issues implicated by having the same transplant surgeon or team work with the two children. *See, e.g.*, AAP Policy Statement, *supra* note 32, at 398.

¹⁶⁸ *See* Guardian ad Litem Report, *supra* note 3, at 4. Professor Tilden’s evaluation is consistent with this conclusion. *See* Tilden, *supra* note 1, at 87–88, 107–09 (suggesting that in all likelihood the transplants from S.C. were ultimately designed to alleviate J.C.’s significant remaining pain and ameliorate her physical appearance).

¹⁶⁹ *See* Guardian ad Litem Report, *supra* note 3, at 4.

¹⁷⁰ *See* Order on Petition, *supra* note 7, at 2–3.

C. *The Law on the Ground Today*

This last Alabama decision and the five other cases I have described here are the only ones I could find records for that authorized pediatric sibling transplants in the period from 1957 to 2013.¹⁷¹ But we know that those are not the only cases since pediatric sibling transplants seem to be a medical commonplace.¹⁷² Indeed, given hospitals' traditionally risk-averse approach to potential liability, it is reasonable to assume both that judges around the country have and continue to be asked for authorization to proceed with pediatric sibling transplants and that, consistent with the view of J.C.'s surgeon's judicial acquaintance from Louisiana, they have found ways to get around the legal obstacles in their jurisdictions. It is also reasonable to assume that judges in areas around major transplant centers proceed apace, either in reliance on old equity cases—mindlessly or willfully ignoring their irrelevance in the present period—or assuming without more that the law does not oppose authorizations so long as the procedural Is are dotted and Ts are crossed. Finally, it is reasonable to assume based on years of pro forma judicial proceedings that at least some hospital counsels or transplant teams are comfortable proceeding in the absence of judicial authorization: Where there is no one to complain about the transplant, it may be done as other surgeries are, within the auspices of medical privacy. This last scenario is perhaps most likely to be true with bone marrow transplants which are relatively noncontroversial in the current period despite their factual invasiveness.¹⁷³

¹⁷¹ There are related cases with available decisions. See *Howard v. Fulton DeKalb Hosp. Auth.*, 42 U.S.L.W. 2322 (Ga. Super. Ct. 1973) (decision on file with author) (authorizing kidney donation by fifteen-year-old mentally retarded girl to her mother); *Curran v. Bosze*, 566 N.E.2d 1319 (Ill. 1990) (denying father authority to require, against their mother's wishes, his twins to submit to bone marrow compatibility testing and harvesting procedure for the benefit of their half-brother); *In re Richardson*, 284 So. 2d 185 (La. Ct. App. 1973) (denying parent authority to consent to kidney donation by seventeen-year-old mentally retarded boy to his sister). Other commentators have written about these cases and their work contains additional references. See *supra* note 31.

¹⁷² See *supra* notes 34, 79–80, 124–28 and accompanying text (describing existing data on point); *infra* notes 174–80 and accompanying text (summarizing the position of the American Academy of Pediatrics on the practice). Especially within the medical community the practice seems to be an accepted fact and what is written about it is not whether it happens but rather how to proceed legally, ethically, and otherwise. See, e.g., AAP Policy Statement, *supra* note 32, at 393–94 (first describing the existence and history of the practice and then noting that “[m]ost pediatric physicians who perform transplants believe it is acceptable to expose minors to the risks of a stem cell donation when that donation offers a substantial prospect of benefit to a close family member and when proper consent is obtained”); Pentz et al., *supra* note 32, at 149 (describing studies of minor bone marrow donors conducted post-harvesting); Pristave & Watson, *supra* note 31, *passim* (advising physicians about how to proceed with pediatric kidney harvesting within the bounds of the law).

¹⁷³ AAP Policy Statement, *supra* note 32, at 392; *infra* note 199.

In what may be the most persuasive evidence of the existence of this practice on the ground, the Committee on Bioethics of the American Academy of Pediatrics (AAP) in 2008 and 2010 for the first time took the public position that it is ethical to use a healthy minor child as an organ source so long as certain conditions are met;¹⁷⁴ its 2008 statement concerned solid organs¹⁷⁵ and its 2010 statement concerned hematopoietic stem cells including bone marrow.¹⁷⁶ In the context of its ethical analysis of stem cell harvesting, the Committee noted its view that it is a “fact that authorization of a stem cell donation by a minor is within the proper realm of parental decisionmaking” and suggested that such “donations” may take place simply based on this parental right—that is, without judicial review.¹⁷⁷ Specifically, the Committee took the position that “legal precedent for stem cell donation by incompetent adults and children is firmly established, [and thus that] as a general matter, donation by a minor should not require court review or approval.”¹⁷⁸ It took essentially the same position with respect to the harvesting of solid organs.¹⁷⁹ Finally, without any apparent sense of the law on the books or of the complicated legal history of pediatric sibling transplants—neither of which relates primarily to GALs—it opined that “[h]istorically, the primary value of the judicial review process was to ensure an independent advocate for the incompetent potential donor.”¹⁸⁰

¹⁷⁴ AAP Policy Statement, *supra* note 32, at 396. As I discuss in Part III, these conditions—which largely mirror those proposed in 1993 by the American Medical Association’s Council on Ethical and Judicial Affairs—are very well-considered and ought to be guideposts as the law develops its own standards in this area.

¹⁷⁵ AAP Clinical Report, *supra* note 34.

¹⁷⁶ AAP Policy Statement, *supra* note 32.

¹⁷⁷ *Id.* at 396.

¹⁷⁸ *Id.* at 400.

¹⁷⁹ AAP Clinical Report, *supra* note 34, at 459 (“Given that legal precedent for living organ donations by incompetent adults and children is firmly established, the AAP does not believe that every donation by a minor should require court approval.”).

¹⁸⁰ AAP Policy Statement, *supra* note 32, at 400. What is especially curious about the AAP’s position is that it considers judicial oversight to be unnecessary in circumstances where the hospital has a “donor advocate” on the view that this advocate satisfies the concerns that begged the presence of a GAL in court. *Id.* This is incorrect for two reasons. First, as the cases described in this section make clear, judicial review is primarily intended to test parental authority, which is a legal question separate from (albeit informed by) the factual question of the healthy child’s interests. Second, according to the AAP’s own description, the model donor advocate does not and is not intended to play the same role as the GAL. The GAL’s role was specifically designed to be adversarial, to assure that someone with authority developed and presented the argument against using the healthy child as an organ source as a way to keep the adults in the case honest. See Baron et al., *supra* note 78, at 171. The work done by the GALs in *Farinelli* and *In re S.C.* exemplify this intended role. In contrast, the AAP’s model donor advocate is not expected to “judge . . . reasonable decisions being made by parents in an intimate family” but rather to “support,” “supplement,” and be “an ally” to parents who are otherwise preoccupied by their ill child’s circumstances; like the policy itself, the advocate is “meant to be quite deferential to parental authority.” Ross, *supra* note 32, at 520. What this means is that in places where the

This is actually the state of the law: As of this writing, two states (Alabama and Wisconsin) by statute authorize the use of healthy minor children as stem cell (but not other organ) donors, and one state (Michigan) by statute allows a mature minor to consent to donate a kidney (but not other organs), on the condition that the consent is approved by a court *ex ante*.¹⁸¹ Also as of this writing, there is only one published decision ever to take the position that a healthy minor child can be used as any kind of organ source (*Hart*);¹⁸² notably, this decision is not only old but also out of a lower state court (in Connecticut) and thus is not binding “precedent” there or anywhere else. There are only a few other available decisions on point (*Masden*, *Foster*, *Huskey*, and *Farinelli* out of Massachusetts and *In re S.C.* out of Alabama), but they are unpublished and thus are not binding “precedent” even in their own jurisdictions. Most importantly, as I have described throughout this Part, none of these decisions stands on anything firmer than quicksand in terms of their formal jurisdictional or precedential value: At the risk of minimizing the complexities at issue, for this purpose equity jurisdiction is essentially dead and neither *Brown v. Board of Education* nor *Strunk v. Strunk* can honestly support a modern claim for authority in this setting. On the other hand, although this was not always the case, it is quite clear today that parental rights and authority are constrained by the law in all jurisdictions that non-accidental physical harm to a child is prohibited; there are exceptions, most notably for treatment and for corporal punishment, but neither saving or ameliorating the life of a sibling nor the psychological benefits that might inure to a donor child are among them. It is thus difficult to understand the basis for the AAP’s view that “legal precedent for . . . donation by . . . children is

AAP policy is implemented, not only is there no *ex ante* judicial review of the decision to proceed with the use of a child as an organ source, but there is also no one whose role it is to put proponents of the surgery to the test, to ensure that the decision in every case takes into account the separate interests of the healthy child and not only the medical emergency and attendant possibilities. The purpose of the adversarial process is to ensure that the ultimate decisionmaker has all of the facts, is aware of all of the arguments, and thus is most likely to arrive at the best result. *See, e.g.*, Robert Gilbert Johnston & Sara Lufrano, *The Adversary System as a Means of Seeking Truth and Justice*, 35 J. MARSHALL L. REV. 147, 147 (2002). Although the protocols associated with donor advocates suggest the criteria to be followed, some of which mirror what a GAL would consider, the protocols are insufficient in comparison with an adversarial process enforced by the courts because they are merely best practices, not mandatory, and because as written they tilt toward permitting the harvesting. *See Ross, supra* note 32, at 520 (“The donor advocate serves as an ally to both the donor child and his or her family, and is only empowered to prevent sibling donations in very rare circumstances.”).

¹⁸¹ MICH. COMP. LAWS ANN. § 700.5105 (West 2014); *see also* ALA. CODE § 22-8-9 (1975); WIS. STAT. ANN. § 146.34 (West 2014).

¹⁸² Recall that *Little*, the only other published decision involving a minor, was based on the premise that the child was an “incompetent” and thus not subject to the usual rules governing children. *See supra* notes 129–39 and accompanying text (discussing this case).

firmly established” unless it is in the lived medical experience that the law and judges are either infinitely malleable or else irrelevant.

II. EXPLAINING THE STATUS QUO

The legal history of pediatric sibling transplants is clear on two points: First, formal law, the law “on the books,” has long been uncomfortable authorizing the necessary harvesting procedures. This discomfort has increased markedly in recent decades to the point where, with some notable exceptions, it may be impossible today to obtain a declaratory judgment lawfully authorizing the surgery; the fact that a judge may provide it does not mean that it is legal.¹⁸³ Second, healthy minor children continue to be used as organ sources for their ill siblings, sometimes with the assistance of lawyers and judges. The medical possibilities and the ethical norms of the medical profession (rather than law) appear to govern outcomes “on the ground.” This second part of the Article explores the reasons for the law’s discomfort with pediatric sibling transplants and the weighty countervailing interests that explain their persistence, and it evaluates the normative and practical implications of this status quo.

A. *The Law’s Discomfort with Pediatric Sibling Transplants*

That the law is and has long been uncomfortable with pediatric sibling transplants is evident in its treatment of the practice beginning with the first recorded case in 1957 through the last available decision in 2003. In that forty-six year period, courts that have been asked to authorize the use of healthy minor children as organ sources for their ill and injured siblings have mostly struggled to establish the substantive basis for authorizing the nontherapeutic procedures in general and then to identify the appropriate standard for making decisions in individual cases. Most recently, they have struggled as a threshold matter even to obtain jurisdiction over the parties.

The reasons for this discomfort and the legal hurdles that result are clear and noncontroversial—at least within the discipline. United States

¹⁸³ An act which is “beyond powers conferred . . . by law” is *ultra vires*. BLACK’S LAW DICTIONARY 1522 (6th ed. 1990). Governmental (including judicial) as well as private actors may be found to have acted *ultra vires* and thus to have their associated acts themselves declared null and void. *See, e.g.*, *Summit Media LLC v. City of Los Angeles*, 150 Cal. Rptr. 3d 574, 584 (Ct. App. 2012) (judge acting *ultra vires*); *Hopewell Valley Citizens’ Grp., Inc. v. Berwind Prop. Grp. Dev. Co.*, 10 A.3d 211, 221–22 (N.J. 2011) (dissenting Justice explaining position that composition of court was unconstitutional and thus that “its acts are *ultra vires*”); *ZYZY Corp. v. Hernandez*, 345 S.W.3d 452, 459 (Tex. App. 2011) (same).

law is based in classical liberal theory and is thus fundamentally committed to the protection of individual rights. Among these rights, the law has long held that bodily integrity and decisional autonomy—including particularly as autonomy relates to bodily integrity—are of paramount importance.¹⁸⁴ The tort of battery and the doctrine of informed consent operationalize these rights by providing individuals with a cause of action against anyone who would seek to violate them. As Professor Dan Dobbs explains in his treatise on torts,

[t]he central core of the battery rules is simple. Subject only to the most limited exception, the defendant must respect the plaintiff's apparent wishes to avoid intentional bodily contact. Hostile, aggressive, or harmful touchings are batteries because the plaintiff wishes to avoid them. But the plaintiff's right to avoid unwanted intentional contact does not depend upon the defendant's hostile intent or even upon the reasonableness of the plaintiff's wishes. A person is entitled to refuse well-intentioned medical treatment as well as the bumptious grapplings of an unwelcome swain. In a world full of uncontrollable events, all persons are at least entitled to prohibit unwanted intentional touchings of any kind.¹⁸⁵

Thus, as the Supreme Court of Illinois explained in *Curran v. Bosze*, a decision denying a non-custodial father the right even to have his children tested for compatibility with their half-brother who was dying of leukemia, “[n]o right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of [the individual’s] own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.”¹⁸⁶ This quoted language is from an 1891 decision of the United States Supreme Court.

Of course because children need adults to take care of them physically, and because children lack the legal if not also the cognitive capacity to consent, these first principles apply differently to their circumstances. But this does not mean that the law denies children’s right to bodily integrity.¹⁸⁷ Indeed, although this was not always the

¹⁸⁴ *Albright v. Oliver*, 510 U.S. 266, 272 (1994) (“The protections of substantive due process have for the most part been accorded to matters relating to marriage, family, procreation, and the right to bodily integrity.”); *Schmerber v. California*, 384 U.S. 757, 772 (1966) (“The integrity of an individual’s person is a cherished value of our society.”); David G. Owen, *Philosophical Foundations of Fault in Tort Law*, in *PHILOSOPHICAL FOUNDATIONS OF TORT LAW* 201, 217–18 (David G. Owen ed., 1995) (“[B]odily integrity interest is accorded a higher abstract value than property and economic interests [and] has a long and deep tradition in the law of torts.” (footnote omitted)).

¹⁸⁵ DAN B. DOBBS, *THE LAW OF TORTS* 54–55 (2000) (footnotes omitted).

¹⁸⁶ *Curran v. Bosze*, 566 N.E.2d 1319, 1323 (Ill. 1990) (alteration in original) (quoting *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891)).

¹⁸⁷ See, e.g., Rhonda Gay Hartman, *Noblesse Oblige: States’ Obligations to Minors Living with Life-Limiting Conditions*, 50 DUQ. L. REV. 333, 362 (2012) (“Although children and adolescents

case, today a parent's rights to touch her child physically and to give proxy consent for others to do the same are formally linked to her responsibility to do so in the child's individual best interests. In this respect, modern law conceives of parents as fiduciaries.¹⁸⁸ As one court has explained,

the parental right to control a child's nurture is grounded not in any absolute property right which can be enforced to the detriment of the child, but rather is akin to a trust, subject to . . . [a] correlative duty to care for and protect the child, and . . . [terminable] by [the parents'] failure to discharge their obligations.¹⁸⁹

It takes a lot for the law to intervene in the parent-child relationship on the basis that the parent has failed to discharge her fiduciary obligations. Indeed, because the law presumes that fit parents act in their children's individual best interests,¹⁹⁰ unless there is a sufficient charge and evidence to the contrary, most parental actions and decisions—including those that are not actually in their child's best interests—are beyond review.¹⁹¹ This presumption exists in part because the law does not want to second-guess parents as they proceed according to their often very different capacities and inclinations—in other words, the law intends to establish a wide range of permissible parenting and parental decisions.¹⁹² However, it does have a few categorical boundaries, and consistent with the law's fealty to bodily integrity most relate to the child's physical welfare.

Of particular relevance to this Article, the law prohibits parents and those to whom they would delegate parental authority from intentionally causing or risking physical harm to a child. This prohibition is enshrined in the tort law of battery and in civil and criminal statutes prohibiting physical abuse; together, these laws create a coherent system that protects the child from physical injuries that have

lack capacity for medical decision making by law, the value of personal dignity, including bodily integrity and self-identity, applies to all persons. Personal dignity is not limited to those having legal autonomy.”).

¹⁸⁸ See *supra* notes 24–28; *infra* note 190 and accompanying text (elaborating on this idea).

¹⁸⁹ *Custody of a Minor*, 379 N.E.2d 1053, 1063 (Mass. 1978) (alterations in original) (internal quotation marks omitted).

¹⁹⁰ *Parham v. J. R.*, 442 U.S. 584, 602 (1979) (“The law’s concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life’s difficult decisions. . . . [I]t has recognized that natural bonds of affection lead parents to act in the best interests of their children.”).

¹⁹¹ See *Reno v. Flores*, 507 U.S. 292, 304 (1993) (“So long as certain minimum requirements of child care are met, the interests of the child may be subordinated to the interests of other children, or indeed even to the interests of the parents . . . themselves.”).

¹⁹² See *supra* notes 9–13 and accompanying text (discussing this political and legal principle).

not been established as being in her individual best interests. Thus, although parents were historically immune from tort liability for the harms they inflicted on their children, “[w]here the parent is guilty of an intentional [as opposed to negligence] tort, the courts [today] agree that the immunity is no defense.”¹⁹³ Only batteries justified by discipline¹⁹⁴ and treatment¹⁹⁵ continue to be privileged. Similarly, where a parent’s good faith (or lack of maliciousness) used to preclude state intervention in the family under the civil maltreatment laws and punishment under the analogous criminal provisions, today unless treatment or reasonable corporal punishment is at issue, parental motivation is irrelevant. Specifically to the point of the pediatric sibling transplant cases, neither the needs of a severely ill or injured brother or sister nor a psychological benefit to the child herself are sufficient to justify a parent’s or delegate’s intentional invasion of the child’s bodily integrity.¹⁹⁶ As the Maryland Court of Appeals (the supreme court of that state) emphasized in an analogous context, the parent of a healthy child “cannot consent to the participation of [that] child . . . in nontherapeutic research or studies in which there is any risk of injury or damage to the health of the subject.”¹⁹⁷

As a doctrinal matter, cutting or piercing a child’s skin, flesh, and (depending on the kind of transplant) bone to the point necessary to remove an organ inevitably satisfies battery law’s definition of a

¹⁹³ DOBBS, *supra* note 185, at 756; *see also id.* at 753–54 (describing the old rule that “parents and those in *loco parentis* could not be held liable for either intentional or negligent torts to their minor, unemancipated children,” the erosion of that rule, and that today “[c]ourts . . . allow[] recovery for intentional or willful torts, [even] where the immunity otherwise remains” (footnote omitted)).

¹⁹⁴ *Id.* at 754.

¹⁹⁵ *See supra* notes 39, 133–34 and accompanying text.

¹⁹⁶ Apart from the law’s allowance for reasonable corporal punishment (which pre-dates all modern restrictions on parental authority) and the pediatric sibling transplant cases, there is only one state court decision arguably authorizing surgery on the basis that this was in the child’s psychological and developmental best interests. *See In re Sampson*, 317 N.Y.S.2d 641, 675–76 (N.Y. Fam. Ct. 1970) (holding that a mother who had consented to plastic surgery on her son’s face, but who refused to consent to the blood transfusions necessary to the operation’s success and the child’s survival, was guilty of child neglect), *aff’d per curiam*, 278 N.E.2d 918 (N.Y. 1972). As I have written elsewhere,

[t]he surgery itself was deemed necessary to cure the child’s apparently substantial cosmetic deformity so that he would have a chance to lead a more-or-less normal life. . . . Everyone’s interest at the time of the litigation was to fix his face so that this damage could be at least partially undone.

Coleman, *supra* note 12, at 553 n.146. *Sampson* is an isolated case both because it has not been followed, and because it is otherwise idiosyncratic. It certainly cannot be relied upon for the proposition that “the law” permits surgery to benefit the child psychologically or developmentally.

¹⁹⁷ *Grimes v. Kennedy Krieger Inst.*, 782 A.2d 807, 858 (Md. 2001). For a detailed discussion of the *Grimes* case and in particular of the occasional collision between law and legal norms on the one hand, and science and medicine and their norms on the other, see Coleman, *supra* note 12, at 578–90.

“harmful or intentional bodily contact”¹⁹⁸ and civil and criminal maltreatment laws’ definitions of “physical harm,” even where these are conditioned by the requirement of “seriousness.”¹⁹⁹ Thus, although the medical and bioethics literatures tend to ignore this threshold point to focus on the short- and long-term consequences (risks) of surgery including on the associated pain,²⁰⁰ for the law the bodily injury that is the surgery itself is central. Some if not all organ harvesting procedures may also fail those parts of the maltreatment definitions that are separately concerned with risk, but this is secondary.²⁰¹ What this means is that the bodily injuries that are a necessary part of pediatric sibling transplants are only lawful if they fit within an exception to the prohibition against intentional physical harm. To the extent that discipline and treatment are the only two “clear and unquestionable” privileges in this area, and that the law requires such “authority,”²⁰² the answer is negative.²⁰³

The arguments that have garnered support in the line of pediatric sibling transplant cases discussed in Part I and in the medical, legal, and bioethics literatures²⁰⁴ simply do not work to bring pediatric sibling transplants within the range of legally permissible harms that might be inflicted on healthy children by their parents and their parents’ delegates: Contrary to the sentiments expressed in *Farinelli*, *Hart*, and

¹⁹⁸ See DOBBS, *supra* note 185, at 54.

¹⁹⁹ Coleman et al., *supra* note 119, at 114–17 (detailing the states’ definitions of physical abuse). All transplants involve subjecting the healthy child to surgery. Even the most minimally invasive and least risky organ donation surgeries—bone marrow and stem cell retrieval—typically require the pediatric donor to undergo general anesthesia and tissue cutting and removal. See, e.g., *The Bone Marrow Harvest Procedure: What Happens After the Procedure?*, CLEVELAND CLINIC, http://my.clevelandclinic.org/services/Bone_Marrow_Transplantation/hic_The_Bone_Marrow_Harvest_Procedure.aspx (last visited Mar. 19, 2014). Laparoscopic nephrectomy, the least invasive, least risky kidney harvesting procedure, is similarly serious; that is, after administering general anesthesia,

[y]our surgeon will make 3 or 4 small cuts, usually no more than 1-inch each, in your belly and side. The surgeon will use tiny probes and a camera to do the surgery. Towards the end of the procedure, your doctor will make one of the cuts larger (around 4 inches) to take out the kidney. The surgeon will cut the ureter, place a bag around the kidney, and pull it through the larger cut.

Kidney Removal, N.Y. TIMES HEALTH GUIDE, <http://health.nytimes.com/health/guides/surgery/kidney-removal/overview> (last visited Mar. 19, 2014) (citing Andrew C. Novick, *Open Surgery of the Kidney*, in CAMPBELL-WALSH UROLOGY (Alan J. Wein et al. eds., 9th ed. 2007)). Traditional kidney harvesting procedures (simple and radical nephrectomies) and other organ retrieval surgeries involve more invasive, and thus commensurately more serious, measures. See *id.*

²⁰⁰ Coleman, *supra* note 12, at 560–61.

²⁰¹ Coleman et al., *supra* note 119, at 110, 114–15.

²⁰² See *supra* note 186 and accompanying text.

²⁰³ Creative advocates may argue that being an organ source is “treatment” and that being required to be altruistic is “discipline.” Given the stingy state of the law in this area, neither of these efforts has been or is likely to be successful.

²⁰⁴ See *supra* Part I (describing these arguments); *infra* Part III (same).

In re S.C., parents do not have the responsibility and thus the right to decide to use one child as an organ source for another; by the terms of tort and maltreatment law (which largely describe the terms of related constitutional doctrine) this decision is outside the boundaries of their consent authority. Contrary to the position taken in the Massachusetts transplant trilogy, in *Little*, and in *In re S.C.*, the healthy child's psychological best interests cannot justify the physical harms and risks inherent in the harvesting surgery; the law is simply not designed to permit the elevation of the former over the latter. And most especially, contrary to the notion that was said to dictate the outcome in *Farinelli* and *Hart*, intentional physical harm to one child cannot be justified on the grounds that, on balance, the reallocation of organs within the family is in its best interests; it is no surprise that this approach was ultimately unsuccessful even within the otherwise renegade line of cases that are the sibling transplant decisions²⁰⁵ since it violates one of the most important principles of American law: That the individual be the basis for decision as to matters that concern especially her physical welfare.

As the remainder of this Article suggests, this legal landscape is not beyond criticism. It does, however, explain the basis for the law's longstanding discomfort with pediatric sibling transplants. Although the transplants may be justified by more holistic takes on personal integrity or by other-than-liberal social norms, they are impossible to reconcile with modern legal doctrine.

B. *The Persistence of Pediatric Sibling Transplants Despite the Law*

The conundrum posed by pediatric sibling transplants is that they persist notwithstanding clear doctrine to the contrary and that mostly no one seems to intervene, including the legal actors who are responsible for administering the states' tort and maltreatment definitions on the ground. The reasons for their willingness in particular to transgress the boundaries of their own authority—to act *ultra vires* and to bear the professional risks of that move—may be as simple as the unbearable plight of a dying child, the basic human instinct to save her, and the inevitable demotion or overwhelming of other weighty concerns. No one wants to have had the power to rescue the child and to have been the reason she died. With respect to those other weighty concerns, the most important is the welfare of the healthy child who would be the organ source. As to him, it has to be that his interests can

²⁰⁵ As far as I can tell, no other pediatric sibling transplant decision took this position; the decisions that followed *Hart* and *Farinelli* all reverted (at least formally) to a “best interests of the [healthy] child” analysis. See *supra* Part I (describing the line of available cases).

be demoted and overwhelmed because he is understood—at least in the moment and in contrast with comparable adults—not to be a full bearer of individual rights. But of course these explanations about instinct and expediency cannot be the basis for principled decisionmaking in law or in ethics. Thus, the cases and the literature suggest some better alternatives.

The view that parents ought to be able to remove organs from healthy children to benefit their ill or injured siblings has been explained on the basis of two related ideas. The first is that intra-family interests balancing is an appropriate alternative to best interests analysis in cases where the premise of fiduciary theory fails; that is, where there is more than one child in the equation. This explanation appears to be a claim within the law—it suggests that existing rules are insufficient for or inapplicable to the special facts of pediatric sibling transplant cases and then proposes an approach to address that vacuum. In contrast, the second explanation is very much a claim outside of the law—essentially it is that “the law is an ass” because the parent-child relationship is better theorized as existing within a family unit made up of interdependent members than within liberalism’s collective of individuals.

The first claim, that fiduciary theory and the “best interests” test are irrelevant in circumstances involving two or more children whose interests are diverse, is based on the practical point that in these circumstances it is impossible to act in the best interests of each child, and thus parents have no choice but to make a decision; they cannot simply abdicate their responsibility to decide.²⁰⁶ Moreover, it makes sense to allow them to make decisions based on an evaluation of the situation as a whole, including by balancing the interests of the two (or more) children at issue.²⁰⁷

²⁰⁶ No one has yet developed this point. However, it has been noted in the family and children’s law literature that fiduciary theory and the best interests test contemplate a parent-child dyad, where the only conflict of interest that might arise is a conflict between the parent’s interests and those of the child. See, e.g., ALLEN E. BUCHANAN & DAN W. BROCK, *DECIDING FOR OTHERS: THE ETHICS OF SURROGATE DECISION MAKING* 236 (1989) (“The case for legitimate departures from the best interest[s] principle as a guidance principle in decision making for children depends exclusively upon the fact that optimizing for the sick child may conflict with the legitimate interests of other *individuals* within the family.”); Loken, *supra* note 24, at 1140–44 (elaborating on “[t]he difficulty of fulfilling parental duties for more than one child” and the implications of this problem for the best interests standard, and suggesting that “parental neglect of the child’s welfare [may be] justified” in circumstances where doing “‘good’ embraces all others, or even just the family unit (including siblings with their own needs)”).

²⁰⁷ Michael T. Morley, Note, *Proxy Consent to Organ Donation by Incompetents*, 111 *YALE L.J.* 1215, 1243 (2002) (“Many important decisions are normally made based on the best interests of the family—children take on after-school jobs, high school graduates forego attending expensive institutions of higher learning, close friends and significant others are left behind for a cross-country move. In poorer families, health care itself is rationed, and the cost of visits to the doctor’s office is balanced against the needs of others in the family.”).

This appears to have been the view of the courts that decided *Hart*, *Farinelli*, and *In re S.C.*, all three of which rejected the best interests standard in lieu of an intra-child or intra-family balancing test. The courts in *Hart* and *Farinelli* were explicit in their use of this alternative approach. Thus, the question in *Hart* was not whether being a kidney source was in the best interests of the healthy child but rather “whether [the court] should abandon the donee to a brief medically complicated life and eventual death or permit the natural parents to take some action based on reason and medical probability in order to keep both children alive.”²⁰⁸ And to resolve this question the court “balanc[ed] . . . the rights of the natural parents . . . to keep both children alive” against “the rights of the donor child.”²⁰⁹ Similarly, the question in *Farinelli* was “whether the parents’ decision [to use their daughter as a bone marrow source for their son] . . . is fair and reasonable in the . . . circumstances,”²¹⁰ and the answer was had by “weigh[ing] and balanc[ing] the individual interests of the two children.”²¹¹ The *Farinelli* court also noted that “it will be a source of comfort, satisfaction and psychological benefit to the parents to know that a transplant is performed for [their son] whose chances of survival without it are dubious at best.”²¹² *In re S.C.* was not explicitly based on intra-family balancing—it purported to rest on a best interests (of the healthy child) analysis. But in fact the parties and the court paid only lip service to those interests.²¹³ The various decisions that ultimately led to the transplant in that case—of the burned child’s surgeon to suggest the procedure, of her parents to proceed according to his suggestion, of their lawyer to pursue an extraordinary legal strategy to avoid the proper jurisdiction of the juvenile court, and of the judge to ignore the petition of the healthy child’s GAL and sign off on the entire transaction—plainly rested on an erasure of the harms and a minimization of the risks to the healthy child in relation to the harms that the injured child had already suffered as a result of the fire that caused her burns, and in relation to the risks of the transplant that would partially heal them. It also plainly rested on the view that, in the circumstances, the girls’ parents should have the right to re-allocate resources within the family.²¹⁴

The intra-child or intra-family balancing approach has a lot of intuitive appeal because it reflects how we typically operate, that is, how

²⁰⁸ *Hart v. Brown*, 289 A.2d 386, 390 (Conn. Super. Ct. 1972).

²⁰⁹ *Id.*

²¹⁰ *Nathan v. Farinelli*, No. 74-87 Equity 11, slip op. 491, 501 (Mass. July 3, 1974) (on file with author).

²¹¹ *Id.*

²¹² *Id.* at 493.

²¹³ See *supra* notes 160–70 and accompanying text (detailing the process in *In re S.C.*).

²¹⁴ *Id.*

routine and reasonable decisions are made within the family. For example, the child with a particular talent, illness, or deficiency will often get more of the family's resources than his sister who makes no particular demands on those resources; and the child who runs into the street or who falls into a river will generally command her parent's full attentions even though it means neglecting (in the colloquial rather than legal sense of the term) her less immediately-needy brother. These are things we do, and in general we do them because we believe that when there is a choice to be made—perhaps particularly in an emergency setting—it makes sense to make it based on what will do the most good or where the need is most clear-cut.

The power of this explanation for the persistence of pediatric sibling transplants is limited, however, by the fact that it reflects an incomplete description of fiduciary theory and the best interests test, and because it posits a lawless choice in this context. It is true that discussions and applications of fiduciary theory and the best interests test tend to contemplate a parent-child dyad where the only conflict of interest that might arise is a conflict between the parent's interests and those of her child; in other words, fiduciary theory and the best interests test have not been developed as tools to resolve conflicts of interest within the family where there are multiple children with diverse interests.²¹⁵ However, although this may be problematic if one looks at these principles only in their aspirational form, their real world application makes clear that they do contemplate such situations. That is, fulfillment of the best interests of the child standard does not actually "require[] selfless dedication to the ideal best interests of the child. . . . [P]arents . . . have legitimate competing interests to balance and reality-driven circumstances to contend with, and thus, inevitably and lawfully will fall short of that ideal."²¹⁶ At the same time, application of these principles requires the drawing of an absolute line at the point where intra-child or intra-family decisionmaking within this framework results in child maltreatment. This means that parents actually have a lot of leeway to make decisions that are favorable to one child and detrimental to another, so long as the detriment does not transcend these boundaries.²¹⁷

Relatedly, these principles tell us much more than simply how to resolve conflicts between a parent and her child. They also tell us something about how we should think about the child herself, and about

²¹⁵ See *supra* notes 206–14 and accompanying text (discussing this flaw in fiduciary theory).

²¹⁶ Coleman, *supra* note 12, at 617; see also BUCHANAN & BROCK, *supra* note 206, at 236 (noting that "even as a guidance principle, the best interest[s] principle is to serve only as a regulative ideal, not as a strict and literal requirement, because parents' obligations toward their other children as well as their own legitimate self-interests can conflict with doing what maximizes the child's well-being, and sometimes may take precedence over it").

²¹⁷ See *Reno v. Flores*, 507 U.S. 292, 303–04 (1993).

the limits to parental decisionmaking and conduct that flow from that concept. Specifically, they tell us that as parents contemplate their choices, the child must be considered as a person in her own right, including with respect to her bodily integrity. And the doctrine that flows from this particular idea is emphatic that respecting the child's bodily integrity denies the parent the right to go so far as to cut (or bruise or poison) her intentionally, unless it is for her own benefit.²¹⁸

Because of this, the argument that the decision whether to remove a healthy child's organ to benefit an ill child is just like other hard decisions made in multi-child families is difficult to sustain. It sets up a false choice between saving or ameliorating the life of one child and removing the organ of another. A parent only has the right to save her child's life, and a court or a surgeon only has the right to help her, by lawful means. So, while she may want (rationally and/or instinctively) to do whatever is in her power to save her dying child, the fact is that she cannot balance competing interests and, based on that analysis, "choose" to use her adult child, her sister's child, or a friend's child to accomplish her goal. If these are her only "choices," she has no choices. A similarly-motivated surgeon or judge who wants to use the ill child's parent's organ is also stuck without options if the parent declines to sacrifice her bodily integrity for this purpose; because the parent's rights to bodily integrity and to autonomous decisionmaking are absolute, a "donation" from them cannot be compelled. In law at least—and here, again, I speak of maltreatment law as it is used to establish the existing boundaries of family privacy—the so-called "choice" to use her own healthy minor child similarly does not exist.

Thus, although interests balancing may be persuasive as a description of how ordinary decisions are made within the family, it does not provide a basis for a parental right to make any number of extraordinary decisions that are unlawful according to established boundaries. Specifically, it does not provide a basis for the extraordinary right, first set out in *Hart* and repeated in *Farinelli*, of a parent to consider among her options removing an organ from her healthy child to benefit an ill sibling.²¹⁹ Standing alone, it does not explain why nontherapeutic organ removal is not prohibited, or how (in terms of our norms and aspirations) we justify expanding the boundaries of family privacy to give a parent this particular option.

The second and more plausible explanation for the persistence of pediatric sibling transplants, and specifically of the view that parents

²¹⁸ See *supra* notes 184–216 and accompanying text.

²¹⁹ Other extraordinary decisions that would fit within this analysis include that of a parent to deprive one of her children of necessities (food, shelter, medical care) as a way to ensure the success of her other child, and to force one of her children to work to support her other child's educational opportunities.

ought to be able to make this choice, is based in a set of informal social norms and aspirations about family and relationships within the family that are only incompletely captured by fiduciary theory and related doctrine. Thus, some scholars have implied that expanding the boundaries of family privacy to allow parents to remove a healthy child's organ to benefit an ill sibling can be justified (and acceptability of the practice explained) if fiduciary theory and its individually-focused best interests test are scrapped in favor of a "unit" theory of the family or an "interdependence" and "obligations" theory of intra-family relationships.

For example, George Annas, Leonard Glantz, and Barbara Katz have suggested that "[t]he transplant cases revolve around the power of the family to protect its own members. When a child is sick the family as a unit is permitted to use its resources and make sacrifices to help the sick member."²²⁰ And Michael Morley has argued that

[f]amilies, especially immediate families, are fundamental units in our society, and to treat each member as a self-interest-maximizer is to misconstrue the nature of familial relations. Many important decisions are normally made based on the best interests of the family Family members regularly are called upon to sacrifice for each other, and parents are most often the ones responsible for managing the allocation of burdens and responsibilities. . . .

In ruling that a court may not compel an unwilling, competent individual to become an organ donor, a Pennsylvania court accurately noted, "Our society, contrary to many others, has as its first principle, the respect for the individual, and that society and government exist to protect the individual from being invaded and hurt by another." However accurate this depiction of the relationship among individuals in society at large may be, it would be a gross distortion to characterize familial relationships in a similar manner. Family members—parents, children, adolescents, and adult incompetents living under their care—owe responsibilities toward each other that do not exist among members of society at large.

The Pennsylvania court went on to declare, "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

²²⁰ GEORGE J. ANNAS ET AL., INFORMED CONSENT TO HUMAN EXPERIMENTATION: THE SUBJECT'S DILEMMA 87 (1977). These authors suggest that "the power of the family to protect its own members" is the real motivation behind the sibling transplant cases: "The courts that permit transplants have gone through incredible feats of mental gymnastics, such as finding benefit where none exists, to overcome [this] general rule." *Id.* And they argue that "[t]he *Farinelli* case, tired of these maneuvers, directly confronted the issue and held that the family could protect its members, and made the decision on that basis." *Id.* See *supra* notes 95–111 and accompanying text (discussing *Farinelli*); see also Loken, *supra* note 24, at 1158 (developing the idea of "obligations" among family members, particularly parental obligations).

another member, is revolting to our hard-wrought concepts of jurisprudence.” Notwithstanding the harsh and unappealing rhetoric with which this sentiment is expressed, such interdependence is an essential feature of families.²²¹

No one has developed this idea further, at least not in this context.²²² A fuller account, one which could explain why people believe that removing an organ from a healthy child to benefit an ill sibling is an appropriate exercise of parental (and sometimes also judicial) authority, might go something like this:

The family as a unit or entity is generally held to be essential to the society institutionally, and to individuals relationally. To the extent that it needs explanation and grounding, this view finds ample support in political philosophy, natural law, evolutionary biology, and psychology.²²³ Many things contribute to the family’s essential nature in

²²¹ Morley, *supra* note 207, at 1243–44 (footnotes omitted) (quoting *McFall v. Shimp*, 10 Pa. D. & C.3d 90, 91 (Ct. Com. Pl. 1978)).

²²² A few scholars have developed related theories of the family without regard to sibling transplants. *See, e.g.*, Dailey, *supra* note 13, at 967 & n.29 (describing historical construction of the family as a unit which “operate[s] according to the private virtues of love, altruism and dependence,” and citing a related view that “[t]he morality of altruism has been supposed to animate the family to the same extent that the morality of individualism has been supposed to pervade the marketplace” (citation omitted)); Fineman, *supra* note 10, at 1220–21 (arguing that “confer[ring] autonomy on caretaking or dependency units” rather than on individuals within such units, is most likely to ensure “collective responsibility for dependency”); Loken, *supra* note 24, at 1200 (suggesting that intra-family obligations arise out of gratitude for prior gifts given); Martha Minow, *All in the Family & in All Families: Membership, Loving, and Owing*, 95 W. VA. L. REV. 275 (1993) (interdependence and obligation; intra-family obligations arise out of the relationship; note that she asks but does not attempt to answer the question how sibling transplants would fare according to this theory of the family); Teitelbaum, *supra* note 15, at 540–42, 544 (describing “conventional understandings of the family” including as a “unit” or “entity” which “reflects both the internal governance of the family and its relation to other governmental units”; criticizing this understanding as “[un]convincing under modern conditions”); *id.* at 552 (noting that family members “are . . . expected to give gifts and provide services to each other that they are not expected to give or provide to others and are, in some sense, encouraged to do so”).

²²³ *See, e.g.*, *Bennett v. Jeffreys*, 356 N.E.2d 277, 285 (N.Y. 1976) (“The nature of human relationships suggests overall the natural workings of the child-rearing process as the most desirable alternative.”); Loken, *supra* note 24, at 1162 (quoting John Locke, “Adam and Eve, and after them all Parents were, by the Law of Nature, under an obligation to preserve, nourish, and educate the Children, they had begotten, not as their own Workmanship, but the Workmanship of their own Maker, the Almighty, to whom they were to be accountable for them.”); *id.* at 1137 (“[O]n a subconscious, biological level we may be programmed to maximize our ‘reproductive success,’ by parenting in such a way as to produce the maximum number of healthy descendants.”); *id.* at 1143 (“The difficulty of fulfilling parental duties for more than one child goes far beyond the initial question of procreation. Some children need more from a parent to survive or thrive, but other children may seem to a parent worth more in terms of their likely overall contribution to the general welfare, however defined. Consider the wrenching choices faced by parents who have a badly disabled or catastrophically ill child, as well as one or more healthy ones.”); *id.* at 1189 (quoting Plato, “This is how every mortal creature perpetuates itself. It cannot, like the divine, be still the same throughout eternity; it can only leave behind new life to fill the vacancy that is left in its species by obsolescence. This . . . is how the body and all else that is temporal partakes of the eternal; there is no other way. And so

these respects, but most central is its ability and willingness to nurture or at least to sustain its members. Whether this function is examined from the perspective that the family is an organic unit whose members exist at least in part for the benefit of the whole, or from the perspective that the family is a collection of interdependent individuals who have mutual obligations of care and support, it contemplates individuals who “do their share” as they are able toward the best interests of the collective and of needy individuals within it.²²⁴ It also contemplates individuals who (at least to a point) sacrifice their selfish interests to help secure the lives especially, but also the general welfare, of their relatives.²²⁵

These sacrifices may be physical because, within the family, bodily integrity is not privileged to the same extent as the preservation of life, relationships, or even parental prerogatives.²²⁶ (Of course, this is not the case vis à vis the outside world.)²²⁷ In fact, sacrifices and losses of physical integrity within the family might be considered both commonplace and expected. Depending upon one’s point of view, they include women bearing children and suffering the pains and risks of childbirth and even breast-feeding, men and women working in physically detrimental and high-risk jobs to support the family or to spare its other members from exposure to detriment and risk,²²⁸ and children suffering the pains of corporal punishment and foregoing educational and other opportunities to contribute their physical labor to a family enterprise.

Moreover, the sacrifices may be made by or required of any family member who has something to give, including young children, because neither autonomy nor choice are relevant in the circumstances. This is

it is no wonder that every creature prizes its own issue, since the whole creation is inspired by this love, this passion for immortality.” (alteration in original)).

²²⁴ Minow, *supra* note 222, at 320 n.166.

²²⁵ Examples of such intra-family sacrifices abound, including men who repeatedly re-enlisted for duty during the Vietnam War to ensure that their brothers would not be called up—based in the law that prohibited the government from conscripting more than one sibling at a time; and adult children who make personal sacrifices to take care of elderly parents.

²²⁶ This norm should not insulate parents who (ab)use their children in ways—e.g., sexual or physical—that bear no relation to the best interests of the family or to the legitimate needs of individuals within the family. On the other hand, it should insulate parents who (ab)use their children to gain an important benefit for the child herself (e.g., one view of corporal punishment, of religious exemptions to medical neglect laws, and of other non-therapeutic surgeries, e.g., gender re-assignment).

²²⁷ See *supra* notes 184–203 and accompanying text (discussing the notion of bodily integrity and its sacrosanct place in American jurisprudence, including as this jurisprudence has influenced the development of child maltreatment law); see also Coleman, *supra* note 12, at 623 (rejecting the view prevalent among some pediatric bioethicists that healthy children owe a duty to society at large to participate as research subjects in more than minimal risk research that may yield benefits to their population sub-group).

²²⁸ Other examples of sacrifices and consequent losses of physical integrity include working in physically debilitating and high-risk jobs to spare others from having to do such work.

because intra-family relations exist outside of the liberal, individualistic paradigm within which these principles operate.²²⁹ This analysis is not altered by the fact that modern medicine has made it possible even for infants to “do their share”—by “giving” cord blood or bone marrow, for example—where previously these youngest of children could only be characterized as dependent. By definition, age (as a proxy for individual decisionmaking capacity) is irrelevant in the equation. Family members are interdependent and expected to sacrifice for one another according to their abilities and the needs of the others.²³⁰ External variables, including the state of medical knowledge, have always affected their options—that is, what they are in fact able to do for one another, and thus the nature of their interdependence.²³¹

Finally, the ability and willingness of the family to nurture and sustain its members contemplates that parents will manage the system that makes the necessary allocations, because among the parties who could make the decisions—the child, the parents, and the state—parents are best suited to assume this role.²³² The pre-competent child cannot be asked to do so because she lacks the experience and judgment necessary to assure sound decisionmaking not only for herself, but also in the interests of those around her. And the state lacks both the capacity and political status to micro-manage intra-family relations. Parents, on the other hand, have both the capacity (by virtue of their maturity and knowledge, including in particular about their children) and the political status (based in accepted ideas of parents as property owners or fiduciaries) to do this work.²³³

As applied to the pediatric transplant setting, these informal norms and aspirations about family suggest that all healthy individuals including young children ought to be available and, whenever capacity

²²⁹ Fineman, *supra* note 10, at 1222 (her “argument in favor of autonomy for the caretaking unit is that some relationships should be considered outside of the equality paradigm”); Morley, *supra* note 207, at 1243–44 (arguing that while liberal principles properly govern the relationship between individuals and the state, they are irrelevant to intra-family governance and in particular to the propriety of intra-family organ sharing).

²³⁰ It is impossible to avoid the reflection that this description of the family and of intra-family relationships sounds a lot like the communist principle “[f]rom each according to his ability, to each according to his needs.” KARL MARX, CRITIQUE OF THE GOTHA PROGRAMME 27 (1875). That communism has been rejected in the United States as a political philosophy which would govern the individual’s relationship to the state says little about how Americans imagine the political philosophy which governs the family as a unit.

²³¹ Other variables that have the same effect on the range of family members’ ability to help one another survive and succeed include physical capacity and geography.

²³² See *supra* notes 23–27 and accompanying text. The “parent” in this scenario may actually be a child, for example, where the mother and father are old and the child is the adult who manages their care, or where the mother and father are absent or lack relevant capacity, and the child, albeit a minor, is the next best option.

²³³ This analysis is entirely consistent with the way the law describes or structures the relationship between the state, parents, and children. See *id.*

allows it, also willing to give an organ to benefit an ill or dying family member. Doing so even where the transplant procedure involves significant injury, pain, recovery time, and long-term consequences for the donor can be considered merely one among many forms of appropriate self-sacrifice in the interests of the family and/or of a needy member of the group. Moreover, decisional authority in this context is properly rested on parents as the natural leaders of the family. As the Alabama probate court concluded in *In re S.C.*, whatever the law might say otherwise

the natural parents . . . of the[] minor children have the right to give their consent to the medical procedures and treatments [associated with the transplant] . . . in order to preserve [their injured child's] life, prevent permanent physical impairment or deformity, and to alleviate prolonged agonizing pain.²³⁴

To this point, I have assumed that a unit theory of the family and an interdependence and obligations theory of intra-family relationships are indistinguishable. Distinctions do exist, however, and they are not inconsequential:

Most important, a unit theory of the family will countenance more sacrifice than will an interdependence and obligations theory of intra-family relationships. As applied to sibling transplants, for example, one might argue that in a family with several small children, the health and wellbeing of the mother and/or father is more critical than the health and wellbeing, and maybe even the survival, of one of the smaller children. This, in turn, would suggest the propriety of taking from one of those smaller children what was necessary to assure her parent's welfare. Presumably, this outcome would be impermissible in a family that is guided by principles of interdependence and obligation because, by definition, these principles dictate respect for and mutuality among the individuals who comprise the collective; that is, regardless of the practical implications, the small child would not be considered less valuable than her parent.²³⁵

To the extent that a unit theory imagines an organic family whose members are in a biological, psychological, and philosophical sense all part of a single whole, it also suggests that removing an organ—skin, for example—from one member to give to another is analogous to an autograft (transferring skin from one to another place on a single person's body). In other words, unit theories of the family blur if not erase entirely the line between the individual and the group, and thus

²³⁴ Order on Petition, *supra* note 7, at 510.

²³⁵ Woodhouse, *supra* note 11, at 1260 (“I believe we could arrive at the same place by focusing on individual rights of adults and children as ‘persons’ that gain added force by being a part of mutual relationships that are reciprocal in nature.”).

make it easier to rationalize the transfer. For example, because identical twins are part of a single whole, if an injured twin needs a large swath of her healthy sister's skin either to live or simply to avoid significant scarring in psychologically or physically sensitive areas, the healthy twin needs to submit to the harvesting even if doing so results in otherwise unnecessary scarring of her own. This analysis is inconsistent with an interdependence and obligations theory of intra-family relationships because this theory recognizes not only the importance of family but also the separate integrity of its individual members and a corresponding limit to their intra-family obligations that is itself based in mutual respect for their individuality. Thus, notwithstanding their genetic status as identical twins, the twins are not one, they are sisters, and the healthy twin may not owe the injured twin a swath of skin if this is merely to assure to the extent possible that they continue to match.

While I suspect that in this time and place a unit theory of the family is likely to be less attractive than an interdependence and obligations theory of intra-family relationships, in general both have quite a lot of appeal because they reinforce the promise that is family. This is perhaps especially important in this increasingly individualistic culture, where the dominant social norms and aspirations tend to emphasize each person's separateness and thus, inevitably, each person's aloneness. Children in particular (along with older and disabled adults) might welcome the existence of a set of strong, at least informal, norms that not only recognize their inevitable dependency but that also privilege caretaking decisions and behaviors that are designed in some cases literally to keep them alive, and in others simply to foster mutuality and interdependence among family members.²³⁶

But there are also two important caveats as these approaches would be applied to the pediatric sibling transplant setting:

First, despite the rhetoric about family unity, interdependence, and obligation,²³⁷ and the general sense from the cases that parents, doctors, and judges are primarily motivated by the desire to save the life of a child no matter how this is to be done, in fact it is only acceptable according to these informal norms and aspirations to require adult incompetents and little children to "donate" an organ. Older but still minor children may be asked or pressured to assent, but if they refuse, at least one of the three parties involved in the procedure (the parents, the doctors, or the court) will most likely decline to proceed. And no competent adult, no matter whether she is a parent or sibling, can be

²³⁶ MARTHA ALBERTSON FINEMAN, *THE AUTONOMY MYTH: A THEORY OF DEPENDENCY* (2005).

²³⁷ See, e.g., Morley, *supra* note 207, at 1244 ("Family members—parents, children, adolescents, and adult incompetents living under their care—owe responsibilities toward each other that do not exist among members of society at large.").

forced even to submit to compatibility testing in this context—where family members seek to pressure a reluctant prospective donor, the medical community has developed ways to protect her, and the law categorically prohibits compulsion. This distinction between “incompetent” and “competent” family members mostly reflects the extraordinary strength of the society’s commitment to individual adults’ decisional autonomy, particularly as autonomy relates to physical integrity;²³⁸ the commitment to alternative norms and aspirations about the family is weak in comparison. Most importantly for present purposes, however, the difference between the way little children and adults are treated reflects the unique property-like power that parents and others are often believed appropriately to have over the children, including with respect to physical invasions.

The second caveat concerning the application of informal norms and aspirations about family to the pediatric sibling transplant context is that it is not always easy to define “family.” The cases suggest that these norms and aspirations only apply within the original intact nuclear family so that “donations” can only be forced within that group. Indeed, even within this family, in circumstances where the harvesting surgery is particularly intrusive and impacting, particularly close biological and emotional ties—for example, those between identical twins—are favored.²³⁹ In contrast, absent fathers who wish to use their healthy children’s organs to benefit relatively unfamiliar half-siblings can be rebuffed,²⁴⁰ which suggests how slim the prospects are for others more distantly removed. This restriction assures that the number of children who are either used as or permitted to be organ sources is relatively low in comparison to what it would be otherwise; depending upon one’s view of and goals with respect to pediatric sibling transplants, this may be a good thing. On the other hand, as Martha Albertson Fineman has acknowledged in a more general context, the “entity version[] . . . [of] family privacy” suffers from “the historic doctrinal limitation that it applies primarily to family units that conform to ideological conventions about appropriate form and function—intact nuclear families.”²⁴¹ In other words, it is inconsistent with progressive and increasingly accepted social norms about family form and also with the more complicated lives people increasingly live. And yet if one were to imagine expanding the notion of family to accommodate this variety of functional family forms as some commentators suggest,²⁴²

²³⁸ See *supra* notes 184–86 and accompanying text (describing this commitment).

²³⁹ See, e.g., *Masden v. Harrison*, No. 68651 (Mass. Eq. June 12, 1957) (decision on file with author); Order on Petition, *supra* note 7.

²⁴⁰ See, e.g., *Curran v. Bosze*, 566 N.E.2d 1319 (Ill. 1990).

²⁴¹ Fineman, *supra* note 10, at 1216.

²⁴² See, e.g., *id.* at 1221 (proposing that autonomy and privacy should be “confer[red] . . . on caretaking or dependency units. . . defined through [their] function[], not [their] form”).

circumscribing the universe of potential pediatric “donors” would become that much more complicated, especially as biological compatibility becomes decreasingly significant.²⁴³

C. *The Dilemma Posed by the Status Quo*

The strength of informal norms and aspirations about the family as a unit or group of interdependent, mutually-obligated individuals goes far toward explaining the persistence of pediatric sibling transplants. (The remainder of the explanation is likely factual: Medicine makes it possible to engage in organ transfers and many adults continue to believe they have property-like power over little children.) The law’s concept of the child as an individual worthy of fiduciary protection, particularly with respect to her bodily integrity, explains the necessary *sub rosa* nature of the practice. These explanations are instructive, particularly because pediatric sibling transplants take place at the intersection of law and medicine where philosophical and ethical collisions are both a commonplace and commonly misunderstood.²⁴⁴

The status quo that exists because of the particular collision at issue here—law that is different on the books than it is on the ground and decisionmaking in the latter context that is necessarily hidden from public view—is both practically and normatively problematic:

It is practically problematic because in most cases it leaves affected parties without a coherent answer to the question whether it is legally permissible to perform a pediatric sibling transplant. Most important, it leaves healthy children who would be used as organ sources without the protections one would expect from law developed and applied in the open. Although thoughtful, respected pediatric ethicists have established good protocols delineating the conditions under which a child may be used as an organ source, these protocols are neither binding nor subject to external review; a particular hospital or transplant team has the choice to abide by them or not.²⁴⁵

The status quo is normatively problematic because of the blurry if not invisible line that is thus drawn—in this case between permissible and impermissible surgeries and ultimately between conduct that is within and beyond the boundaries of family privacy. In these circumstances law loses its expressive function except to the extent that

²⁴³ See, e.g., *ABO Incompatibility in Transplants*, CEDARS-SINAI, <http://www.cedars-sinai.edu/Patients/Programs-and-Services/Comprehensive-Transplant-Center/Kidney-and-Pancreas/Conditions-and-Treatments/ABO-Incompatibility-in-Transplants.aspx> (last visited Mar. 14, 2014) (noting that “innovative new procedures allow the transplant team to break the ABO incompatibility barrier”).

²⁴⁴ See Coleman & Rosoff, *supra* note 122 (discussing these collisions).

²⁴⁵ See *infra* notes 286–88 and accompanying text (evaluating these protocols).

it announces the absence of rules beyond the good faith or ethical grounding of the adults in the equation. The immunity and flexibility that results are certainly valued by the adults and institutions (including hospital risk managers and general counsels) who are involved in pediatric sibling transplants, but it is difficult to make the case that the most vulnerable parties in the mix are properly served.

III. SETTING THE BOUNDARIES OF FAMILY PRIVACY

Parents use of minor children as organ sources for their ill and injured siblings tests the boundaries of family privacy in unique ways. Unlike other things parents do that cause their children harm, pediatric sibling transplants are at once prohibited by the law and the fiduciary norms and aspirations that dictate its terms and permitted by powerful competing informal norms and aspirations about family and also perhaps about children as property. This state of affairs suggests that society is conflicted not only about the location of the boundaries of family privacy, but also in the first instance about the tools that it is prepared to use to set them. As I note at the end of Part II, the effects of this situation are both practical and normative, and most are negative: The legal status of pediatric sibling transplants is hazy at best; healthy children who would be used as organ sources are left without the protections one would expect from rules that are developed and administered in the open; and ultimately the law expresses only dysfunction.

In this last part of the Article I agree with scholars who have preceded me that the boundaries of family privacy ought to be drawn using fiduciary theory. I join the sometimes-controversial claim that fiduciary theory requires the law and legal doctrine to respect not only the child's physical integrity but also her emotional and developmental welfare, including her evolving personhood. And I argue that as applied to pediatric sibling transplants, this requires the law expressly to recognize the fact of pediatric sibling transplants in all of their possible forms and to adopt rules that will consistently and adequately protect the interests of the child who would be used as an organ source.

A. *Defining the Boundaries According to Fiduciary Theory*

Scholars in this modern period generally agree that those who take care of children, including their parents and their parents' delegates, are or should be guided in their decisionmaking by fiduciary principles. They do not all use this term, and they disagree about how exactly to characterize the parent-child relationship and in particular about

whether the child ought to be recognized as having “rights” as against her parents in cases of intra-family conflict.²⁴⁶ Notwithstanding their differences, however, they agree that

the child is no longer as she was throughout much of Western history—the equivalent of property or else a mere extension of her parents who could do with her as they wished. . . . Rather, the child today is an individual, albeit a preautonomous one, to whom her parents and society owe basic obligations of nurture and respect. An important aspect of this modern vision is that the child’s body and mind are ultimately her own, not to be used to her detriment by the adults who are responsible for her care and development. To the contrary, her parents’ right to exercise discretion in the ways they guide her along the path to adulthood is directly tied to the fulfillment of their fiduciary obligations of nurture and respect, including to the development of a relationship with her that honors these commitments.²⁴⁷

With some notable exceptions, this theoretical approach appears to be shared by pediatric bioethicists and others in the medical and scientific communities who view the child as the patient and the requirement of proxy (parental) consent as protective of her individual best interests.²⁴⁸

This concept of the child and account of the parent-child relationship have their origins in two related revolutions: The political individuation of the child beginning in the late 1800s and the development of a science-based model of child development beginning in the mid-to-late 1900s.²⁴⁹ The former made it inevitable that children would come to be seen as individuals, still inextricably tied to but also clearly distinct from their parents and the society, and that, at the very least, questions would be asked about the nature of their separate status within the democracy. The latter has assured both that this status continues to be different from that of adults and that children are entitled to care that corresponds with their developmental needs and interests.

The boundaries of family privacy that are established according to fiduciary theory are different from those that obtained in previous

²⁴⁶ See Coleman, *supra* note 12, at 615 (citing Scott & Scott, *supra* note 16, at 2402–03; Woodhouse, *supra* note 18, at 313–18); *id.* at 616 n.387 (citing Bartlett, *supra* note 24, at 297–98).

²⁴⁷ *Id.* at 615–16 (footnotes omitted); see also *Bennett v. Jeffreys*, 356 N.E.2d 277, 281 (N.Y. 1976) (“[T]he modern principle [is] that a child is a person, and not a subperson over whom the parent has an absolute possessory interest. A child has rights too, some of which are of a constitutional magnitude.” (citations omitted)).

²⁴⁸ See, e.g., COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, *supra* note 29, at 1–2; Ramsey, *supra* note 24; Lainie Friedman Ross, *Health Care Decisionmaking by Children: Is It in Their Best Interest?*, 27 HASTINGS CENTER REP. 41 (1997). But see Loretta M. Kopelman, *Children and Bioethics: Uses and Abuses of the Best-Interests Standard*, 22 J. MED. & PHIL. 213 (1997).

²⁴⁹ See generally Buss, *supra* note 22, *passim*.

periods where entity theories of the family and concepts of the child as property were predominant. Parents and their delegates are no longer believed to be entitled to cause harm to children that is not in the children's own (as opposed to the family's or the parents') best interests.²⁵⁰ This condition inevitably restricts the kinds and degrees of permissible harm that may be caused, and also the nature of the exceptions that can be developed.²⁵¹

These restrictions, and the embedded concept of the child as a pre-autonomous person deserving of society's respect and protection, themselves are rightly privileged—the boundaries of family privacy ought to be located according to the coordinates they dictate. It is undoubtedly in the interests of children (and other vulnerable members of a society) that the society establish policies and laws that are consistent with a sense of their vulnerability and a commitment to their protection. Such policies and laws are also in the interests of society itself: Practically, respect for and protection of children and other individuals within vulnerable sub-populations maximizes the likelihood that they will flourish as persons and thus that they can become successful, contributing members of the society. Ethically, such respect and protection are indicators of a mature, confident society that does not abide the easy erasure of the interests of weaker individuals by those who are in positions of power.

The boundaries of family privacy that are established according to these norms and aspirations should not be ignored simply because adults sometimes have competing interests; indeed, the doctrines that operationalize these boundaries draw a firm line beyond which they cannot go, regardless of their motivations, precisely because their conflicting interests have historically caused children significant harm. Thus, parents who needed or wanted free labor or money could use or lease out their children with impunity when the child was viewed as property or even as one with his parents and family.²⁵² According to these same norms and aspirations, it was no stretch for parents and their delegates also to (ab)use and neglect the children's bodies and minds, for theirs was the right and the power.²⁵³ It is important in this respect that, like the interest in saving or ameliorating the life of an ill or injured child, adults' competing interests in these prior periods—running a family farm or business, funding its operations, and sustaining entrenched hierarchies—were often not only normative but laudable; adults often (ab)used children for good reasons.

²⁵⁰ See *supra* notes 18–28 and accompanying text (describing the connection between fiduciary theory and the best interest presumption and test).

²⁵¹ See *supra* notes 186–97 and accompanying text (setting out the rules that result).

²⁵² See *supra* notes 20–22 and accompanying text (describing this effect).

²⁵³ *Id.*

There are differences, of course, between a property theory of the child and an entity or interdependence and obligations theory of the family and intra-family relations: Presumably the former would justify outright destruction whereas the latter would not. But to the extent that both allow for a range of treatment, from the child as treasure to the child as organ source—and the latter either according to Jodi Picoult's *My Sister's Keeper*²⁵⁴ or Kazuo Ishiguro's *Never Let Me Go*²⁵⁵—even entity and interdependence and obligations theories of the family and intra-family relationships risk too much. As others have noted before me,

to speak of the family as having its own goals and purposes and to speak of the familial perspective and familial objectives is to engage in dangerous reification. . . . Given the very great inequality of power between parents and children, reference to the family's interest or "familial objectives" is all too likely to serve as a cover for the parents' interests precisely in those cases in which the latter conflict with those of the child.²⁵⁶

In any event, as I will argue in the next section, it is better to consider the more appealing aspects of entity and interdependence and obligations theories of the family, and of intra-family relationships within a fiduciary framework—for example, in the context of a best interests analysis—by taking into account the child's developing personhood and the role of her family members in that development. In this respect I agree with Barbara Bennett Woodhouse that

²⁵⁴ JODI PICOULT, *MY SISTER'S KEEPER* (2005) (portraying a child who was conceived to be a stem cell donor for her sister, who was periodically used as an organ source after the original "donation," and who was loved by her parents and treated as a full member of the family).

²⁵⁵ KAZUO ISHIGURO, *NEVER LET ME GO* (2005) (portraying children cloned from their relatives and raised apart from them so that they could eventually harvest their organs without the need to address emotional and relational ties).

²⁵⁶ BUCHANAN & BROCK, *supra* note 206, at 236–37. As Lee Teitelbaum has noted, the idea of

the family unit in its "entity" or anthropomorphic form leaves little space for recognizing individual claims—the interests that arise from a wide range of individualized decisions and arrangements—within a family. Respect for the "privacy" of the family unit seemingly requires ignoring other, possibly competing, bearers of rights—the individual family members.

Teitelbaum, *supra* note 15, at 554; *see also* Dailey, *supra* note 13, at 981 ("Individual autonomy and communal family life are compatible only so long as family life remains harmonious. When family consensus breaks down, and family members either voluntarily seek or are legally required to seek public resolution of their differences, constitutional protection for the family unit becomes problematic."); Scott & Scott, *supra* note 16, at 2473 ("Conflicting signals are sent by a legal regime that emphasizes parental rights as well as the welfare of the child, but links the two by balancing the one against the other. It is not surprising that this is understood to mean that when parental rights are vindicated, children's welfare is sacrificed.").

[i]n rejecting the 'entity' or 'unit' as a governing paradigm [we] do not mean to deny the importance of relationships to family theory or to claim that 'the family' is no more than a casual grouping of isolated individuals. But there are better ways to express the truth of family connectedness, ways that do not subsume the child's identity and agency.²⁵⁷

The argument in favor of fiduciary theory as the basis to draw lines beyond which parents and their delegates cannot go also has a pragmatic basis. It is unrealistic to think that law and policy in this period can be made to recognize the primacy of approaches that re-imagine the child as property or even as subsumed within a family that disregards her status as an individual worthy of respect in her own right. Constitutional doctrine, federal and state statutory law, and the states' common law are all uniform in their commitment to the born child as an individual whose interests are carefully delineated and whose proxies are limited accordingly.²⁵⁸ Although state law is malleable to some extent, it is ultimately subject to the supremacy of federal law;²⁵⁹ and although the latter affords parents significant liberty, the rebuttable presumption is that they will exercise that liberty according to first principles: in the best interests of the child.²⁶⁰

B. *Adopting a Holistic Approach to Fiduciary Theory*

Although fiduciary theory is established as the basis to draw the boundaries of family privacy, its particulars are subject to discussion. That is, scholars and policymakers can and do usefully debate what it means to act responsibly toward the child, including the aspects of the child's welfare that are subject to respect and protection. For purposes of this Article, the most salient features of that debate concern the extent to which the child's physical integrity is privileged and the ambivalence that characterizes the treatment of her emotional and developmental integrity.

Consistent with the way law and policy treat adults, children's law and policy focus on the child's physical welfare. Tort and maltreatment law protect the child from personally unnecessary batteries, including those that would be inflicted by her parents and their delegates. The privileges or exceptions that define the batteries that count as necessary are scarce: Only medical treatment and reasonable corporal punishment, both of which are focused on the best interests of the child

²⁵⁷ Woodhouse, *supra* note 11, at 1259.

²⁵⁸ See Coleman, *supra* note 12, at 545–52.

²⁵⁹ U.S. CONST. art. VI.

²⁶⁰ See *supra* notes 187–97 and accompanying text (describing this doctrine).

herself, are formally recognized.²⁶¹ There is often conflict about the nature and degree of physical harm that should justify the state's intrusion on family privacy to protect the child according to these rules,²⁶² but the fundamental commitment to the child's physical welfare is beyond dispute.

In contrast, law and policy are at least ambivalent about the child's emotional and developmental welfare. There are certainly times when important competing interests are demoted, particularly in favor of children's educational development. (Here it is appropriate to cite to *Brown v. Board of Education*, which privileged African-American children's right to an integrated education and to the associated psychological and developmental benefits above the white citizenry's interest in separation of the races in public institutions.)²⁶³ But mostly, children's law and policy mirror the law's general disdain for things emotional. Thus, although tort law no longer immunizes parents and their delegates from liability for intentional torts, one would be hard pressed to develop a viable claim for "emotional battery" or "intentional infliction of emotional distress."²⁶⁴ Maltreatment law lists "emotional abuse" and sometimes also "emotional neglect" as legally recognized harms that provide the basis for state intervention into the family to protect the child, but these are both severely defined and rarely used on their own; to the extent they are the basis for state action, it is generally as appended to a charge of physical harm.²⁶⁵ Finally, although constitutional doctrine does suggest (mostly implicitly) that aspects of the child's developing personhood are subject to protection,²⁶⁶ unlike

²⁶¹ See *supra* notes 194–95 and accompanying text (describing this doctrine and its commitments).

²⁶² See, e.g., Coleman et al., *supra* note 119, at 113–19 (setting out the states' different approaches).

²⁶³ 347 U.S. 483 (1954); see also *Pierce v. Soc'y of Sisters*, 268 U.S. 510 (1925) (holding that although the state could require children's attendance in some schools, it could not bar parents from choosing an otherwise legitimate private institution); *Meyer v. Nebraska*, 262 U.S. 390 (1923) (holding that the state could not bar parents from providing their children with an education in part in German, but it could require parents to send their children to some school).

²⁶⁴ See generally G. Steven Neeley, *The Psychological and Emotional Abuse of Children: Suing Parents in Tort for the Infliction of Emotional Distress*, 27 N. KY. L. REV. 689, *passim* (2000).

²⁶⁵ See, e.g., CAL. WELF. & INST. CODE § 300(c) (West 2014).

²⁶⁶ See, e.g., *Bellotti v. Baird*, 443 U.S. 622 (1979) (recognizing the right of a mature minor to consent, with judicial oversight, to an abortion and the significance of the decision whether to bear and raise a child to the minor's construction of her future); *Parham v. J. R.*, 442 U.S. 584 (1979) (recognizing a child's interest in being free from involuntary institutionalization and the significance of such institutionalization for the child's construction of his reputation and dignity); *W. Va. State Bd. of Educ. v. Barnette*, 319 U.S. 624 (1943) (recognizing children's right to religious expression and the significance of religion to their families' construction of their identities).

physical harm²⁶⁷ and apart from the education²⁶⁸ and adolescent reproductive autonomy²⁶⁹ cases, this interest has not been the basis for intervention in the family to protect the child from parentally-inflicted harm.

It is understood that emotional injuries can cut as deeply and be as impacting as physical ones; yet there are good reasons for the government's restraint with respect to their recognition. This is perhaps particularly true in the intra-family setting where the infliction of such injuries is ubiquitous and likely unavoidable, but where children are still best raised. In the case of parentally-inflicted psychological and developmental harm, the concerns include the conceptual problem of drawing a line between permissible and impermissible harm; the practical problem of how to evaluate and measure harm to determine if it meets the threshold requirements for intervention; and the fact that intervention in even dysfunctional families itself risks significant harm.²⁷⁰ It is this last point especially that disturbs those who are most protective of family privacy and that makes the claim for recognition of an interest in emotional and developmental welfare controversial: Unlike physical injuries which either exist or not and which, when they exist, are mostly ascertainable, emotional injuries are subject to speculation and problems of proof and are thus more likely to provide the basis for unwarranted interventions, even by officials acting in good faith.

I do not intend to minimize the nature or extent of these concerns. However, recognizing them does not require ignoring the fact that being a good fiduciary to a child—acting and making decisions in her best interests—is meaningless as a standard of care if it ignores her psychological and developmental welfare.²⁷¹ As proof of principle, simply imagine a boy whose parent takes fine care of his physical wellbeing at the same time that she devastates him emotionally and developmentally to the point where he suffers a range of disabling and even destructive conditions; here I intend to describe commonly understood environmental triggers for, among other things, severe

²⁶⁷ See, e.g., *Santosky v. Kramer*, 455 U.S. 745 (1982) (parental rights can be terminated where there is clear and convincing evidence of unfitness based on physical abuse and neglect).

²⁶⁸ See *supra* note 263 and accompanying text (noting some of the education cases).

²⁶⁹ See, e.g., *Bellotti*, 443 U.S. at 622 (providing a judicial bypass for adolescent girls seeking to avoid parents who would be obstacles to abortions).

²⁷⁰ See Coleman, *supra* note 9, at 414–19, 518–21 (emphasizing the ironic costs of state intervention in the family to protect the child including the emotional costs associated with home visits and removals).

²⁷¹ See, e.g., *Emotional Abuse*, AM. HUMANE ASS'N, <http://www.americanhumane.org/children/stop-child-abuse/fact-sheets/emotional-abuse.html> (last visited Mar. 14, 2014); Stephanie Partridge, *Recognizing and Understanding Emotional Child Abuse*, MORE4KIDS, <http://safety.more4kids.info/202/signs-of-emotional-child-abuse> (last visited Mar. 14, 2014).

depression and psychopathy.²⁷² It would be dishonest to claim that this parent had acted as a good fiduciary in her son's best interests, and a theory of the parent-child relationship that allowed for this claim would lack integrity. Fiduciary theory ought therefore always be described holistically, accounting for all-important aspects of the child's welfare. To the extent that this description begs implementation problems—and it does—I agree with others who have argued that these can and should be addressed on a case-by-case basis.²⁷³

There is a tremendous amount of literature within many disciplines that elaborates on what it means for a parent to account for the child's psychological and developmental welfare. For purposes of this Article, it suffices to note the longstanding concerns about the short- and long-term psychological implications of being used as an organ source and also of not being permitted to donate. Although these implications have properly been described as speculative given how specific-to-the-circumstances emotional harm can be and also given the dearth of empirical data on point,²⁷⁴ the Texas appellate court in the *Little* case was correct that to the extent they can be ascertained, they are both relevant and important to consider.²⁷⁵

Finally, doing this work consistent with a holistic account of fiduciary theory requires attention to the effects of emotional and developmental benefits and injuries on the child's evolving identity or personhood. As Professor Emily Buss has described it, this evolution is “the process by which an individual develops a sense of his own values, interests, and abilities, and an understanding of how he relates to his broader world.”²⁷⁶ It is generally understood that “[t]he [child's] personhood . . . develops [best] in a cocoon of enveloping relationships—a tight-linked system of support, nurturance, and guidance that socializes the child as a rational member of a collective

²⁷² See, e.g., Willem H.J. Martens, *The Hidden Suffering of the Psychopath*, PSYCHIATRIC TIMES, Aug. 25, 2006, available at <http://www.psychiatrictimes.com/psychotic-affective-disorders/hidden-suffering-psychopath-0> (summarizing characteristic features of a psychopath's childhood and tying these to the genetic bases for psychopathy); *Emotional and Psychological Trauma*, HELPGUIDE.ORG, http://helpguide.org/mental/emotional_psychological_trauma.htm (last visited Mar. 14, 2014) (summarizing events and circumstances in childhood that can lead to severe depression).

²⁷³ See, e.g., Sana Loue, *Redefining the Emotional and Psychological Abuse and Maltreatment of Children: Legal Implications*, 26 J. LEGAL MED. 311, 320–23 (2005); Jessica Dixon Weaver, *The Principle of Subsidiarity Applied: Reforming the Legal Framework to Capture the Psychological Abuse of Children*, 18 VA. J. SOC. POL'Y & L. 247, 268–69 (2011); J. Robert Shull, Note, *Emotional and Psychological Child Abuse: Notes on Discourse, History, and Change*, 51 STAN. L. REV. 1665 (1999).

²⁷⁴ AAP Clinical Report, *supra* note 34, at 455–56.

²⁷⁵ See *supra* notes 138–39 and accompanying text (noting the court's sentiments in this regard).

²⁷⁶ Buss, *supra* note 22, at 14. This process is different from the developmental process, which usually refers to cognitive, social, educational, and emotional maturation.

group.”²⁷⁷ Initially, of course the child’s “collective group” is his original family, but over time it is also comprised of (or even replaced by) outsiders to the original family: peers, teachers, and other adults. This “matrix of sustaining and constitutive relationships[] . . . endow[] [him] with an intellectual, moral, and cultural inheritance.”²⁷⁸ Ultimately, though, “this same self ‘is determined to make that inheritance his own by fashioning an individual character and life plan, and by turning his participation in social practices into performances expressive of his individuality.’”²⁷⁹ What this means is that good fiduciary choices must take into account the child’s personhood in the moment of decision, but also that it is a transitional moment in her identity formation and that she will soon grow to be someone with additional or even different constitutive and deeply meaningful relationships, experiences, and values.

C. *Developing Law to Govern Pediatric Sibling Transplants*

To assure that the parties are doing right by both children in a potential pediatric sibling transplant situation, it is necessary for the law to emerge from its longstanding *sub rosa* position, and for rules to be developed based in these fiduciary principles. Until it does, as the legal history shows, the risks are simply too high that inadequate attention and respect will be paid to the multiple important interests of the healthy minor children who would be used as organ sources. This is because when rules are not transparent, they can be manipulated or even ignored with impunity in circumstances where they appear to be obstacles to the desired result. In the case of pediatric sibling transplants, this situation is exacerbated by a misunderstanding about what the rules actually permit and require; and it is not remedied by otherwise thoughtful medical ethics guidelines because these are by definition non-binding and also because they are inconsistent with fiduciary theory in some aspects.

²⁷⁷ Brook K. Baker, *Traditional Issues of Professional Responsibility and a Transformative Ethic of Client Empowerment for Legal Discourse*, 34 *NEW ENG. L. REV.* 809, 875 (2000); cf. *AM. LAW INST., PRINCIPLES OF THE LAW OF FAMILY DISSOLUTION: ANALYSIS AND RECOMMENDATIONS* § 2.03 (2002); *id.* § 2.02 cmt. e (“[T]he continuity of existing parent-child attachments after the break-up of a family unit is a factor critical to the child’s well-being. Such attachments are thought to affect the child’s sense of identity and later ability to trust and to form healthy relationships.”).

²⁷⁸ Baker, *supra* note 277, at 875.

²⁷⁹ *Id.* at 875–76 (quoting STEPHEN MACEDO, *LIBERAL VIRTUES: CITIZENSHIP, VIRTUE AND COMMUNITY IN LIBERAL CONSTITUTIONALISM* 219 (1990)).

The move to bring pediatric sibling transplants into the open and expressly within the cognizance of existing law and its fiduciary influences would likely have one of two “real world” effects:

The first could be to cause states to proscribe the practice in all circumstances on the grounds that its necessary invasions fit squarely within the definition of physical abuse and that an exception would be unworkable because a healthy child’s interests cannot be adequately protected (no matter how clear the protocol) where a dying or very ill or injured child is the counterweight. As one judge is said to have opined, “with [a child’s] life at risk, no court would hold against the parents’ wishes and the physician’s recommendation for the harvesting procedures.”²⁸⁰ Bone marrow transplantation might be the exception if the case is adequately made either generally or in individual cases that both the physical invasions involved and the short- and long-term psychological and physical risks are indeed negligible.²⁸¹

The second effect of a move to bring pediatric sibling transplants within existing law could be to cause states to permit the practice as an exception to the rule that intentional serious physical harm to a child is prohibited abuse, but likely only in circumstances where the evidence was compelling that the physical and psychological harms and risks inherent in the harvesting would be outweighed by non-speculative benefits to the donor child. Given that some pediatric sibling transplants make sense from whatever theoretical or ethical perspective one holds, this second, fine-tool approach would be preferable. To take the simplest case again, fiduciary theory would certainly permit (and even encourage) a bone marrow transplant where a physically and emotionally healthy older adolescent in a loving and supportive relationship with his parents and sibling clearly wants to make the donation—the benefits of this process given his developmental stage, including to the continued positive evolution of his personhood, could be shown to outweigh the harms and risks inherent in the surgery.

The standard that would govern this new exception has two critical components, both of which are designed to ensure that decisionmakers in individual cases focus their attentions on the healthy child herself; that they understand that their role is to protect her multifarious interests; and that they only permit transplants that are consistent with that fiduciary responsibility:

The first of these components is its evidentiary burden, which requires that advocates of the transplant (usually parents and their ill or

²⁸⁰ See Tilden, *supra* note 1, at 97 (in the context of the *In re S.C.* discussion).

²⁸¹ Although one might think that this has already been done given that the procedure appears to be commonplace, in fact only two states have been convinced to adopt laws on point and the American Academy of Pediatrics has only recently opined on its ethical status. See *supra* notes 122, 174–76 and accompanying text.

injured child's doctors) produce child-specific evidence to support their claims about harms, risks, and benefits, and which demands that this evidence be clear and convincing before authority to conduct the procedure is granted. This is to counter the tendency of courts and hospitals to proceed on the basis of generalizations and suppositions, most of which are never brought home to the healthy child herself and which otherwise lack evidentiary support. Consistent with the suggestion made by Baron, Botsford, and Cole in 1975, and apparently accepted by most judges since then, the petitioners' facts and the weight of their evidence should be challenged by an adversary to the surgery; this on the view that the adversarial process is an effective way to know the truth about the procedure and the child's circumstances.²⁸² "Donor advocates" as envisioned by some in the medical community are insufficient for this purpose because they are by design parties to a collaborative process which focuses on both of the children's interests and which is deferential to parents' wishes.²⁸³ In such conditions and given the context—usually fast-paced decisionmaking in the face of a dying child—it is a real risk that unless an individual is designated specifically for this purpose, no one in the process will have an interest in identifying facts and making arguments that would counsel against the transplant. As the Alabama decision in *In re S.C.* case suggests, including a good GAL for the healthy child is insufficient standing alone to guarantee that such evidence is treated appropriately, but the odds that this evidence will be suppressed, minimized, or even ignored inevitably increase if such a GAL is absent.

The second is its recognition that the child's psychological and developmental interests in this special context may be as significant as her physical interests. As I explain in Part II, the law to date has not generally seen fit to permit intentional physical injuries to a child where the only arguable benefits are psychological.²⁸⁴ This is in line with its traditional privileging of physical harms and its separate concerns about recognizing emotional harms.²⁸⁵ I believe that this view is well-taken in almost all other circumstances; however, it is lacking in the special case of pediatric sibling transplants both as a practical matter because they cannot proceed in the absence of evidence of psychological benefit since there is no (or negative) physical benefit, and as a theoretical matter because both allowing and disallowing a transplant can, depending on the facts, have extraordinarily damaging implications for the healthy

²⁸² See *supra* note 180 and accompanying text (discussing the role of the GAL in judicial proceedings).

²⁸³ See *id.* (discussing the concept of and problems with the AAP's construction of the child's donor advocate).

²⁸⁴ See *supra* notes 196–97 and accompanying text (explaining this point).

²⁸⁵ See *supra* notes 261–70 and accompanying text (discussing this background).

child who would be used as an organ source. To ignore these implications is, again, contrary to her best interests and inconsistent with adults' fiduciary obligations.

Given the significance of the child's developing personhood in particular, it is essential that the rule and process that is ultimately developed to assess psychological harms and benefits assures careful consideration of the child's real ties to the members of her nuclear family but also in particular to the sibling who needs an organ, of the family's relevant cultural norms and values, and of the ways and extent to which she has, to that point, made them her own. This rule and process must also assure careful consideration of the likelihood that the significance of these ties, norms, and values will change as she grows, and that others of equal or greater significance may develop. Because of competing obligations, changed family circumstances and relationships, a fear of surgery, or simply a particular sense of bodily integrity, it is not unusual for adult family members to decline voluntarily to donate an organ to an ill or injured sibling, even in otherwise loving, functional families. Although it is expedient both to ignore or minimize this possibility in a given case, and to conclude that a present-day analysis of the future possibilities is too difficult in any event, honest fealty to fiduciary principles demands that decisionmakers try their best to understand the child in all of these respects.

Apart from the conditions that I have just described, developing the rule and process to govern a "sibling transplant exception" to the law prohibiting intentional physical harm to a child would not require policymakers or judges to begin from scratch:

First, there is useful guidance to be drawn from the available pediatric sibling transplant cases, both in terms of what they got right and what they got wrong. Thus, most were correct—as in consistent with law and its fiduciary influences—to set the standard as the best interests of the healthy child; to use a balancing test to establish those best interests, which focused only on that child; and to attempt to ascertain the child's emotional and developmental interests but also to acknowledge the difficulties inherent in that enterprise. At the same time, most were wrong—as in inconsistent with the law and its fiduciary influences—not to require an important threshold of evidence to support best interests arguments, since this is the only way to assure that these are more than just arguments; not to focus initially on the physical harm that is the surgical intrusion itself, since this is just as if not more important from the law's perspective than the short- and long-term associated risks; and to assume that parental responsibility and authority is or should be so broad as to permit even extraordinary physical intrusions on a healthy child's body so long as these are undertaken in good faith.

Second, as I have already noted, the medical community itself has carefully considered pediatric sibling transplants from its own professional and ethical perspectives and has developed protocols consistent with these requirements. These protocols are based in many shared principles and thus can provide additional guidance for the law. Thus, both the Council on Ethical and Judicial Affairs (CEJA) of the American Medical Association (AMA) and the Committee on Bioethics of the American Academy of Pediatrics (AAP) have established the following “stringent criteria”²⁸⁶ for using healthy children as organ sources: that other sources or options do not exist to address the ill child’s circumstances; that both the healthy and the ill child will benefit significantly from the transplant, and specifically that the healthy child will benefit psychologically; that transplants only take place between close family members; that the transplant poses a low medical risk for the healthy child; and that the healthy child assent to the procedure.²⁸⁷ These protocols are notable for their focus on assuring that the interests of the healthy child are examined carefully and honestly, on their insistence that every condition be met, and for their sense that this requirement cannot be satisfied by unsupported assertions. Like the law itself, these criteria are not without flaws. Most notably, neither requires a transparent process involving a neutral decisionmaker, and the AAP’s proposal in particular is (as subsequently interpreted)²⁸⁸ overly deferential toward parents’ wishes and decisions. But ultimately they can help to fill in some of the details of what it would mean to do “best interests” in this context.

CONCLUSION

A healthy minor child should be used as an organ donor only if there is compelling factual evidence that the psychological benefits to that child outweigh the necessary physical injuries. Such evidence will often be difficult, even impossible, to muster. But it is only in these circumstances that we can know that we are appropriate stewards of her mental and physical health; that we are not sacrificing her for the

²⁸⁶ AAP Clinical Report, *supra* note 34, at 456–57.

²⁸⁷ See COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, *supra* note 29. It chose the “clear benefit” standard in lieu of the best interests test because it believed the latter to be “vulnerable to manipulation” and thus to permit “the decision maker’s own subjective values” too much influence in the outcome of the process. *Id.*; AAP Clinical Report, *supra* note 34; AAP Policy Statement, *supra* note 32.

²⁸⁸ See *supra* note 180 (discussing this deference).

benefit of another simply because, in the excruciating moment of decision, that seems like the right thing to do.²⁸⁹

The law properly recognizes a right of family privacy, which includes a right to make decisions about the family's culture, how its children will be raised, and how its relationships will be managed. It also properly recognizes that parents are usually best placed to make those decisions because they have the cognitive capacity, life experience, and intimate knowledge necessary to do this well. However, these rights are not and should not be limitless. In the modern context where the theory of the parent-child relationship is a fiduciary one, and where the concept of the child is that of a pre-autonomous person deserving of respect and protection, the law must set the boundaries of family privacy consistent with that theory and concept.

Pediatric sibling transplants test the modern boundaries of family privacy in a way that perhaps no other parenting choice does: The harvesting surgery causes important physical harm to the healthy child who would be used as an organ source—harm the law normally characterizes as a battery and as abuse—on the basis of other-than-fiduciary principles. That is, despite pro forma arguments about the harvesting being in the best interests of the donor child, long-rejected entity theories of the family and property theories of the family's children appear to underlie decisions by judges and others to proceed with transplants.

It is probably because of this disconnect that the law's role in authorizing the surgeries remains *sub rosa* despite their prevalence. That is, the use of a minor child as an organ source is not a privileged battery, nor is it an exception to the law in every state that intentional physical injury to a child is abuse unless it is justified as medical treatment or reasonable corporal punishment. And there is a real dearth of case law on point; indeed, the single published decision authorizing a pediatric sibling transplant lacks precedential value. Nevertheless, there is good evidence both that judges have and continue to authorize transplants off the record, and that at least some hospitals are willing to proceed in the absence of judicial authorization on the basis of rulings by their internal ethics committees.

The law ought not abdicate its legitimate line-drawing authority in this setting; and it ought not permit the boundaries of family privacy to be reset according to notions about children as property or families as organic entities. These notions are well-understood to pose enormous risks for vulnerable family members including especially children, who became eligible for protection from the state only when they were

²⁸⁹ DORIANE LAMBELET COLEMAN, *GOOD QUESTION: AN EXPLORATION IN ETHICS* (2011), available at <http://kenan.ethics.duke.edu/wp-content/uploads/2012/08/GQ-Coleman.pdf>.

reconceived as individuals whose dignity was valued accordingly. Although there may be good reasons to consider using a healthy child as an organ donor for her ill or injured sibling, these should not be permitted to trump the child's hard-won rights unless they are clearly consistent with her fiduciary interests. Developing transparent, enforceable standards to govern the decision whether to permit a pediatric sibling transplant is precisely the law's role.