

# THE MINOR TRANSPLANT DONOR\*

G. S. Sharpe\*\*

## I. INTRODUCTION

No topic has provided a forum for interdisciplinary co-operation between physicians and lawyers so broad as that of "consent". Physicians are included among those privileged few who are given a licence to touch, manipulate and cut the bodies of others without fear of legal reprisals in the form of a tort action for assault and battery. The physician's legal immunity is based in most situations on the fact that the patient has consented to the touching involved in the physician's treatment of him. For this reason, the law places great emphasis on the nature and form of the consent obtained before recognizing its validity.

The general law regarding consent has been well canvassed.<sup>1</sup> In short, while consent may be tacit or implied,<sup>2</sup> express instructions override any such implied consent.<sup>3</sup> The consent must be in relation to the operation actually performed<sup>4</sup> unless the patient's life or health is immediately endangered, and unless it is impracticable to obtain the patient's consent.<sup>5</sup> Even where the patient's life is threatened, it appears express instructions not to administer a blood transfusion, for example, cannot be disobeyed where the patient is an adult and no minor children are involved.<sup>6</sup> Further, the consent must not be vitiated by duress<sup>7</sup> or misrepresentation.<sup>8</sup> Finally, the patient must have both the legal<sup>9</sup> and mental<sup>10</sup> capacity to give a valid consent.

How does age affect ability to give a valid consent? What modifica-

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\*\* B.A. 1966, LL.B. 1972, Osgoode Hall. Assistant Professor of Law, Faculty of Law (Common Law Section), University of Ottawa.

<sup>1</sup> For a recent treatment of the requisites of a valid consent see Rozovsky, *Consent to Treatment*, 11 OSGOODE HALL L.J. 103 (1973).

<sup>2</sup> O'Brien v. Cunard S.S. Co., 154 Mass. 272, 28 N.E. 266 (1891).

<sup>3</sup> Mulloy v. Hop Sang, [1935] 1 W.W.R. 714 (Alta. Sup. Ct.).

<sup>4</sup> Marshall v. Curry, [1933] 3 D.L.R. 260, 60 Can. Crim. Cas. Ann. 136 (N.S. Sup. Ct.).

<sup>5</sup> Tabor v. Scobee, 254 S.W.2d 474 (Ky. 1951).

<sup>6</sup> *In re Brooks Estate*, 205 N.E.2d 435 (Ill. 1965); Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson, 201 A.2d 537 (N.J. 1964).

<sup>7</sup> Beausoleil v. Soeurs de la Charité, 53 D.L.R.2d 65 (Qué. 1964).

<sup>8</sup> Halushka v. University of Saskatchewan, 53 D.L.R.2d 436 (Sask. 1964).

<sup>9</sup> This is usually the age of majority; this will be examined more closely in the body of the article.

<sup>10</sup> See, e.g., Ontario Mental Health Act, ONT. REV. STAT. c. 269 (1970).

tions of the general law regarding consent are necessary to deal with minors where it is difficult or unwise to rely solely on parental consent? Such questions are of particular importance when examining a minor's ability, or lack thereof, to give consent to experiments or organ transplants. This paper will indicate some of the problems and some of the solutions, both judicial, and legislative, in this difficult area. As a preliminary consideration, the law relating to procedures beneficial to the minor will be examined. A consideration of experiments and transplants involving minors will follow.

## II. AGE: TREATMENT BENEFICIAL TO THE MINOR

Although Canadian law normally requires parental consent for the performance of non-emergency medical procedures on minors,<sup>11</sup> there is some indication<sup>12</sup> that minors approaching majority may give their own consent upon reaching the so-called age of discernment. The position taken<sup>13</sup> is that so long as a minor has, in fact, the intellectual capacity to fully appreciate the nature and consequences of a medical procedure performed for his benefit, then he should be able to give a valid consent. In the 1971 Ontario case of *Johnston v. Wellesley Hospital*,<sup>14</sup> the capacity of a twenty-year old to give a valid consent was at issue. The court adopted Lord Nathan's view that: "An infant who is capable of appreciating fully the nature and consequences of a particular operation or of a particular treatment can give an effective consent thereto."<sup>15</sup>

Since the decision in this case, the Ontario legislature has reduced the age of majority from twenty-one to eighteen. However, it is clear from the above decision that the age of majority and the age of consent are not necessarily coterminous. For consent, the test apparently is whether the patient is old enough to be able to appreciate the nature of the treatment and come to a reasonable decision.

The vagueness of such a standard creates a severe dilemma for physicians. Since it depends substantially upon the maturity of the individual minor patient, the range for effective consent may vary between, say fourteen and eighteen. Besides, how does a doctor actually know whether a patient is sixteen or eighteen? Even assuming, where there has been an apparent consent by such a patient, that the courts will not vitiate its effect unless convinced that it was unreasonable for the physician to conclude that the patient was mature enough to make such a decision on his own,

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<sup>11</sup> See, e.g., W. MEREDITH, *MALPRACTICE LIABILITY OF DOCTORS AND HOSPITALS* at 139-40 (1956).

<sup>12</sup> See NATHAN, *MEDICAL NEGLIGENCE* at 174-76 (1957); and Bowker, *Experimentation on Humans and Gifts of Tissue*, 19 MCGILL L.J. 161, at 172-73 (1973).

<sup>13</sup> Skegg, *Consent to Medical Procedures on Minors*, 36 MODERN L. REV. 370, at 373 (1973).

<sup>14</sup> *Johnston v. Wellesley Hospital*, [1971] 2 Ont. 103 (1970).

<sup>15</sup> *Supra* note 12, at 176.

the *ex post facto* nature of this evaluation by a court of a good faith judgment by the doctor may be enough to prevent most physicians from treating apparent minors without parental consent, in anything but emergency circumstances. Probably this is the safest legal advice that can be offered. And yet even this advice might have its unhappy legal (not to mention medical) consequences, if the minor suffers injury by the refusal of the physician to render urgently needed treatment, particularly if the refusal by the physician is after preliminary treatment has been commenced.

The problem is critical with respect to the treatment of sexual and drug problems of adolescents. The number of minors needing such treatment has now reached epidemic proportions. Yet they will not come forward for needed treatment without an assurance of confidentiality from the very persons, that is, their parents, who can give a consent which will effectively protect the physician from possible legal action. A physician faces a dilemma of major proportions when treating a fifteen-year old boy for venereal disease or prescribing birth control pills to a fifteen-year old girl.

Indeed, a 1970 British Columbia decision<sup>16</sup> chastised a physician for installing an intrauterine device in a fifteen-year old girl without first contacting her parents. The court refused to accept the doctor's argument that, "there is nothing improper about a doctor taking a 15-year old girl as a patient and giving her medical treatment without the consent of her parents."<sup>17</sup>

American courts<sup>18</sup> and legislatures<sup>19</sup> have now begun to recognize that mature minors may give a valid consent to beneficial medical procedures where they have the capacity to fully comprehend the nature and consequences of the treatment.

England's Family Law Reform Act<sup>20</sup> permits physicians both in and out of hospitals to accept sixteen-year olds as patients and to treat them without parental consent. Although physicians under this Act are not faced with the necessity of making a determination of mental capacity of the patient, they must determine their age before proceeding, which may not

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<sup>16</sup> *Re "D"* and Council of the College of Physicians and Surgeons of British Columbia, 11 D.L.R.3d 570 (B.C. Sup. Ct. 1970).

<sup>17</sup> *Id.* at 577.

<sup>18</sup> See *Younts v. St. Francis Hospital & School of Nursing Inc.*, 469 P.2d 330 (Kan. 1970); *Lacey v. Laird*, 139 N.E.2d 25 (Ohio 1956).

<sup>19</sup> Miss. Code Ann. § 7129-7181 (1966) permit "Any unemancipated minor of sufficient intelligence to understand and appreciate the consequences of the proposed surgical or medical treatment or procedures" to consent to medical care. For a more complete listing of similar American statutes, see Pipel, *Minors' Rights to Medical Care*, 35 ALBANY L. REV. 462, at 472-87 (1972); and Wadlington, *Minors and Health Care: The Age of Consent*, 11 OSGOODE HALL L.J. 115, at 124-25 (1973).

<sup>20</sup> Family Law Reform Act 1969, c. 46, § 8:

The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian.

be any easier to ascertain with certainty than the vaguer "maturity" standard.

A proposal similar to England's was recently defeated in Saskatchewan by a narrow margin for fear of "legislating away from parental control."<sup>21</sup>

A recent issue of the *Ontario Bar News*<sup>22</sup> reported that the Council of the Ontario Branch of the Canadian Bar Association in response to a request by the Ontario Medical Association passed two resolutions urging that informed minors capable of appreciating the nature and implication of required medical or surgical treatment be permitted to give a valid consent. This appears to already be the common law position.

Since 1972, the Ontario Minister of Health has had the authority pursuant to The Public Hospitals Act,<sup>23</sup> to make regulations specifying the age and conditions under which a patient may give a valid consent for a surgical operation, diagnostic procedure or medical treatment to be performed on himself in a public hospital. Consequently, a Regulation<sup>24</sup> was recently adopted permitting those sixteen years of age or older to give a valid consent to a surgical operation, diagnostic test, or a form of medical treatment without either obtaining parental consent or determining the capacity of the individuals (where they are minors) to fully appreciate the nature or consequences of the proposed form of treatment.

Thus, physicians in Ontario now find themselves in the peculiar position of being able to prescribe birth control pills and devices for minor females without first contacting their parents, so long as they are seen in hospital, but they still face potential battery suits when dealing with these same individuals in their offices outside of hospitals.

### III. AGE: NON-BENEFICIAL MEDICAL PROCEDURES

#### A. Experiments

While many jurisdictions have been hard-pressed to authorize the acceptance of a minor's consent to *beneficial* medical treatment, opposition

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<sup>21</sup> See Fairbairn, *Comments*, 109 C.M.A.J. 76 (1973).

<sup>22</sup> Anon, *Endorse Medical Consent by Minors*, 3 ONTARIO BAR NEWS No. 1 at 10 (1973):

One, that legislation be enacted to provide that without prejudice to any consent that may otherwise be lawful, the consent of any person to medical treatment, including surgery and blood donation, shall be as valid as the consent of a person of full age if the minor is informed of and has sufficient understanding to appreciate the nature and implications of the proposed treatment and there is good medical reason for such treatment.

Two, that legislation be enacted to provide that doctors, dentists and hospitals be permitted to provide surgical, medical or dental treatment exclusive of sterilization procedures without the consent of the patient's parents where delay would endanger the life or health of the patient.

<sup>23</sup> The Public Hospitals Act, ONT. REV. STAT. c. 378 (1970), as amended by ONT. STAT. 1972, c. 90, § 39(1) (*oa*).

<sup>24</sup> See ONT. REV. REG. 729, as amended by Ont. Reg. 100/74, §§ 49, 49(a), made under The Public Hospitals Act.

becomes overwhelming when the proposed medical intervention is of no perceived direct benefit to the minor. Regardless of the minor's capacity to fully appreciate the nature and consequences of the proposed procedure, policy dictates that no consent—whether it be that of the minor or of his parents—should be an acceptable authority to justify the use of children in medical experimentation.

However, at least one Canadian writer has put forward the view that a "mature minor" could give a valid consent for the purposes of medical experimentation.<sup>25</sup> Indeed, other writers have gone so far as to countenance experimentation on children where there is no discernible risk.<sup>26</sup> The American Medical Association's Code of Ethics permits the use of minors in non-therapeutic situations where adults would be unsuitable subjects and the consent of a parent or guardian is obtained.<sup>27</sup> However, American judges<sup>28</sup> and writers<sup>29</sup> have severely criticized such a position.

Quebec<sup>30</sup> has adopted legislation permitting minors "capable of discernment" to submit to medical experimentation with parental and court authorization where a benefit (not necessarily the minor's) is anticipated and no serious health risk results.<sup>31</sup>

In spite of these views, it is submitted that this is an area where the age of majority ought to be rigidly applied thus forbidding the participation of minors regardless of "discernment" and "valid consent" considerations. This position is in keeping with a judgment of a war crimes tribunal at Nuremberg,<sup>32</sup> article seven of the United Nations' International Covenant on Civil and Political Rights<sup>33</sup> and the Declaration of Helsinki.<sup>34</sup>

<sup>25</sup> Bowker, *Legal Liability to Volunteers in Testing New Drugs*, 88 C.M.A.J. 745, at 748 (1963).

<sup>26</sup> Mitchell, *The Child and Experimental Medicine*, 1 BRIT. M.J. 721 (1964); Brecher, *RESEARCH AND THE INDIVIDUAL: HUMAN STUDIES* at 67-68, as quoted in Bowker, *supra* note 12, at 176.

<sup>27</sup> As quoted in Bowker, *id.* at 175.

<sup>28</sup> Burger, *Reflections on Law and Experimental Medicine*, 15 U.C.L.A.L. REV. 436, at 438 (1968).

<sup>29</sup> Ramsay, *The Ethics of a Cottage Industry in an Age of Community and Research Medicine*, 284 N.E.J. MED. 700, at 705-6 (1971).

<sup>30</sup> Article 20 of the Quebec Civil Code provides that:

A person of full age may consent in writing to disposal, *inter vivos* of a part of his body or submit to an experiment provided that the risk assumed is not disproportionate to the benefit anticipated.

A minor capable of discernment, may do likewise with the consent of the person having the paternal authority and of a judge of the Superior Court, provided that no serious risk to his health results therefrom.

The alienation must be gratuitous unless its object is a part of the body susceptible of regeneration.

The consent must be in writing; it may be revoked in the same way.

<sup>31</sup> One can never be certain of this in advance.

<sup>32</sup> *Infra* note 68.

<sup>33</sup> As quoted in Bowker, *supra* note 12, at 174.

<sup>34</sup> The Declaration of Helsinki, by the World Medical Association, requires *informed* consent on the part of the intended subject in all non-therapeutical medical research. See Mulford, *Experimentation on Human Beings*, 20 STAN. L. REV. 99, at 105 (1967).

The Food and Drugs <sup>35</sup> and Narcotic Control Acts <sup>36</sup> provide specific safeguard procedures which must be followed when using "experimental" drugs. Some justification is evident if the use is intended to benefit the infant recipient. Clearly one would have little quarrel with a physician wishing to use experimental medication to aid a child dying of leukemia even though he intends to add his patient's results to the statistics of a paper dealing with the use of this new drug.

However, suggestions that experimentation on children with no direct benefit intended for them should be justified so long as no harmful results are anticipated, parental consent is obtained, and a right of legal action against the physician <sup>37</sup> is maintained, are fallacious, as the experimental nature of the drug or procedure contains intrinsic non-predictive qualities which, on retrospective evaluation, could become clearly manifest as harmful to the subject. Only an individual with full capacity to appreciate the possibility of risk should be brought into the process of experimental medicine.

While it has been argued in favour of allowing minors to participate in experimentation that physicians are likely to ignore any rule that purports to ban entirely all non-therapeutic research on minors, <sup>38</sup> enforcement of such a legislative enactment would realistically face no more obstacles and could be subject to the same system of checks as are employed in enforcement of any legislation affecting physicians. It is submitted that safeguards such as research committee approval before proceeding with experiments on minors would be rather hollow. A realistic assessment reveals that the common goal of scientific advancement inherent in all members of such committees would likely flavour their decision. Similarly, the attempts set out in Article 20 of the Quebec Civil Code <sup>39</sup> to entrust control to a court would have little effect as laymen would still be forced to rely on medical opinion before making a decision.

If experimentation on minors is to be permitted where direct benefit to the minor is envisaged, then a determination of whether or not a true "benefit" is likely to result becomes critical. In such circumstances, when dealing with minors within the doctor-patient relationship, at the very least utilization of an objective determinant such as Mulford's "investigator-monitor" system <sup>40</sup> (wherein both a "monitor," a medical doctor concerned solely with the subject's welfare, and an "investigator" would attend any

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<sup>35</sup> Food and Drugs Act, CAN. REV. STAT. c. 38 (1952). Regs. of 13.5.66, G. 04, and 13.11.70, G. 06.

<sup>36</sup> Narcotic Control Act, CAN. REV. STAT. c. 35 (1960). Reg. § 39, SOR/70-473, and § 47, SOR/71-665 and SOR/72-337.

<sup>37</sup> Bowker, *supra* note 12, at 176. Some have argued that ethical experimental procedures should never expose the researcher to legal liability in the absence of negligence. Bowker feels that the parents' consent should not be binding on the child so as to prevent a claim for damages where he is injured.

<sup>38</sup> Mulford, *supra* note 34, at 107.

<sup>39</sup> *Supra* note 30.

<sup>40</sup> *Supra* note 34, at 109.

research project involving non-therapeutic experimentation, either one having the power to stop the experiment at any time) must be considered as a minimally-acceptable safeguard.

While there is much support for preventing even an informed consent from safeguarding the experimenter from civil liability in the case of mature adult subjects,<sup>41</sup> it is submitted that an absolute prohibition should be imposed on non-therapeutic medical experimentation on minors.<sup>42</sup>

Karl Brandt, chief medical defendant before the Nuremberg Military Tribunals, justified Nazi medical experiments on the grounds that: "The demands of society are placed above every individual human being as an entity, and this entity, the human being, is completely used in the interest of that society."<sup>43</sup> It would seem monstrous to apply this philosophy to children.

### B. Transplants

It is established that children fare poorly on long-term hemodialysis,<sup>44</sup> the process whereby impurities are removed from the blood by means of an apparatus designed to replace the function of failing kidneys. Therefore, it is medically advisable in the case of a child with serious kidney dysfunction to resort, sooner rather than later, to a kidney replacement via transplantation. In such cases, "the closer the genetic match between donor and recipient, the greater the likelihood of survival of a renal transplant and the more permanent the function of the transplanted kidney."<sup>45</sup> Moreover, young people respond more positively to surgery and better resist infections which develop because of the utilisation of immunosuppressant agents designed to prevent the triggering of the rejection mechanism. Since by 1980 over one-half of the world's population will be under twenty-five,<sup>46</sup> the issue of whether minors should act as live kidney donors will become of great importance in the future.

What sort of risks is the kidney donor exposed to? It has been said that the donor subjects himself to minimal risks.<sup>47</sup> It is noteworthy that insurance companies make no premium adjustments for an individual with only one kidney. However, the donor must still be exposed to the risks

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<sup>41</sup> *Id.* at 114, and *Medical Experiment Insurance*, 44 Miss. L.J. 865, at 873 (1973).

<sup>42</sup> This position has received fairly wide support by legal writers. See Leavell, *Legal Problems in Organ Transplants*, 44 Miss. L.J. 865, at 873 (1973).

<sup>43</sup> 2 Control Council Law No. 10 Nuremberg Military Tribunal Trial 29-30 (1946-1949).

<sup>44</sup> Najarian & Simmons, *Life Insurance Perspectives for the Living Kidney Donor*, 14 *TRANSPLANTATION* at 439 & 488 (1972).

<sup>45</sup> *Id.* at 445; and Richards, *Medical-Legal Problems of Organ Transplantation*, 21 *HAST. L.J.* 77, at 83 (1969).

<sup>46</sup> Woodside, *Organ Transplantation: The Doctor's Dilemma and the Lawyer's Responsibility*, 31 *OHIO STATE L.J.* 66, at 79 (1970).

<sup>47</sup> Cook, *Transplantation, Incompetent Donors: Was the First Step or the Last Taken in Strunk v. Strunk?*, 58 *CALIF. L. REV.* 754, at 764 (1970); and see *Hart v. Brown*, 289 A.2d 386, at 389 (Conn. 1972).

involved in the administration of anaesthesia and major surgery, and the child will be required to proceed through life with one kidney, ever cognizant of the fatal results should injury or disease affect his one remaining organ. Dr. Gerald Cook, a surgeon at Toronto's Western Hospital and one of Canada's leading renal transplant specialists, defines the risks to the donor as including the chance that he will die on the operating table or as the result of a "post-op" complication. However, as to the future risks to the donor who must proceed through life with only one kidney, Dr. Cook feels that such an individual would possess the same total renal function as a person with paired kidneys. The second kidney is unnecessary as this merely results in the presence of four times as much kidney tissue as is really needed.<sup>48</sup>

Dr. Cook also indicated that of 113 kidney transplants performed at the Western Hospital over a seven-year period, three-quarters are alive and well today. During this period, only two live donor kidneys failed out of thirty transplanted. In a comparison of the relative effectiveness of live, related donor transplants and those from cadavers, Dr. Cook made the following observations:

Year(s) of Kidney Survival following Transplant.	Transplant from Live Related Donor	Transplant from Cadaver
1	65%	60%
2	50%	45%
3	45%	30%

Dr. Cook prefers not to use live donors unless they provide a "better match" than would a cadaver kidney. While the ideal situation admittedly exists between identical twins, this latter occurrence is relatively rare. However, twenty-five per cent of all siblings are Histocompatibility-Locus Antigen (H.L.A.) identical, thus providing a very good match. (Dr. Cook is of the opinion that in a normal family environment where a child requires a transplant, a great deal of pressure is placed on his "H.L.A. identical" sibling.<sup>49</sup>

Although sibling donations are in many cases the *medical* preference, several jurisdictions have taken steps legislatively to restrict this procedure to infants of certain ages. For example, in 1970, the Michigan legislature passed an Act<sup>50</sup> which prohibits children from serving as live transplant

<sup>48</sup> As related to members of a Seminar in Medical-Law at Osgoode Hall Law School, Toronto, Canada, in the spring of 1973.

<sup>49</sup> It is interesting to note that at a certain Los Angeles centre, the H.L.A. profile of all individuals awaiting a kidney across North America is kept on file. It is the usual custom in Toronto when a pair of kidneys become available to use one locally and make the other available internationally. Thus, if a recipient in Fort North would provide a better "match" than Toronto recipients for an available Toronto kidney, it would be flown to Texas, if time permitted.

<sup>50</sup> Mich. Pub. Acts, No. 5 (1970). Perhaps the age of fourteen was adopted from two Massachusetts cases, *Masden v. Harrison* and *Huskey v. Harrison*, *supra* note 90, wherein twins who were found by the court to be capable of understanding the nature and consequences of the surgery were of that age.



donors unless they are at least fourteen years of age and only so long as the intended recipient is a member of the donor's immediate family.

The British Columbia Human Tissue Gift Act<sup>51</sup> prohibits live organ donations by persons under the age of nineteen, which is the age of majority in British Columbia,<sup>52</sup> and further specifies that a donation is not valid unless the donor "is able to make a free and informed decision,"<sup>53</sup> free from all coercive elements.

A recent amendment<sup>54</sup> to this Act authorizes the parents of a minor to validly consent to the publication of the name of an organ donor or recipient who is a minor, although such a consent would be invalid for the purpose of making a donation. It seems curious that the legislature would prohibit a minor from making a valid donation but enact legislation purporting to allow a minor donor's parents to consent to the publication of such a donor's identity. How could a minor act as a donor if such a course is prohibited? The only plausible explanation lies in an examination of section 3(2) which validates the consent of a minor for the purposes of donation, "if the person who acted upon it had no reason to believe that the person who gave it had not attained the age of nineteen years."

Thus, in the case of a sixteen-year old donor who manages to deceive transplant physicians into believing he is nineteen years of age, parental consent would be necessary to authorize publication of his identity.

In Ontario, The Human Tissue Gift Act, 1971<sup>55</sup> permits only adults to make both live and *post-mortem* gifts of their organs (although, in the latter case, permission may be given by next of kin for the taking of organs from the bodies of deceased minors). Section 3(1) of this Act allows a live transplant donation only from a person who has reached the age of majority, is mentally competent, and freely capable of making an informed decision.

Since the age of majority in Ontario is presently eighteen, the statute thus appears to establish that age as the floor for a valid consent to a live organ donation. However, it is possible to argue that when the transplant is performed in a hospital, the recent amendments to the regulations under the Public Hospitals Act permit a sixteen-year old to give a valid consent to act as a transplant donor. The amendment lowering the acceptable age of consent for in-hospital surgery to sixteen provides that:

No surgical operation shall be performed on a patient or an out-patient unless a consent in writing for the performance of the operation has been signed by

(a) the patient or out-patient, as the case may be, where the patient or out-patient is,

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<sup>51</sup> Human Tissue Gift Act, B.C. Stat. 1972 c. 37.

<sup>52</sup> The Age of Majority Act, B.C. REV. STAT. c. 2 (1970), lowered the age of majority from twenty-one to nineteen.

<sup>53</sup> *Supra* note 51, § 3(1).

<sup>54</sup> An Act to Amend the Human Tissue Gift Act, B.C. Stat. 1973 c. 120, § 11.

<sup>55</sup> Ont. Stat. 1971 c. 83.

- (i) sixteen years of age or over, or
- (ii) married.<sup>56</sup>

Whether or not this amendment now permits sixteen-year old persons or fifteen-year old married persons to validly consent to act as live organ donors will depend upon whether or not "age of majority" in section 3(1) of the Human Tissue Gift Act is interpreted as over-riding the Public Hospitals Act. If The Public Hospitals Act is given preference for in-hospital procedures, it is arguable that minors in Ontario can now validly consent to act as transplant donors.

Those jurisdictions which have legislation dealing with live organ transplants have settled the minimum age for consent to such donations, albeit not consistently as demonstrated by the three different minimum ages chosen by Michigan, British Columbia and Ontario. Most jurisdictions, however, have not legislated in this field. In such jurisdictions, the problem of minor organ transplant donors is left to be dealt with pursuant to common law principles.

Needless to say, the historic common law makes no comment on the subject. The best it can do is offer principles which may or may not be relevant to a peculiarly late 20th Century problem. The practically relevant common law jurisprudence is all within the past three decades; *i.e.*, the period during which startling advances in medical science have given rise to a number of novel legal dilemmas of which the minor transplant donor is merely one.

What is the state of the common law on this subject? As previously noted,<sup>57</sup> a court would likely uphold the validity of a minor's consent when his age is close to the age of majority, and he appears fully cognizant of a proposed course of medical treatment.

In the United States, the first *Restatement of Torts*<sup>58</sup> stated that a minor *could* give an effective consent to a proposed medical treatment in the absence of parental authorization where he was sufficiently intelligent to comprehend its nature and consequences. In 1965, however, when the *Second Restatement*<sup>59</sup> was drafted, this rule was deleted.

While it is easy to understand that a discerning minor's consent should be acceptable in certain instances, as, for example, in the case of *necessary* surgery, it is legitimate to ask whether a similar solution is correct where the surgery appears to be of no observable benefit to the infant, as in the case of an infant organ donor. And what about organ donation from an undiscerning minor? Clearly, a consent from such a person alone is worth nothing, nor should it be. Should parental consent be required in all minor

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<sup>56</sup> *Supra* note 49.

<sup>57</sup> *Supra* note 14.

<sup>58</sup> RESTATEMENT OF TORTS § 59 (1934).

<sup>59</sup> RESTATEMENT (SECOND) OF TORTS § 59 (1965). Perhaps this rule was deleted in support of a policy requiring the attainment of the age of majority by an infant before permitting him to give a valid consent.

organ donation situations? More importantly, should even a parental consent be sufficient authorization? After all, as the United States Supreme Court noted in *Prince v. Massachusetts* in 1943:

Parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves.<sup>60</sup>

In Canada, it may be questionable whether such surgery is lawful even where a prospective adult donor is concerned. Section 45 of the Canadian Criminal Code authorizes surgery for the "benefit" of an individual where "it is reasonable to perform the operation." Both of these factors appear to be lacking in the case of a live transplant donor.<sup>61</sup> Could the surgeon be charged with "maiming" pursuant to section 228(a) of the Criminal Code? As Lord Justice Edmund Davies has observed: "A man may declare himself ready to die for another, but the surgeon must not take him at his word."<sup>62</sup>

Of course, live tissue donors are not volunteering "to die for another." For example, kidney transplants represent a very small mortality risk, but, on the other hand, the operation is hard to describe as beneficial to the donor in any objective sense.

In any event, the question of criminality in such cases appears realistically to be moot. There are, after all, statutes approving live donations in several jurisdictions, including Ontario. The procedure has become an "accepted medical practice" and evidently a socially acceptable one also. The doubtful legal arena remains that of the live minor organ donor.

In the 1941 American decision of *Bonner v. Moran*,<sup>63</sup> the aunt of the fifteen-year old plaintiff took him to a doctor where he gave his consent to the removal of some of his skin in an attempt to benefit his severely-burned cousin. The court expressed doubt as to whether such a young person could fully appreciate a type of surgery which involved sacrifice on his part and was entirely for the benefit of another. The surgeon was criticized for not explaining to the parents or infant the nature or extent of the operation. Even assuming the ability of the boy to fully appreciate the import of his tissue donation, the court rejected the first *Restatement of Torts* position that the Surgeon should not be held liable if the boy was able to appreciate the nature and consequences of the surgery and consented thereto. The

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<sup>60</sup> *Prince v. Massachusetts*, 321 U.S. 158, at 170 (1964).

<sup>61</sup> Such surgery also appears to run contrary to the section of the physician's Hippocratic Oath which requires that: "The regimen . . . [he] adopt[s] shall be for the benefit of . . . [his] patients according to . . . [his] ability and judgment and *not* for their hurt or any wrong." (Emphasis added). *History of Medicine*, 15 ENCYCLOPEDIA BRITANNICA 94B (1966); the Code of Ethics of the Canadian Medical Association directs physicians to "consider first the well-being of the patient."

<sup>62</sup> Dworkin, *The Law Relating to Organ Transplantation in England*, 4 MODERN L. REV. 353, at 359 (1970).

<sup>63</sup> *Bonner v. Moran*, 139 A.L.R. 1366, at 1369 (1941).

court did indicate, however, that had the parents consented to this non-beneficial surgery on their child, this consent would have been sufficient authorization for the surgeon to proceed.

This decision amounts to a substantial extension of the normal position that a parent is the legal, as well as logical, person to authorize medical treatment of a minor, certainly of those minors too young to understand the nature of the treatment. This parental capacity is predicated on an assumption that the parent will exercise it for the "benefit" of the minor. The fiduciary nature of the parent's position in respect to the exercise of this power is illustrated by the situation where a parent refuses to exercise his power to authorize patently needed medical treatment for his child, as in the controversial cases where Jehovah's Witness parents refuse to permit blood to be transfused to a child when reasonable medical opinion says it is urgently required. This failure to "benefit" the child is regarded as "child neglect," and the state thereupon inserts itself in the parental role and exercises consent for the benefit of the child.

Thus, the validity of any authorization by a parent of a live organ transplant between siblings may, with respect to the donor child, stand or fall upon finding some "benefit" to that child. In objective terms, this requirement could, if pursued with absolute intellectual honesty by those involved in the process, prove an insuperable obstacle to such transplants. For example, it is indeed questionable whether the Children's Aid Society could act pursuant to legislation designed to protect the interests and well-being of children, such as section 20 of The Child Welfare Act<sup>64</sup> in Ontario, where parents refuse their consent and a fifteen-year old wishes to donate a kidney to his brother. In such a case, it would be difficult to justify the donation as "treatment necessary for his health or well-being," as is often done in the *Jehovah's Witness* child cases.

However, where parents and child are willing, American courts have attempted to perceive a "benefit" for the potential donor. In the 1950's the Massachusetts courts came down with three<sup>65</sup> decisions in very similar fact situations. Each involved a set of infant twins, fourteen years of age in two instances and nineteen in the third. In each case, one twin was affected by a fatal kidney ailment, and the question arose as to whether the court would authorize removal of a healthy child's kidney to benefit his dying brother. In all three cases the courts looked beyond the parents' consent and questioned the potential donor to determine whether he was sufficiently intelligent to understand the nature and consequences of the surgery so as to permit him to give a free, fully-informed consent. The "benefit" problem was resolved in one of these cases—that of *Masden v. Harrison*—by hearing the testimony of psychiatrists to the effect:

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<sup>64</sup> ONT. REV. STAT. c. 64 (1970).

<sup>65</sup> *Masden v. Harrison*, No. 68651 Eq., Mass. Sup. Jud. Ct., June 12, 1957; *Huskey v. Harrison*, No. 68666 Eq., Mass. Sup. Jud. Ct., Aug. 30, 1957; *Foster v. Harrison*, No. 68674 Eq., Mass. Sup. Jud. Ct., Nov. 20, 1957; as cited *infra* note 66, at 50 n.1, and *infra* note 76, at 891.

. . . that grave emotional impact may be visited upon Leonard [the donor] if the defendants refuse to perform this operation and Leon [the donee] should die, as apparently he will . . . Such emotional disturbance could well affect the health and physical well-being of Leonard for the remainder of his life. I therefore find that this operation is necessary for the continued good health and future well-being of Leonard and that in performing the operation the defendants are conferring a benefit upon Leonard as well as upon Leon.<sup>66</sup>

Surely, however, psychiatric evidence is not required in order to persuade one to accept the view that emotional harm could result to a twin if his brother were to die.<sup>67</sup> In resorting to psychiatric testimony to establish a "benefit", it is assumed that the potential donor is a "mature" infant of normal intelligence and emotional development. By even the widest interpretation of these cases, it is difficult to find a positive benefit to the donor. The "benefit" referred to by the psychiatrists involves the prevention of *emotional* suffering in the donor. However, it should be noted that in two of these cases, the donee ultimately died so that the healthy twin did undergo some emotional suffering as a result of his brother's death, the prevention of which was the "benefit" intended by the surgery, although presumably no guilt feelings remained.

If donation by minors are to be countenanced, the line must be drawn somewhere. While it is already difficult to justify the attitude of the Massachusetts courts and the Michigan legislature in permitting a fourteen-year old to act as a donor, Curran and Beecher, in their article, *Experimentation in Children*, make the incredible suggestion that the age of seven would not be too young for a donation to an immediate family member so long as "they were found clearly to understand the nature of the procedure and the loss and risks to themselves involved."<sup>68</sup>

A seven-year old child with this level of understanding must indeed be rare. For example, the surgeon involved in the Massachusetts twin cases—Dr. Murray of the Peter Bent Brigham Hospital in Boston—feels that the psychological "benefit" loses its validity under the age of twelve at which point children have no awareness of psychological gain or trauma. He thus refuses donors under that age, even though the potential recipient will necessarily die.<sup>69</sup>

In a recent Connecticut decision, *Hart v. Brown*,<sup>70</sup> involving seven-year old twins, the diseased twin suffered from hemolytic uremic syndrome, a condition which ultimately necessitated removal of her kidneys via bilateral nephrectomy. While the prospect of survival without a transplant was quite dim, medical evidence indicated that utilization of her twin's kidney in a

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<sup>66</sup> As quoted in Curran, *Kidney Transplantation in Minors*, 1 MEDICO-LEGAL DIGEST 47, at 48 (1960).

<sup>67</sup> *Id.* at 48.

<sup>68</sup> Curran & Beecher, *Experimentation in Children*, 10 J.A.M.A. 77, at 83 (1969).

<sup>69</sup> Cronan, *Spare Parts from Incompetents: A Problem of Consent*, 9 J. FAMILY L. 309, at 313 n.23 (1969).

<sup>70</sup> *Hart v. Brown*, *supra* note 47.

transplant would likely assure success. The furthest psychiatrists could go was to indicate that the seven-year old donor would "benefit" from the happier home environment which would follow a successful transplant. Besides psychiatric testimony, the court attempted to justify its decision to authorize the donation by claiming that the donor had been "informed" of the surgery and "desired to donate her kidney." A clergyman testified that such action was morally and ethically sound. Her parents and a guardian *ad litem* of the child, appointed for the purpose of the case, also urged the court to authorize the donation.

The court, in permitting the organ donation, emphasized the negligible risks involved, the extreme benefit to the donee, and that it would be "unjust, inequitable and injudicious . . . [t]o prohibit the natural parents and the guardians *ad litem* of the minor children the right to give their consent under these circumstances."<sup>71</sup>

The only recognition of the "benefit to the donor" problem was a statement by the court that the transplant would result in "some benefit to the donor."<sup>72</sup> This so-called benefit was based solely on psychiatric testimony of a better home environment resulting from survival of the dying twin. Thus, although the court's ultimate determination of the case may have been founded on some new "balancing" test, psychiatrists were once again used to get around the benefit problem in order to permit parents to employ a healthy child in an endeavour to save a sick one.

The fallacious nature of this "psychological benefit" argument would seem to be quite obvious. Effectively, the court's decision was based on a simple balancing of the effects of the transplantation on the donor child against its importance to the donee.<sup>73</sup> Perhaps this test should replace the "benefit" test utilized in other decisions involving minors.<sup>74</sup> It would, at least, do away with the unpalatable charade of a parade of psychiatric experts finding a "benefit" in what is patently non-beneficial to the donor. However, if such test were adopted, court considerations of impending transplants by minor donors would likely become a "rubber-stamp" procedure. In all cases where the minor donor is in good health, the benefits to the recipient could be shown to greatly outweigh any potential harm to the donor.

It is submitted that more important considerations than the absence of "substantial harm" to the donor are involved when organ donation by a minor is contemplated, particularly when that minor is of tender years. Such factors not only include the lack of benefit to the infant donor, but also the almost certain inability of the minor to make a truly "informed" decision.

When a donation by children of tender ages is authorized, a restriction to members of the immediate family is normally imposed. It could be

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<sup>71</sup> *Id.* at 391.

<sup>72</sup> *Id.*

<sup>73</sup> Allensworth, *Parental Consent to an Operation*, 4 TEXAS TECH. L. REV. 244 (1972).

<sup>74</sup> *Id.* at 248.

forcibly argued that all live donations between family members should be prohibited because of the impossibility of potential donors ever giving a truly "voluntary" consent. This is particularly true when histo-compatibility tests disclose that a family member would make an excellent donor, as he immediately comes under tremendous pressure to act as a donor. No matter how subtle the duress, truly "free" consent is next to impossible to obtain in such a case.<sup>75</sup> With children, it could be expected that the pressure would take a more overt form. Much has been made of the parents' ability to consent on behalf of their children. Where this involves surrendering an organ, it is submitted that such action should be prohibited. Where a jurisdiction permits a child to be a donor, it should be the court's duty<sup>76</sup> to interview the infant and decide whether he possesses the requisite intelligence, understanding, and desire to proceed.

No matter how medically advisable it may be to utilize children as transplant donors, the courts or the parents must not be permitted to deprive a child of one of his vital organs without his consent or his intelligent comprehension.<sup>77</sup>

If the coercive forces which operate within a family in these circumstances should preclude recognition of consents by minor children to act as transplant donors from being "voluntary", then apparent consents by prisoners hopeful of an earlier release are probably even less realistically called "voluntary." The case against permitting prisoner donations is even stronger than that against infant sibling donations in view of the fact that no "psychological benefit" can be perceived.

The courts and legislatures have repeatedly stated that, with a minor, parental consent is not sufficient, and comprehension by the minor must also be considered. One might expect that this position would make donation by institutionalized incompetents impossible. However, in 1969, the Kentucky Court of Appeals in *Strunk v. Strunk*<sup>78</sup> approved such a donation.

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<sup>75</sup> See *supra* note 62, at 359.

<sup>76</sup> For this view see Curran, *A Problem of Consent: Kidney Transplantation In Minors*, 34 N.Y.U.L. Rev. 891, at 894 (1959).

<sup>77</sup> One American writer, commenting on the Massachusetts decision, stresses that: It is almost beyond belief to think that a fourteen year-old child could have the ability to understand such a problem, no matter how well the physician might have attempted to explain the risks to him. *Supra* note 46, at 78.

<sup>78</sup> *Strunk v. Strunk*, 445 S.W.2d 145 (Ky. 1969). Unfortunately, the *Strunk* philosophy was followed in the 1973 case of *Howard v. The Fulton-Dekalb Hospital Authority*, 42 U.S. Law Week 2322 where a court authorized a kidney donation from a fifteen year old mental retardate to her dying mother even though the said court found, "that there was no intelligent, written consent by her . . ." (i.e. the daughter). In apparent contradiction, the court based its permissive stance on the statement that "the kidney transplant should be allowed to proceed as long as the daughter and the mother consent to the donation." (Emphasis added).

In the only sensible decision thus far, a Louisiana court in *In re Richardson*, 284 So.2d 185 (1973) refused to permit a seventeen year old mentally retarded boy to donate a kidney to his thirty-two year old sister of normal intelligence but dying from a kidney disease, even though both parents consented and it was established that, while the probability of the sister "rejecting" an organ from another family member was over

This case involved two brothers. Tommy, twenty-eight years of age, suffered from chronic glomerulus nephritis, an inflammation of both kidneys resulting in their destruction, and was being kept alive by hemodialysis treatment. Jerry, who was a year younger, was an institutionalized mentally retarded person. Tommy could not be kept on the artificial kidney much longer, and it was clear that he would not be able to survive several cadaver transplants. Jerry was the best match of all the live donors available, and his mother, as Committee, petitioned the court for authority to proceed with the operation. In prior cases, it was always emphasized, though often extremely doubtful on the facts, that the live donor understood the general nature of the surgery and its object, and gave his consent together with that of his parents. In this instance, however, Jerry's I.Q. of thirty-five corresponded with a mental age of six, and this was quite apparent on questioning. For example, although he appeared to understand that the operation would hurt and involved giving a kidney to his brother, he thought his brother was 55, that two plus two made three, and that his brother's old kidney "would be put in the garbage can."<sup>79</sup> It is difficult to suggest that Jerry met the comprehension test laid down in the three prior decisions involving twins. Perhaps the underlying rationale here was similar to what has been suggested of *Hart v. Brown*; that is, a balancing of the benefit to the donee against the harm to the donor, with little emphasis placed on the "comprehension" of the donor, for obvious reasons.

Indeed, the "benefit" problem in *Strunk* was dealt with in much the same manner as in the three Massachusetts twin cases referred to earlier. A psychiatrist was utilized to supply opinion that Jerry would be "saddened" by the loss of his brother and would have "some understanding" of this loss. Thus, it would be to Jerry's "benefit" to donate a kidney and so avoid these emotional effects.

It is frightening to observe a court go through this sort of pretence. Although the Court of Appeal, by a four to three vote, upheld the decision authorizing the surgery, it is submitted that the case was wrongly decided. The minority opinion reiterated the established common law test that the ability to fully understand and consent is a prerequisite to the donation of a part of the human body. In rejecting the "benefit" argument seized upon by the majority, the dissenting view stated that:

The majority opinion is predicated upon the finding of the circuit court that there will be psychological benefits to the ward but points out that the incompetent has the mentality of a six-year old child. It is common knowledge beyond dispute that the loss of a close relative or a friend to a six-

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20 per cent, this figure would be reduced to 4 per cent with her brother's kidney. The court considered and rejected the *Strunk* case, and emphasized that Louisiana law "is designed to protect and promote the best interest of a minor." The "construed benefit" arguments of prior decisions were expressly rejected, the court concluding that neither parents nor the courts could authorize such a procedure.

<sup>79</sup>Savage, *Organ Transplantation with an Incompetent Donor: Kentucky Resolves the Dilemma of Strunk v. Strunk*, 58 KENTUCKY L.J. 129, at 147 (1970).



year old child is not of major impact. Opinions concerning psychological trauma are at best most nebulous. Furthermore, there are no guarantees that the transplant will become a surgical success, it being well known that body rejection of transplanted organs is frequent. The life of the incompetent is not in danger, but the surgical procedure advocated creates some peril.<sup>80</sup>

It is noteworthy that in fact the majority and dissent did agree that the consent of a Committee was not sufficient authority for a transplant, and that some "benefit" must be established for the potential donor.<sup>81</sup> In the *Strunk* decision it seems obvious that the "benefit" argument is very weak indeed where the donor remains in a setting far removed from his family and has the mental age of a six-year old child. It is ludicrous to argue that he possesses sufficient intelligence to give a free and informed consent. In light of the apparent rejection by both the Massachusetts and Kentucky courts of the proposition that a parent's (or Committee's) consent is sufficient to authorize organ removal from a minor or incompetent donor without some evidence of a "benefit" to such a donor, and in light of the perceived invalidity of the courts' "psychological benefit" stance, one must ask what other factor might be operating here.

It seems that the crux of the case rests on a balancing of the social worth of two individuals—not only by the courts, but by their parents as well.<sup>82</sup> At one point in these proceedings, Mrs. Strunk expressed the view that:

Every person has some purpose in life, even those who have the misfortune of being born with very low mental capacity. It must be Jerry's purpose then, because he has been denied the mental ability to make any contribution to date, to now donate an organ of his body to save the life of the one person he loves the most . . . .<sup>83</sup>

The moral dilemma involved in making such social worth evaluations is extreme.<sup>84</sup> The suggestion that an incompetent might provide the useful function of supplying others with organs, and thus "pay his own way" through life has been made.<sup>85</sup> This idea is put another way by Cook:

Thus, if a state can promote its well-being by sterilizing incompetents,

<sup>80</sup> *Supra* note 78, at 150.

<sup>81</sup> *Supra* note 47, at 760-61 n.42.

<sup>82</sup> Indeed, in a recent article appearing in the *JOURNAL OF FAMILY LAW* where the *Strunk* decision was considered, the author suggested that:

It is quite possible that underlying the court's decision was not a concern for the incompetent's best interest alone, but a balancing of the relative utility of two human lives; one healthy but incompetent and without responsibility, the other competent, married and critically ill.

*Supra* note 69, at 315.

<sup>83</sup> *Supra* note 69, at 315, n.27.

<sup>84</sup> Sanders & Dukeminier, *Medical Advance and Legal Lag: Hemodialysis and Kidney Transplantation*, 15 U.C.L.A. Rev. 357, at 373 (1968).

<sup>85</sup> *Equity-Transplants — Power of Court to Authorize Removal of Kidney from Mental Incompetent for Transplantation into Brother*, 16 WAYNE L. REV. 1460, at 1467 n.62 (1970).

thereby diminishing its unproductive population — it could also promote its well being by removing kidneys from incompetents to increase the number of its productive members and perhaps should be allowed to do so.<sup>86</sup>

Although some may prefer this stance,<sup>87</sup> it is submitted that the acceptance of such propositions raises the same ghosts as those described by Mr. Justice Steinfeld who, in delivering the dissenting opinion in the *Strunk* decision, spoke of his "indelible recollection of a government which, to the everlasting shame of its citizens, embarked on a program of genocide and experimentation with human bodies."<sup>88</sup>

Thus far, the focus has been primarily on the attitudes of courts and legal writers with respect to the consent of minors as transplant donors. What views do physicians hold on this question? In the summer of 1971, a survey entitled the *Osgoode Hall Medical-Legal Questionnaire*<sup>89</sup> was sent to all the members<sup>90</sup> of the Ontario Medical Association. Questions relevant to this paper are presented below, along with the responses obtained:

Questions Asked	Possible Responses (Correct answer in italics where applicable)	Percent Responses	Total Number Processed
54. A 10 year old patient of yours requires an immediate kidney transplant to survive. His parents have consented to the use of one of his healthy twin brother's kidneys. If you proceed with the surgery you would be liable to	A. civil action by the healthy twin (brought by his legal representatives);	A. 13.2	1827
	B. disciplinary action by the College of Physicians and Surgeons;	B. 0.9	
	C. criminal proceedings;	C. 1.2	
	<i>D. all of the above;</i>	<i>D. 12.2</i>	
	E. none of the above.	E. 72.5	
55. An adult in excellent health comes to a hospital, and offers, after being fully informed of the possible consequences, to donate one of his kidneys to the next medically suitable donee the hospital has. The hospital accepts the donor's offer and a transplant is subsequently performed. The hospital and the doctors who perform the transplant, may notwithstanding the consent given, be liable to	A. be open to successful civil suit;	A. 9.8	1825
	B. disciplinary action by the College of Physicians and Surgeons;	B. 1.6	
	C. criminal proceedings;	C. 0.8	
	<i>D. all of the above;</i>	<i>D. 6.6</i>	
	<i>E. none of the above.</i>	<i>E. 81.2</i>	
56. In your opinion, whatever the law may or may not be in	A. strongly agree;	A. 77.2	1838
	B. mildly agree	B. 12.2	

<sup>86</sup> *Supra* note 47, at 770.

<sup>87</sup> *Supra* note 43.

<sup>88</sup> *Supra* note 78, at 149.

<sup>89</sup> Designed by the Medical-Legal Study Group of Osgoode Hall Law School, 1970-71, under the auspices of R. J. Gray and G. S. Sharpe.

<sup>90</sup> About 9,500 members.

the circumstances of Q. 55, the	C. mildly disagree;	C. 5.2
hospital and the doctors should	D. strongly disagree.	D. 5.3
not be liable to any disciplinary		
consequences		

It is disappointing to note that almost three-quarters of the physicians who answered the questions incorrectly believed that no liability would attach if they were to proceed with the removal of a kidney from a healthy ten-year old child. American case law clearly requires "more" than parental consent, and it is doubtful whether the "psychological benefit" argument would carry much weight in Canadian courts. Notwithstanding the *Strunk v. Strunk* decision (where an individual with a mental age of six was thought to possess sufficient cognizance to give an "intelligent" consent), it is unlikely that our Courts would maintain that a ten-year old child could appreciate the nature and consequences of donating a kidney. In any event, as indicated earlier, the Ontario Human Tissue Gift Act prohibits donation by anyone who is not competent or under the age of eighteen, so that a physician proceeding under the circumstances in Question Number 54 would be in breach of this Act and be liable to fine and imprisonment.

Question Number 55 presents the picture of the true "Good Samaritan"—an individual willing to anonymously donate a kidney to a needy recipient. This case, if any, illustrates the situation where a live transplant donor might be acceptable since no possibility of coercion or duress derived from covert family pressures can be suggested.

The situation where the prospective donor is not related to the intended recipient at least would better ensure the real voluntariness of the consent.<sup>21</sup> However, if strangers may donate organs, the possibility of a marketplace in body organs becomes feasible. A well-off individual with a diseased kidney could "purchase" that of a destitute soul. Ontario has taken steps to prevent such an occurrence in section 10 of The Human Tissue Gift Act which reads as follows:

No person shall buy, sell or otherwise deal in, directly or indirectly, for a valuable consideration, any tissue for a transplant, or any body or part or parts thereof other than blood or a blood constituent, for therapeutic purposes, medical education or scientific research, and any such dealing is invalid as being contrary to public policy . . .<sup>22</sup>

However, the possibility of under-the-table payments for organ transplant consents in the guise of true donations remains.

In jurisdictions without statutes, sales of organs by potential adult donors appear to be permissible. One serious difficulty exists in the case of adult, stranger organ donors; that is, the mental stability of such donors.

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<sup>21</sup> One cannot help but agree with Dworkin who feels that: "Although the medical prospects are better where the blood relationship is closest, the chances of a truly voluntary consent are greater where the relationship is distant or nonexistent." *Supra* note 62, at 359.

<sup>22</sup> *Supra* note 55.

## III. CONCLUSION

It is submitted that transplants between live, related individuals should be prohibited. If legislation to this effect were passed, much of the trauma and guilt feelings which American courts utilize as the foundation for their "psychological benefit" rationale authorizing the donor's act could be avoided. With the enactment of such legislation, an infant, incompetent, or any adult relative who might be a medically suitable donor could not play an active role in the transplant because of the legal prohibition.<sup>83</sup> If, however, a jurisdiction should decide to adopt the Massachusetts position and permit a minor to donate an organ to a close relative, then the vital determination of whether such donor is able to comprehend the nature and consequences of the proposed act<sup>84</sup> should be made by a court, "since a court is less likely to be coerced by emotional attachments and pressures, but rather can weigh the alternatives in a more objective and detached manner."<sup>85</sup>

As well as prohibiting donations between family members, it is further submitted that incompetents, prisoners, or anyone subject to coercive pressures by others, should *under no circumstances* be permitted to be a live transplant donor.

Professor Daube argues that those who have attained the age of majority *should* be permitted to donate if they so desire on the ground that, "from an age when we encourage or even compel a person to lay down his life for his country, he should also be allowed to make a potential sacrifice for a near relation."<sup>86</sup> However appealing and valid such an emotional viewpoint may be, safeguards must be taken to ensure the fulfillment of the legal requirement that a fully informed, freely obtained consent be given before undertaking *any* surgical procedure. This position must be strictly enforced when the outcome of the operation necessarily bestows no observable benefit on an individual, and the "voluntariness" of the act is in doubt. The only means of imposing true safeguards involves forbidding transplants between relatives. For others, legislation should prohibit the sale of organs, and where an individual wishes to serve as a live organ donor, the legislation should require that a psychological assessment be made in order to ensure that his decision is that of a fully informed, stable and mature mind. If this view smacks of pessimism in suggesting that "sane" people do not give kidneys to strangers, so be it. It must be confessed that this is the author's possibly cynical, but also perhaps realistic view of society. It might, perhaps,

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<sup>83</sup> For other aspects of this view see Daube, *Transplantation: Acceptability of Procedures and the Required Legal Sanctions*, in *ETHICS IN MEDICAL PROGRESS* 197 (G. Wolstenholme & M. O'Connor 1966); and *supra* note 47, at 767.

<sup>84</sup> It is interesting to note that most criminal codes normally make allowance for children because of their inability to form the requisite *mens rea* for many crimes.

<sup>85</sup> Steincamp, *Jurisdiction—Incompetent Donor's Consent to a Kidney Transplant*, 10 *WASHBURN L.J.* 157, at 160 (1970).

<sup>86</sup> Daube, *supra* note 93, at 199.

be preferable to adopt the French position<sup>97</sup> which imposes an absolute prohibition on transplants from live donors and to concentrate on alternative means of assistance, such as improving transplants from cadavers, developing portable (wearable) dialysis apparatus, and ultimately designing a truly functional artificial kidney.

With respect to the use of children as organ donors, the view expressed by Gerald Dworkin, Professor of Law at the University of Southampton, that, "parents . . . cannot be philanthropic on behalf of their children and the law must protect a child even against his own philanthropy . . ." <sup>98</sup> appears to be most reasonable.

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<sup>97</sup> Castel, *supra* note 44, at 357 n.61.

<sup>98</sup> *Supra* note 62, at 360-61.