IAFL Oslo Week
Moral Maze: Medicine and Family Law Webinar
Wednesday 3rd June 2020

Supporting Documents

Chaired by: Sir Nicholas Francis (England)
Panel: Suzanne Kingston (England), Delphine Eskenazi (France), Johan Sarvik (Sweden), Lola López-Muelas Vicente (Spain), Anne Lamkin Durward (Alabama, USA)

Medicine X Family Law
(Prepared by Suzanne Kingston and Nicola Rowlings, Mills & Reeve)

Where parents disagree over medical treatment
Based on Re B (A Child: Immunisation) [2018] EWFC 56

Case study
G is a 5 year old girl. She is an only child. Her parents, M and F, separated three years ago and there have been a variety of disagreements between them since about G's upbringing. G lives with M and spends time with F.

M and F now disagree over whether G should receive her latest set of immunisations. Before they separated, M and F were agreed that G should be immunised and she received the vaccinations recommended for a child of her age.

G is due to have booster vaccinations as well as a flu vaccine. M wants G to have these booster vaccinations. F objects

English and Welsh case references
Re B (A Child: Immunisation) https://www.bailii.org/ew/cases/EWFC/HCJ/2018/56.html

LCC v A, B, C and D and others https://www.bailii.org/ew/cases/EWHC/Fam/2011/4033.html

A and D v B and E https://www.bailii.org/ew/cases/EWHC/Fam/2003/1376.html

F v F https://www.bailii.org/ew/cases/EWHC/Fam/2013/2683.html

Re M and (Parental Responsibility: Immunisations) https://www.bailii.org/ew/cases/EWFC/HCJ/2016/69.html

London Borough of Barnet v AL and others https://www.bailii.org/ew/cases/EWHC/Fam/2017/125.html

Questions for case study one

What is the legal position in relation to parental responsibility following the breakdown of a relationship or marriage?

What is the legal position in relation to parents making decisions over medical treatment for their children before relationship or marriage breakdown? Does this change following relationship or marriage breakdown? If so, how?

What happens when separated parents disagree over medical treatment for their children? How is a decision ultimately made? If a court application is needed, please explain the nature of the application, the evidence required, the principles / law applied by the courts and the orders available to the court. Do the principles / law applied and orders available differ depending upon the urgency of the need for treatment (e.g. immunisations vs blood transfusions) or upon the certainty of the treatment (e.g. immunisations vs chemotherapy)?

Is dispute resolution used to help the parents find an agreement?

Are there mechanisms available to help avoid a dispute in the first place?

In your experience, are these disputes rare or commonplace? If you have dealt with this in practice, please give an outline of a recent case and an indication of the time taken to resolve the dispute and a broad indication of the legal costs (if any) incurred.

In your experience, if a judge is involved in making an ultimate decision, what is their opinion of parents who cannot agree on medical treatment for their children? For example, do they try to discourage these applications and encourage parents to use a dispute resolution method?

Where doctors and parents disagree over treatment – religion

Case study
A newborn baby is brought into hospital by her parents. She has jaundice, a condition that is readily and easily treatable. However, the baby's parents are Christian Scientists and they refuse the hospital's proposed course of treatment and want to take their baby home. They believe that prayer alone will heal their child. Without treatment, the doctors are confident that the baby will develop complications which are likely to prove fatal.

What about where the treatment advised has less certain results e.g. chemotherapy? What about where a child has an injury e.g. a broken leg but the parents refuse to allow the hospital to treat it?

English and Welsh case references
Re N https://www.bailii.org/ew/cases/EWFC/HCJ/2015/40.html

Birmingham Children's NHS Trust v B and C https://www.bailii.org/ew/cases/EWHC/Fam/2014/531.html

Re S https://www.bailii.org/nie/cases/NIHC/Fam/2013/8.html (Northern Irish decision)

Questions for case study 2

What is the legal position in relation to parental autonomy over medical treatment for their children? Does this change if the parents are in dispute with the doctors treating their child? What special considerations are taken into account (if any) where the parents' objection to a treatment or course of action is down to their religious beliefs?

What happens when parents disagree with doctors over medical treatment for their children? How is a decision ultimately made? If a court application is needed, please explain the nature of the application, the evidence required, the principles / law applied by the courts and the orders available to the court. Do the principles / law applied and orders available differ depending upon the urgency of the need for treatment or upon the certainty of the treatment?

Are all religious objections treated consistently? Are some religious objections treated less favourably than others?

Are there any significant or landmark decisions in your jurisdiction that deal with parents objecting to medical treatment on the grounds of religion? If so, please give a brief outline of those cases.

To what extent (if any) can third parties (for example, religious organisations) take part in the decision making process?

Where doctors and parents disagree over continuing life sustaining treatment
Based on Alfie Evans case

Case study
A is a two year old boy. He is the only child of M and F. Despite being born at full term and apparently healthy, by four months old M began to have concerns that A was not developing as he should. By six months old, A was showing marked signs of significant developmental delay and extensive medical tests have revealed that he has an unidentifiable neurodegenerative disorder.

Following a number of seizures, A now requires around-the-clock life sustaining treatment. He has been in a semi-vegetative state for over a year.

The doctors caring for A want to withdraw the treatment they are providing. The medical view is that there is no prospect of A recovering and his condition is fatal. He is being kept alive only by mechanical means and his doctors want now to provide palliative care only.

A's parents are firmly opposed to the treatment being withdrawn and want to be able to travel to an overseas hospital for a second opinion. The relationship between the doctors and parents has completely broken down. M and F, for example, have engaged a variety of foreign medical experts to advise them and have arranged a number of medical examinations of A in direct defiance of A's clinical team. They believe that A could be successfully treated elsewhere.

English and Welsh case references
Alder Hey NHS Trust v Evans https://www.judiciary.uk/judgments/alder-hey-nhs-trust-v-evans/

Evans v Alder Hey NHS Trust https://www.judiciary.uk/wp-content/uploads/2018/05/evans-v-alder-hey-appeal-judgment.pdf

In the matter of Alfie Evans https://www.supremecourt.uk/docs/in-the-matter-of-alfie-evans-court-order.pdf

Charlie Gard judgments https://www.serjeantsinn.com/news/judgments-case-charlie-gard/

Kings College Hospital NHS Foundation Trust v Thomas and others https://www.judiciary.uk/judgments/kings-college-hospital-nhs-foundation-trust-v-thomas-and-haastrup/

Re C (Baby: Withdrawal of medical treatment) https://www.familylaw.co.uk/news_and_comment/re-c-baby-withdrawal-of-medical-treatment-2015-ewhc-2920-fam

Baby Charlotte https://inews.co.uk/news/health/charlie-gard-case-charlotte-wyatt-high-court/

Portsmouth City Council v King and others https://www.judiciary.uk/wp-content/uploads/2014/09/judgment-ashya-king-08092014.pdf

Questions for case study 3

What is the legal position in relation to parental autonomy over medical treatment for their children? Does this change if the parents are in dispute with the doctors treating their child?

What happens when parents disagree with doctors over medical treatment for their children? How is a decision ultimately made? If a court application is needed, please explain the nature of the application, the evidence required, the principles / law applied by the courts and the orders available to the court. Do the principles / law applied and orders available differ depending upon the urgency of the need for treatment or upon the certainty of the treatment?

Are there any significant or landmark decisions in your jurisdiction that deal with parents objecting to medical treatment? If so, please give a brief outline of those cases.

In your opinion, does your jurisdiction favour parental choice over professional advice when it comes to decision making over life sustaining treatment? How would you advise a parent seeking to object to the proposed medical treatment?
To what extent (if any) are court proceedings dealing with a dispute between doctors and parents heard in public? What is the level of public interest in these cases? Are reporting restrictions used to preserve the anonymity of the family and professionals involved?

To what extent (if any) can third parties take part in the decision making process? To what extent does the state intervene in the decision making process?

To what extent (if any) are you aware of parents either coming to your jurisdiction to take advantage of an approach more in favour of parental choice or leaving to seek treatment in another jurisdiction?

If there are court proceedings involved, what options do parents have to help pay for legal costs?

Where a child patient does not consent to treatment or refuses treatment
Based on Re E (A Minor: (Wardship: Medical Treatment) [1993] 1 FLR 386

Case study
P is a 15 year old boy. He is serious and intelligent and is considered to be more mature than his peers. He and his family) are Jehovah's Witnesses. P is an active member of the congregation and there is no suggestion that his family have forced their views upon P. He has previously expressed his adamant refusal to receive blood products in the event he was to receive an injury. He also carries a "no blood card".

P suffers an epileptic fit and falls fully clothed into a bath of hot water. He sustains very severe scalds with over 50% of his body suffering burns and 40% of those burns are third degree burns. The burns specialist sees P and advises that the injuries are very likely to prove fatal and at least three operations are needed to ensure P's survival. The prognosis thereafter is very optimistic. However, if P will not accept blood transfusions, these operations cannot take place. The doctors advise P's parents (but not P) that without the operations gangrene will set in and P will suffer a harrowing death. P is steadfast in his opposition to surgical intervention and blood transfusions and understands that his decision means that he will die.

P's parents have said that they will support P in whatever the ultimate decision is. There is no concern that P will be shunned by his congregation if he accepts the treatment proposed.

English and Welsh case references
Re L (Medical Treatment: Gillick Competency) [1998] 2 FLR 810

Re E (A Minor: (Wardship: Medical Treatment) [1993] 1 FLR 386

Re S (A Minor) (Medical Treatment) [1994] 2 FLR 1065

Re R (A Minor) (Wardship: Medical Treatment) [1992] 1 FLR 190

South Glamorgan County Council v W and B [1993] 1 FLR 574

Questions for case study 4

What is the legal position in relation to a child's autonomy over medical treatment for their own medical treatment? Does this change if the child is in dispute with the doctors treating them? Does this change if the child is in dispute with their parents too? Does this change depending on whether the child is consenting to treatment or objecting to treatment?

What happens when children disagree with doctors over their medical treatment? How is a decision ultimately made? If a court application is needed, please explain the nature of the application, the evidence required, the principles / law applied by the courts and the orders available to the court. Do the principles / law applied and orders available differ depending upon the urgency of the need for treatment or upon the certainty of the treatment?

Are there any significant or landmark decisions in your jurisdiction that deal with children objecting to medical treatment that guide your advice to clients? If so, please give a brief outline of those cases.

How are the views of the child taken into account and heard? How much weight is given to a child's views? Does this change according to the child's age or understanding? Does this change depending on whether the child is consenting to treatment or objecting to treatment?

Is anyone appointed to legally represent the child in any court proceedings? If so, who and what is their role?

What special considerations are taken into account (if any) where the child's objection to a treatment or course of action is down to their religious beliefs?

Are there any significant or landmark cases where a child's objection has outweighed medical advice? If so, please give an outline of those cases.

What privacy can a child expect over their medical records and conversations they have with medical professionals (including mental health professionals and health care professionals in school)? Can a parent (ever) access that information? Are there any situations when a parent couldn't access that information?

What happens if there are issues as to the child's mental capacity to make decisions over their medical treatment?

Genetically informed medicine and medical confidentiality
Based on ABC v St George's Healthcare NHS Trust and Others [2017] EWCA Civ 336

Case study
An adult patient with an inherited fatal disease (Huntingdon's Disease) has asked his doctors not to disclose information about his condition to his adult daughter. The daughter however comes upon the information by chance just before she is due to give birth.

The daughter takes a genetic test which reveals that she too suffers from the same condition as her father and there is a 50% chance she has passed it on to her child. Has she known this, she says, she would have terminated the pregnancy.

English and Welsh case references
ABC v St George's Healthcare NHS Trust and others https://www.bailii.org/ew/cases/EWCA/Civ/2017/336.html

Questions for case study 5

Does your jurisdiction recognise a duty to warn third parties of a familial risk of genetic disease? How does this sit with any principles regarding patient confidentiality?

Should parents be able to insist on genetic testing of their children as part of their "parental responsibility"? Is there a difference between tests (whether genetic or not) that screen for disorders and illness that can be treated successfully (e.g. type 1 diabetes) and those that cannot be treated (e.g. Huntingdon's disease)?

Do children have a right "not to know"? Should they be allowed to make their own decision when they are considered competent (see case study 4) or when they are an adult?

In the case of separated parents, how would you approach a dispute between parents about the genetic testing or screening of their children? What principles / approach would your courts apply?

MORAL MAZE

Anne Lamkin Durward
Massey, Stotser & Nichols, P.C.
1780 Gadsden Highway
Birmingham, AL 35235
adurward@msnattorneys.com

When given the task of reporting on what the United States would do in a particular situation, it is impossible to state this is what all 50 states and territories would do. So in order to give a sampling of what various jurisdictions would do, I called upon Fellows from around the States to give us their take on each situation. This paper would not have been possible without Amanda Trigg in New Jersey, David Pollock in Pennsylvania, JoAl Cannon Sheridan in Texas, and Peter Buchbauer in Virginia. They are responsible for the content from their jurisdictions and their insight is invaluable. I would also like to thank Chris Bales, a law student at the Cumberland School of Law at Samford University, for helping me with the research for Alabama.

For ease of reference through the paper, I have "color coded" the states: Alabama is Red, New Jersey is Green, Pennsylvania is Blue, Texas is Orange, and Virginia is Purple. What I found most interesting was that we were more similar that we were different in how our various courts would handle each situation.

In Alabama, and in most states, the definition of custody is determined by statute. For Alabama the definitions are found in §30-3-151, *Alabama Code* and are as follows:

(1) JOINT CUSTODY. Joint legal custody and joint physical custody.
(2) JOINT LEGAL CUSTODY. Both parents have equal rights and responsibilities for major decisions concerning the child, including, but not limited to, the education of the child, health care, and religious training. The court may designate one parent to have sole power to make certain decisions while both parents retain equal rights and responsibilities for other decisions.
(3) JOINT PHYSICAL CUSTODY. Physical custody is shared by the parents in a way that assures the child frequent and substantial contact with each parent. Joint physical custody does not necessarily mean physical custody of equal durations of time.
(4) SOLE LEGAL CUSTODY. One parent has sole rights and responsibilities to make major decisions concerning the child, including, but not limited to, the education of the child, health care, and religious training.
(5) SOLE PHYSICAL CUSTODY. One parent has sole physical custody and the other parent has rights of visitation except as otherwise provided by the court.

How custody looks is also defined in the Alabama Code under §30-3-153 when parents are implementing their parenting plan, or the court is doing so for them:
(a) In order to implement joint custody, the court shall require the parents to submit, as part of their agreement, provisions covering matters relevant to the care and custody of the child, including, but not limited to, all of the following:

(1) The care and education of the child.
(2) The medical and dental care of the child.
(3) Holidays and vacations.
(4) Child support.
(5) Other necessary factors that affect the physical or emotional health and well-being of the child.
(6) Designating the parent possessing primary authority and responsibility regarding involvement of the minor child in academic, religious, civic, cultural, athletic, and other activities, and in medical and dental care if the parents are unable to agree on these decisions. The exercise of this primary authority is not intended to negate the responsibility of the parties to notify and communicate with each other as provided in this article.
(b) If the parties are unable to reach an agreement as to the provisions in subsection (a), the court shall set the plan.

The custodial arrangement and the designation of legal custody or primary authority and responsibility come into play throughout the fact situations discussed below. This will also be the general rule in other jurisdiction in the United States and that is also reflected in the analysis herein.

Where parents disagree over medical treatment

Alabama:

Before the breakdown in a relationship, both parents have equal rights to direct the care of their children. Problems can arise after a breakup if careful consideration is not given to how the custodial arrangements will work and who will have decision making authority over education, medical, religion, athletics, activities and other important life issues.

If the parents are divorced, it will depend on whether the parties have joint or sole custody and the custodial order. *Ala.Code* § 30-3-151. Otherwise, parents have equal fundamental rights of parenting. If a parent has sole legal custody, then that parent's decision as to the care and treatment of the child is what controls absent court intervention.

As to the specific question in the case study, tt shall be the responsibility of the parents or guardians of children to have their children immunized or tested as required by *Ala. Code* § 16-30-1. In order to enroll in public school, the children have to be vaccinated unless there is a religious or medical reason not to do so. However, if there is a dispute between the parents, the court will intercede. With proper evidence being presented as why or why not the parent wishes to vaccinate the child or not, the court can make the determination for the child's medical care. The court could also allow one parent to have the medical decision making authority for the child or could even change who has the medical authority or legal custody depending on what the court deems to be in the child's best interests.

To have this matter brought before the court, a parent would file a petition to modify or a petition to require medical treatment depending on what relief the parent is seeking. The quickness that the court would reach the issue would depend on the nature of the treatment being

sought. So if it was treatment that is necessary for chemotherapy or blood transfusions for example, the parent would file an emergency motion in conjunction with his/her petition to seek quicker relief from the court.

Of course, when it comes to children and what is in their best interests, the court would first want the parents to make the decisions for their children. But United States case law has recognized that the courts can act when a parent is not acting in the child's best interests. If this situation arises, the courts will rely on expert witnesses (doctors, medical professionals, treating physicians and the like) to assist it in making an informed decision for the care of the child. If neither parent is allowing medical care for the child, a doctor or hospital can file a petition with the court seeking court intervention to compel medical care be given to a child. The court then has to balance the parent's fundamental right to parent their child versus the medical care that the doctors deem necessary and why both sides have taken the positions that they have taken.

New Jersey:

Pascale v. Pascale, 140 N.J. 583 (1995), citing *Brzozowski v. Brzozowski*, 265 N.J. Super. 141 (Ch. Div. 1993). Twenty-five years after the issuance of this opinion by the New Jersey Supreme Court, it remains authoritative on the question of joint custody, and that the best interests of a child are the court's lodestar when considering the rights and responsibilities of both parents to a child. Interpretations and methods of implementation of these standards vary widely in subsequent case law. When parents disagree, a court may go as far as modifying a joint custody arrangement to insure that a child's needs receive proper attention without delaying treatment or triangulating medical professionals between the parents. See e.g. *M.T. v. D.T.*, 2016 WL 6821807 (N.J.Super.Ch.), unreported (citing *Pascale v Pascale*, 140 N.J. at 596; *Beck v Beck*, 86 N.J. 480, 486 (1981), *Nufrio v. Nufrio*, 341 N.J. Super 548, 555 (App. Div., 2001).

Pennsylvania:

In re Green, 452 Pa. 373, 292 A.2d 387 (1973). Where the proposed medical treatment was advisable but not necessary to preserve the child's life, the child should be consulted, notwithstanding parental objections. Minor son suffered from paralytic scoliosis and was in need of an operation. His mother was a Jehovah's Witness and consented to a corrective operation so long as no blood transfusions were given. As such the operation could not be performed. A petition was filed to appoint a guardian so that the surgery could be done. That petition was dismissed. That decision was reversed by the Pennsylvania Superior Court. The PA Supreme Court reinstated the trial court decision after reversal and remand.

The son of separated parents had two attacks of poliomyelitis causing problems of obesity. In addition, son suffered from paralytic scoliosis (94% curvature of the spine). Mother, with whom he lived, consented to a recommended "spinal fusion" to relieve son's bent position but since she was a Jehovah's Witness and she refused to consent to any blood transfusions which are necessary for surgery. This caused the Director of the State Hospital for Crippled Children at Elizabeth-town, Pennsylvania, to file a "petition to initiate juvenile proceedings" seeking to have son declared a "neglected child" and himself appointed guardian so that he could consent to the transfusions. Although the operation would be beneficial to son, his life was not

immediately imperiled by his physical condition. Therefore, as between mother and the state, the state did not have an interest of sufficient magnitude to outweigh the parent's religious belief. On remand the trial court found the following: … "[Son] answered all questions without hesitation and appeared to understand the benefit he might receive from the operation and the possible complications if he did not have it. In view of all the testimony, it is clear that he does not wish to have this operation." In addition, a review of the notes of testimony of the evidentiary hearing discloses that [son's] decision was not based solely on religious grounds. He also stated that he had been in the hospital a long time already, and that no one "says it is going to come out right."' Therefore, the lower court decision to dismiss the hospital petition was reinstated.

"The issue of immunization of children is a legal custody decision. *See H.C. v. J.C.*, 60 A.3d 863 (Pa. Super. 2012)(PA Superior Court affirmed the Lehigh County trial court giving father authority to obtain human papillomavirus vaccinations for the parties' twin teenage daughters over mother's objections. The lower court held that the health benefits to be gained by the administration of the vaccine pursuant to established medical guidelines outweighed Mother's beliefs as to why the vaccine should not be administered); *Schoen v. Schoen*, 48 A.3d 490 (Pa. Super. 2012) (PA Superior Court affirmed the lower court's decision to grant father authority to have the parties' children immunized over mother's objections. The lower court was within its discretion to grant father the right to have the children vaccinated where there was competent, expert medical testimony that having the children vaccinated was in their best interests and where mother proffered no evidence whatsoever that the vaccinations would be harmful to the children even where mother framed her objection on religious principles)." *Bertin, Michael E., PA Child Custody* (2020).

Texas:

In Texas, the court can award rights and duties to a parent and they can be exclusive, joint or independent. The main ones are non-emergency invasive medical decisions, education, right to determine residence and psychological/psychiatric decisions. The presumption is that (other than right to determine residence) the rights will be shared jointly unless there is good cause to award otherwise.

In Texas there is an ongoing debate (that varies from county to county on occasion) as to whether immunizations are "invasive" medical procedures. The majority of courts in Texas hold that they are NOT invasive so either parent may have the child immunized regardless of whether the other disagrees. Texas also overrides the anti-vaxxers in some ways because vaccinations are required for public school attendance and school attendance is required and a parent can face criminal penalties for failing to enroll children under 16 in school.

Virginia:

In Virginia, Virginia Code Section 22.1-271.2 mandates immunizations in order to enroll a child in public school. The only exceptions are where a parent submits an affidavit that the administration of immunizing agents conflicts with the student's religious tenets or practices and

where a medical professional indicates that the required immunizations may be detrimental to the student's health.

Since M has primary custody, it is likely that F could not stop immunization absent a court order. The Court would need to find either one of the grounds of that statute or that the immunization would not be in the best interests of the child.

Where doctors and parents disagree over treatment - religion

Alabama:

Where doctors and parents disagree over treatment because of a religious reason, the doctors can pursue any legal remedies, including filing suit to compel treatment if the treatment is for emergency medical treatment *Ala. Code* §26-14-7.2. This can be done to prevent the withholding of medically indicated treatments for life-threatening conditions to prevent serious harm to the child. A parent will not be charged with neglect if that parent is legitimately practicing his or her religious beliefs, but the court can still require the medical services be provided when the child needs them.

The court must determine whether the parent's decision to refuse medical treatment will endanger the child's health or well-being to the extent that at child would be found to be dependent. The court needs to examine what other methods of treatment may be available and whether the parent's decision will affect the child's life, prevent/cause permanent injury or will alleviate prolonged agonizing pain for the child. Only if the court finds that the evidence reaches that threshold should the court intervene.

New Jersey:

N.J.S.A. 9:6-1.1 and 9:6-21(1)(c) (A child shall not be considered neglected or abused solely because their parents provide spiritual treatment in accordance with the practices of a recognized religion. However, this exemption does not apply when laws related to communicable diseases and sanitary matters are violated.)

In Re Conroy, 486 A.2d 1209, 98 N.J. 321 (N.J. 1985) citing to *State v. Perricone*, 37 N.J. 463, 181 A.2d 751, cert. denied, 371 U.S. 890, 83 S.Ct. 189, 9 L.Ed.2d 124 (1962) (affirming trial court's appointment of guardian with authority to consent to blood transfusion for infant over parents' religious objections; or *Muhlenberg Hosp. v. Patterson*, 128 N.J.Super. 498, 320 A.2d 518 (Law Div.1974) (authorizing blood transfusion to save infant's life over parents' religious objections).

Pennsylvania:

Zummo v. Zummo, 394 Pa.Super. 30, 574 A.2d 1130 (1990). Religious upbringing in conflict. 'The constitutionally recognized parental authority over the upbringing of children is augmented by the Free Exercise and the Establishment Clauses of the First Amendment with regard to the religious upbringing of children. [citations including] *Wisconsin v. Yoder*, 406 U.S. 205 (1971) The US Supreme Court has held that 'parental authority in matters of religious

upbringing may be encroached upon, only upon a showing of a "substantial threat" of "physical or mental harm to the child, or to the public safety, peace, order, or welfare."' *Wisconsin v. Yoder*, *supra*, 406 U.S. at 230. … Parents in healthy marriages may disagree about important matters; and, despite serious, even irreconcilable, differences on important matters, the government could certainly not step in, choose sides, and impose an orthodox uniformity in such matters to protect judicially or bureaucratically determined "best interests" of the children of such parents. Rather, intervention is permitted only upon a showing of a substantial risk of harm to the child in absence of intervention, and that the intervention proposed is the least intrusive means adequate to prevent the harm. *Wisconsin v. Yoder*, *supra*. … a parent may pursue whatever course of religious indoctrination which that parent sees fit, at that time, during periods of lawful custody or visitation. If the other parent objects and seeks restrictions, the objecting parent must establish a substantial risk of harm in absence of the restriction proposed. *Cf. Wisconsin v. Yoder, supra*…'

Texas:

In Texas our courts have repeatedly held that doctors can override the religious decision of parents in a number of circumstances to protect the health and safety of the child. One exception is blood transfusions when Jehovah's Witnesses decline the infusion. In the example of jaundice, Texas would likely override the decision not to treat, but as a precaution the hospital may use legal action to get a court order or call in Child Protective Services to "remove" the child and have the ability to make the decision so the child can get treatment.

Virginia:

Parents have a constitutionally protected liberty interest to make decisions involving their child. In addition, the free exercise of religion will likely cause a court to side with the parents unless the decision could be viewed as abuse or neglect or the government can show a substantial state interest in overruling the parent's decision. The more significant the issue, e.g., life or death, the more likely the state may advance a significant state interest. It is totally fact specific as to whether the parent's decision will control.

Where doctors and parents disagree over continuing life sustaining treatment

Alabama:

Any legally authorized medical, dental, health or mental health service may be rendered to minors of any age without the consent of a parent or legal guardian when, in the physician's judgment, an attempt to secure consent would result in delay of treatment which would increase the risk to the minor's life, health or mental health. *Ala. Code* § 22-8-3

Alabama has long recognized the principle that parents are, by the common law, under the legal duty of providing medical attention for their children. *Ex parte University of South Alabama*, 541 So.2d 535 (Ala.1989); *Osborn v. Weatherford*, 27 Ala.App. 258, 170 So. 95 (1936). 572 So.2d 1225. *R.J.D. v. Vaughan Clinic, P.C.*, 572 So. 2d 1225 (Ala. 1990). As

referenced above, the courts will intercede when the parents are no longer acting in the best interests of the child and the child is being harmed by their actions or inactions. The court should defer to the parents' decision making authority unless the medical/professional advice shows that the child is suffering or not receiving the appropriate emergency medical care that he/she needs. A court order would be necessary to change how the child is to be treated if it is contrary to the wishes of the parents.

New Jersey:

See analysis above.

Texas:

This is a tougher one as it concerns life sustaining treatment. In Texas, there would likely have to be a court order sustaining the treatment. Heather King had a case where a pro-life group intervened and kept a brain dead lady alive to give birth to a baby the doctors knew would not survive. It took several months to get a court order for the husband to override the injunction forcing the life sustaining treatment. Based on that case, I would think the hospital/doctors would have to get a court order as an "interested party" to withdraw the treatment.

Virginia:

This scenario requires the same analysis as the previous hypothetical.

Where child patient does not consent to treatment or refuses treatment

Alabama:

Any minor who is 14 years of age or older, or has graduated from high school, or is married, or having been married is divorced or is pregnant may give effective consent to any legally authorized medical, dental, health or mental health services for himself or herself, and the consent of no other person shall be necessary. *Ala. Code* § 22-8-4

The parent or legal guardian of a minor who is at least 14 years of age and under 19 years of age may authorize medical treatment for any mental health services even if the minor has expressly refused such treatment services if the parent or legal guardian and a mental health professional determine that clinical intervention is necessary and appropriate. Access to the mental health records of the minor will follow the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Public Law 104-191. *Ala. Code* § 22-8-10

In certain circumstances, a minor may have the legal ability to consent to medical treatment and he/she will not be subject to treatment he or she does not want. A parent cannot make the child undergo the treatment either when the minor can be shown to have sufficient maturity. Additionally, if the child wishes to have a certain treatment, the doctor would need to secure the child's consent even if the parent does not want that treatment to happen.

If the parents and the child are united in how the child wishes to be treated, the medical professionals would probably not be able to challenge those wishes.

New Jersey:

Not applicable, but see *N.J.S.A.* 9:17A-6 (2014) (Consent by a minor over voluntary and non-compensatory blood donation. A minor at the age of 17 is free to donate blood or undergo screening in the presence of one parental consent.). See also *N.J.S.A.* 9:17A-4 (2012). (Consent by a minor to treatment for alcoholism, drug dependency, venereal disease (including HIV/AIDS), etc. and confidentiality provisions.)

Texas:

In Texas a child 15 years of age would have a voice in his/her medical treatment if an ad litem was appointed and the ad litem would be required to take that into consideration. But as a minor, the parents would have the ultimate decision. It is doubtful the state would intervene in this case if the mature child does not want treatment and the parents are supportive of that, especially in the blood transfusion instance.

Virginia:

Given that the parents and the child are united in the decision to refuse treatment, it is likely that the decision of the child will control.

Genetically informed medicine and medical confidentiality

Alabama:

The doctors would have to honor the patient's instructions that his medical condition not be disclosed. How the daughter obtained this information is unclear, but HIPPA would prevent the disclosure by the doctors. Alabama does not have a patient-doctor privilege but you still have the confidentiality requirements of HIPPA as to the release of any information. Alabama does have a psychiatrist/counselor-patient privilege. This privilege cannot be waived by anyone but the patient.

As for whether the parent could authorize genetic testing, this would fall under the parent's right to authorize medical treatment so it would be allowed. If the parents cannot agree, the doctor would have to determine who is authorized to consent to the treatment as detailed in the above fact patterns.

New Jersey:

General recognition of cause of action for "genetic tort," see *Safer v. Estate of Pack*, 715 A.2d 363, 314 N.J.Super. 496 (N.J. Super. App. Div. 1998).

Texas:

Not sure this is really an issue in the US with the HIPPA requirements. But father could definitely sue whomever disclosed his information. Not sure what daughter can do with a late term pregnancy. Would be a tough case to prove against father/grandfather for any damages and would depend on if child tested positive for the disease.

Virginia:

The physicians would not be able to disclose the patient's condition absent his consent. However, the daughter has learned about it from other means. While she may have decided to terminate the pregnancy early had she known, Roe v. Wade will control her ability to terminate the pregnancy at a later stage. Since her concern is not necessarily tied to her health, it is unclear whether she would be permitted to terminate late term.

LIBRA
AVOCATS

MEDECINE AND FAMILY LAW

French Law Aspects by Delphine Eskenazi

I. Where parents disagree over medical treatment

1. What is the legal position in relation to parental responsibility following the breakdown of a relationship or marriage?

French Family law has a concept called **Parental Authority,** each parent has parental authority over their children and even after divorce or separation, they both will continue to keep it (art. 373-2 of the civil code).

Parental Authority is a set of rights and duties that parents have over their children, and that can be submitted to the control of a judge. PA is a matter of public order (art. 376 of the civil code), therefore it is not permitted to contract a convention which modify provisions regarding PA.

However, if common parental authority is the principle, one parent can be deprived of its PA exercise if it is in the **child interest** (art. 373-2-1 of the civil code).

Usually, parent must demonstrate than the other parent **put the child at danger**. The danger must be **obvious,** because of the action or inaction of the parent, and cause a risk to the security of the child, health or morality of the child (Appellate court of Colmar, civil chamber 5 B, 16 Feb. 2016, n° 15/04112).

2. What is the legal position in relation to parents making decisions over medical treatment for their children before relationship or marriage breakdown? Does this change following relationship or marriage breakdown? If so, how?

French civil code enunciates the following principle: all decisions regarding the children must be decided **jointly** by the parents (art. 372-1 of the civil code).

Even if parents are separated or divorced this principle must apply. When parents get divorce, the family judge rules over the **modalities of the exercise of PA** (often based on the agreement of the parents). It is very common to use the followings provisions in divorce agreement:

"Parents, even if separated, shall take together important decisions concerning the protection of the health, safety and morals of children, while involving children in decisions affecting them, in accordance with their age and degree of maturity;

Parents, even when separated, ensure the education and proper development of their children, and must therefore inform each other about the organization of their children's lives (school life, sport, culture, medical treatment, leisure activities, holidays, etc.)".

French law allows parents who are not married to organize the exercise of the PA through a contract submitted to the family judge.

3. ***What happens when separated parents disagree over medical treatment for their children? How is a decision ultimately made? If a court application is needed, please explain the nature of the application, the evidence required, the principles / law applied by the courts and the orders available to the court. Do the principles / law applied and orders available differ depending upon the urgency of the need for treatment (e.g. immunisations vs blood transfusions) or upon the certainty of the treatment (e.g. immunisations vs chemotherapy)?***

When separated parents disagree over medical treatment, they can petition a family affairs judge **to obtain a decision on the <u>modalities of exercise</u> of PA**. When a parent is asking for a modification of the exercise of the PA, he/she must demonstrate to the court that a **change of circumstance occurred,** and such change shall affect the modalities of exercise of PA.

Article 373-2-11 of the civil code enunciate different clues that the family affairs judge shall consider making its ruling.

Article 373-2-11:

"*When deciding on the way parental authority is to be exercised, the judge shall take into consideration in particular:*

1° The practice that the parents had previously followed or the agreements they may have previously entered;

2° The feelings expressed by the minor child under the conditions set out in article 388-1;

3° The ability of each of the parents to assume their duties and respect the rights of the other;

4° The results of any expert assessments that may have been carried out, considering the age of the child;

5° The information gathered in any social inquiries and counter-investigations provided for in article 373-2-12;

6° the pressure or violence, of a physical or psychological nature, exerted by one of the parents on the other."

When deciding on the way PA is to be exercised, the judge shall take into consideration the **practice previously followed by the parents or the agreements they may have had previously.** Each parent must show evidence to the family judge to establish previous practices or any agreement.

Appellate court of Lyon, on April 11, 2017[1] ruled on **immunization** and treatments in case of parent's disagreement. In this case, the dad is a doctor who lived aboard, and the principle residence of the children was with their mother in France.

The divorce judgement decided that the father had to reimburse the mother fees for treatments and immunization on presentation of bills. He wanted this decision reversed and he further requested that the agreement of both parents to be obtained in advance for non-compulsory immunizations and treatments related to children's stays abroad and that, in the event of disagreement on a treatment, the costs will be borne by the parent who has decided to have the treatment administered.

Appellate court of Lyon decided to confirm the previous ruling, and remind the parents that: "***It is not for the Court to enter the medical discussions set out by Mr. P., who has a doctorate in pharmacy, on the necessity or compulsory nature of a vaccine, since the legislation is subject to change and epidemics are constantly evolving in this field. The geographical remoteness of the father does not entitle the mother to take unilaterally, without prior consultation with Mr. P. and without consulting him, decisions concerning Alexandre and Elsa, which may be associated with them in view of their age***".

In case of disagreement, the family affairs judge is always going to rule in the best interests of the child. However, the judge can intervein when it comes to **mandatory immunizations**, in such case, parents who refuse the immunization can be criminally charged (art. L. 3111-2 of the Public Health Code).

4. ***Is dispute resolution used to help the parents find an agreement? Are there mechanisms available to help avoid a dispute in the first place? In your experience, are these disputes rare or commonplace? If you have dealt with this in practice, please give an outline of a recent case and an indication of the time taken to resolve the dispute and a broad indication of the legal costs (if any) incurred. In your experience, if a judge is involved in making an ultimate decision, what is their opinion of parents who cannot agree on medical treatment for their children? For example, do they try to discourage these applications and encourage parents to use a dispute resolution method?***

Family mediation is a process that can help the parents to find an agreement. Mediation take place out of a court room. The mediator is independent and cannot be part of the ultimate agreement, only parents can decide on an agreement. Then, it is possible to petition the family judge to ask for the agreement to be ratify.

[1] Cour d'appel, Lyon, 2e chambre B, 11 Avril 2017 – n° 16/00986

The family judge can try to conciliate the parties and can propose a mediation to the parents who cannot find an agreement (art. 373-2-10 of the civil code).

In my experience, the most frequent disagreement between parents as regards medical treatments relate to the necessity for the children to be followed by a psychotherapist. In France, both parents must agree and otherwise, as explained before the family affairs judge will decide.

I have had to deal with applications relating only to this issue and it can take between 6 to 9 months to be resolved in Court.

II. When doctors and parents disagree over treatment – religion

1. *What is the legal position in relation to parental autonomy over medical treatment for their children? Does this change if the parents are in dispute with the doctors treating their child? What special considerations are taken into account (if any) where the parents' objection to a treatment or course of action is down to their religious beliefs?*

According to the Public Health Code, parents must decide on medical treatments for their children, the decision belong to them (art. R. 1112-34 of the PHC). Parents must give a written authorization to the doctors in order to proceed with the medical treatment (art. L. 1111-2 of the PHC).

Case law established a **presumption of agreement for routine acts** such as mandatory care (such as certain immunization), routine care (e.g., minor injuries, minor infections, routine dental care), routine care in the child (treatment of common childhood illnesses) or in a particular child (continued treatment or care of a recurring illness, even if serious).

Furthermore, **article 8 on right to privacy** of the European Convention on Human protects parents over their decision on their children healthcare (CEDH 11 Dec. 2014, req. no 43643/10).

When parents disagree with doctors over medical treatment for their children **the principle is the following: if the doctor does not have the consent of the parents, he cannot proceed with the medical care unless there is an emergency.**

As long as the decision of the parents is not dangerous of the health of the child, then religious practice is not taken into account.

Provisions of the Public Health Code :

Art. Al.1 R. 1112-34: "*The admission of a minor is pronounced, **unless it is necessary**, at the request of a person exercising parental authority or judicial authority.*"

Art. R. 1112-35: "*Subject to the provisions of article L. 1111-5, if at the time of admission of a minor it appears that written authorization to operate on him and to carry out the acts connected with the operation could not, if necessary, be obtained at short notice from his father, mother or legal guardian because of their removal, or*

for any other reason, they must, as soon as the minor is admitted, sign an authorization to operate and to carry out the acts connected with the operation.

If the father, mother or legal guardian can give written authorization at short notice, they shall be requested to do so as soon as an operation becomes necessary.

In the event of refusal to sign this authorization or if the consent of the minor's legal representative cannot be obtained, no surgery may be performed except in cases of emergency.

However, where the health or bodily integrity of the juvenile is likely to be jeopardized by the refusal of the juvenile's legal representative or the impossibility of obtaining the consent of the juvenile, the doctor in charge of the service may refer the matter to the Department of Public Prosecutions in order to initiate educational assistance measures to enable him to provide the necessary care."

2. ***What happens when parents disagree with doctors over medical treatment for their children? How is a decision ultimately made? If a court application is needed, please explain the nature of the application, the evidence required, the principles / law applied by the courts and the orders available to the court. Do the principles / law applied and orders available differ depending upon the urgency of the need for treatment or upon the certainty of the treatment?***

If parents disagree with doctors over medical treatment for their children, French law established two manners of dealing with this situation:

- **<u>Emergency cases</u>: doctors can overcome the refusal of the parents without petitioning the judge because health of the child is at risk.**

According to article **L. 1111-4, paragraph 6, of the Public Health Code : "*in the event that a refusal of treatment by the person with parental authority or the tutor is likely to have serious consequences for the health of the minor, the doctor shall provide the necessary treatment*".**

Thus, in a decision of 4 March 2003 (Appellate Court of Bordeaux, 4 March 2003, req. No. 99BX02360), the Administrative Court of Appeal of Bordeaux ruled that the **doctors who had performed a blood transfusion on a minor despite the refusal of the parents did not commit a fault.**

- **<u>Other cases</u>: when there is a danger, one of the parents, the child, the doctor can ask the Prosecutor to initiate a procedure called the "assistance éducative" before the juvenile judge.**

If there was a danger, the juvenile judge could also be petition by one of the parents, by the child, by the establishment to which the child had been entrusted or **by the public prosecutor's office informed by the doctor** (art. R. 1112-34 of the PHC). **The juvenile judge has the sovereign right to decide whether there is a danger.** The juvenile judge shall obtain the agreement of the parents on any matter, **but he will always rule in the best interest of the child.**

Principle: All decisions regarding children health belong to the parents.

Exception: when health or bodily integrity of the juvenile is likely to be jeopardized by the refusal of parents, the doctor can proceed with the treatment in case of emergency, or informed the Prosecutor who will initiative a procedure called "assistance éducative".

3. ***Are all religious objections treated consistently? Are some religious objections treated less favorably than others?***

In France, secularism is a constitutional principle and according to it, all religion shall be treated the same way. All doctors must respect this fundamental principle (it does not matter if doctors exercise in a public or private structure), otherwise, it is a discrimination based on religion according to French law.

4. ***Are there any significant or landmark decisions in your jurisdiction that deal with parents objecting to medical treatment on the grounds of religion? If so, please give a brief outline of those cases.***

The *Cour de cassation* has accepted that a circumcision may be a common act if it is medically necessary, but this is not the case if it is **a ritual circumcision** (Civ. 1re, 26 Jan. 1994, n°92-10.838), **both parents must agree**.

In this case, both appellate court and the *Cour de cassation* refused a visitation right to the father because he imposed to his two boys a circumcision, he did not inform nor ask permission to the mother. The *Cour de cassation* decided that such circumstances caused a threat to the mental stability of the children.

In other words, if circumcision is part of a religious ritual, both parents must agree to perform it.

The *Cour de cassation* also ruled that the father who took advantage of the exercise of his custody right to take the serious decision to have the child circumcised for ritual purposes, without medical necessity and without the mother's consent is liable (TGI de Paris, 29 sept. 2000). Later, it also ruled that if the child is aged 11, he should agree as well to proceed with the circumcision (TGI Lyon, 25 July 2007).

5. ***To what extent (if any) can third parties (for example, religious organisations) take part in the decision making process?***

As I said, only parents can decide on medical decisions for their children. However, in a case of a "assistance éducative" procedure, third parties such as the juvenile child judge and child welfare services can be part of the decisions.

Article R. 1112-34 of the Public Health Code states: "***However, where no person exercising parental authority can be reached in good time, admission shall be requested by the child welfare service***".

In this circumstance and only in this circumstance, when no one is present to consent, child welfare service can ask for the admission of the child in hospital before the juvenile judge.

III. Where doctors and parents disagree over continuing life sustaining treatment

1. ***What is the legal position in relation to parental autonomy over medical treatment for their children? Does this change if the parents are in dispute with the doctors treating their child?***

The principle remains the same regarding to continuing life sustaining treatment: **decisions belong to the parents.**

If the parents are in dispute with the doctors regarding the treatment of their child, the decision will be ultimately made by a college of doctors (art. L. 1110-5-1 et L. 1111-4 du CSP).

2. ***What happens when parents disagree with doctors over medical treatment for their children? How is a decision ultimately made? If a court application is needed, please explain the nature of the application, the evidence required, the principles / law applied by the courts and the orders available to the court. Do the principles / law applied and orders available differ depending upon the urgency of the need for treatment or upon the certainty of the treatment?***

If parents disagree with doctors, doctors must ask the parents' authorization in any case, article R.4127-37-2 (III) of the PHC states : "*When the decision to limit or stop treatment concerns a minor or a protected adult, the doctor shall also seek the opinion of the holders of parental authority or the tutor, as the case may be, except in situations where the emergency makes such consultation impossible*".

In France, decisions over unreasonable continuance of life sustaining treatment when a patient cannot give his opinion are ultimately submitted to **a collegial decision of doctors** (article L.1110-5-1 of the PHC). **Doctors must consult parents to obtain their opinion when the child is a minor.**

This collegial procedure takes the form of consultation with the members of the health care team present, if any, and the reasoned opinion of at least one doctor, called in as a consultant. There must be no hierarchical link between the doctor in charge of the patient and the consultant. The reasoned opinion of a second consultant shall be obtained by these doctors if one of them considers it useful (article R.4127-37-2 of the PHC). Then, when a decision is made, the doctor informs the parents.

This decision can be contest before an Administrative court with a specific procedure called the *"référé suspension"* (emergency petition for suspension), where the parents can argue with the decision made by the college.

First, the judge must verify whether or not the decision falls within the hypotheses provided for by the dispositions of the PHC. Then, the judge is going to ask about the presence of any last will of the sick person, but it will not determine the outcome of its decision. The judge can ask for an second expertise. Ultimately the judge can only rule on the continuation of the treatment.

3. ***Are there any significant or landmark decisions in your jurisdiction that deal with parents objecting to medical treatment? If so, please give a brief outline of those cases.***

The *Conseil d'État* in a decision dated March 8, 2017, ruled that supposing that a young child (of one year-old) could be considered "*unable to express his or her will*" and therefore could be subject to the collegial procedure provided for in the provisions of Articles L. 1110-5-1 and L. 1111-4 of the Public Health Code and a doctor's decision taken on the sole advice of his parents, pursuant to article R. 4127-37-2 (these texts being concerned with the cessation of treatment in the event of unreasonable obstinacy), **the decision ordering the medical team to continue the treatment should be approved.**

French law was declared conform with the provisions of the ECHR by the European Court on January 25, 2018 (Afiri et Biddarri c. France, req. no 1828/18).

4. ***In your opinion, does your jurisdiction favour parental choice over professional advice when it comes to decision making over life sustaining treatment? How would you advise a parent seeking to object to the proposed medical treatment? To what extent (if any) are court proceedings dealing with a dispute between doctors and parents heard in public? What is the level of public interest in these cases? Are reporting restrictions used to preserve the anonymity of the family and professionals involved?***

The previous cited infamous case of Marwa, who was a baby who suffered at the age of 10 months from a virus infection which caused serious and permanent neurological lesions. As a result, the doctor in charge decided, two months after his arrival in intensive care, to initiate a collegial procedure with a view to stopping treatment for "unreasonable obstinacy on a person who is unable to express his will", in compliance with the provisions of the law (Art. L. 1110-5-1, CSP). The procedure unanimously concluded with this ruling.

However, the parents petition to court to obtain an emergency hearing. On 16 November 2016, the judge decided to suspend the execution of the doctor's decision to stop treatment and ordered a medical expertise. In the light of the results of the expertise, carried out by three doctors, the court concluded that the situation of unreasonable obstinacy had been called into question. It ordered the continuation of treatment. The hospital in charge of the little girl challenged the judge's decision and then referred the matter to the *Conseil d'État.*

Finally, the *Conseil d'État* ruled that the situation of Marwa did not constitute unreasonable obstinacy : "*the administration of treatment that is disproportionate, unnecessary or aimed solely at the artificial maintenance of life" - sufficiently characterized in the sense of the law to lead to an immediate interruption of treatment*".

In France, hearings are public because it is a fundamental principle of the Rule of law. However, the law provides that in certain cases or for certain matters, the public may not have access to hearings specially when right to privacy is at stake.

Furthermore, article 6 § 1 of the ECHR itself allows derogation from the publicity of the hearing "*in the interests of morals, public policy or national security in a democratic society,* ***when the interests of juveniles or the protection of the private life of the parties to the proceedings so require,*** *or to the extent strictly necessary in the opinion of the court , when in special circumstances publicity would prejudice the interests of justice...*".

However, even if the debates are private, such cases always become public because usually the doctors and the family talk to the press.

5. ***To what extent (if any) can third parties take part in the decision-making process? To what extent does the state intervene in the decision-making process?***

The state cannot in any circumstance intervein in such decision. For instance, President François Hollande refused publicly to take part of the debate relating to Mr. Vincent Lambert and said that this matter should be dealt before the courts. No one except the parents and doctors should take part of the decision-making process.

6. ***To what extent (if any) are you aware of parents either coming to your jurisdiction to take advantage of an approach more in favor of parental choice or leaving to seek treatment in another jurisdiction?***

I did not have a case yet with this issue.

7. ***If there are court proceedings involved, what options do parents have to help pay for legal costs?***

There is a legal aid in France but only for litigants whose ressources are inferior to a certain level, which is very low in France (equivalent of the minimum salary in France).

IV. Where a child patient does not consent to treatment or refuses treatment

1. ***What is the legal position in relation to a child's autonomy over medical treatment for their own medical treatment? Does this change if the child is in dispute with the doctors treating them? Does this change if the child is in dispute with their parents too? Does this change depending on whether the child is consenting to treatment or objecting to treatment?***

- **Principle:** Article L. 1111-2 of the Public Health Code provides that minors "*have the right to receive* ***information*** *themselves and to participate in decision-making concerning them in a manner appropriate to their maturity*". The information the child is likely to receive is determined by the doctor according **to the maturity of the child**.

- ***Consent of the child:*** Article L. 1111-4 of the Public Health Code requires that the consent of the minor **be systematically sought** if he or she is capable of expressing his or her wishes and participating in the decision based on the juvenile' maturity.

- **However, if his/her consent must be sought, it is not required by the law that he actually give his consent.**

- ***Dispute between child and parents:*** The doctor may overrule the minor's refusal if the person exercising parental authority has given his or her consent.

- ***Dispute between the child and the doctor:*** again, if parents gave their consent, the doctor can proceed with the medical act.

Two exceptions:

- **Contraceptive methods**: doctor can prescribe a contraceptive method to the minor without the consent of the parents (L. 5134-1 du CSP);

- **Abortion**: the minor may dispense with parental consent to undergo a voluntary termination of pregnancy if she does not wish to inform her parents (para. 2), even if the principle remains the consent of one of her parents (art. L2212-7 du CSP).

2. ***What happens when children disagree with doctors over their medical treatment? How is a decision ultimately made? If a court application is needed, please explain the nature of the application, the evidence required, the principles / law applied by the courts and the orders available to the court. Do the principles / law applied and orders available differ depending upon the urgency of the need for treatment or upon the certainty of the treatment?***

The juvenile can benefit from a right to secrecy according to article L. 1111-5 of the Public Health Code. It means that for some medical act, the juvenile may be dispensed with the consent of his parents.

Art. L.1111-5 of the PHC:
"*By derogation from article 371-1 of the Civil Code, the doctor or midwife* ***may dispense with obtaining the consent of the holder or holders of parental authority*** *to the medical decisions to be taken when preventive action, screening, diagnosis, treatment or intervention* ***is necessary to safeguard the health of a minor****, where the latter expressly opposes consultation of the holder or holders of parental authority in order to keep his or her state of health secret. However, the doctor or midwife must first obtain the minor's consent to this consultation.* ***If the minor maintains his or her opposition, the doctor or midwife may implement the preventive action,*** *screening, diagnosis, treatment or intervention. In this case, the minor shall be accompanied by an adult of his or her choice.*"

According to the provisions of this article, the juvenile can consult without the consent of his parent if it is "necessary to the safeguard" of his health.

The doctor shall seek the consent of the juvenile however, if he refuses the doctor can proceed with the medical act anyway.

In such case, the minor can be accompanied with the adult of his choice.

3. ***Are there any significant or landmark decisions in your jurisdiction that deal with children objecting to medical treatment that guide your advice to clients? If so, please give a brief outline of those cases.***

Most cases are circumstantial and depending on the facts on a case by case basis, there is no landmark decision.

4. ***How are the views of the child taken into account and heard? How much weight is given to a child's views? Does this change according to the child's age or understanding? Does this change depending on whether the child is consenting to treatment or objecting to treatment?***

As I said, in French law, **the child must be informed on his medical treatment**, it is mandatory, and doctors must fulfil this obligation.

However, if the child consent must be sought by the doctor, it is not mandatory to obtain his agreement for a medical act. If the parents agree, then the doctor can perform the medical act. The views of the child are taking into account based on his **maturity** meaning his age and ability to understand things.

5. ***Is anyone appointed to legally represent the child in any court proceedings? If so, who and what is their role?***

During a court proceeding, the child can be represented by an ***"Ad hoc* Administrator"** who will represent the minor and defend his/her interests before the Juvenile Court concerning the procedures of educational assistance.

The Administrator can be appointed where the interests of the minor child appear or are in conflict with those of his or her legal representatives (Articles 388-2 and 389-3 of the civil code). The legal administrator shall represent the minor in all civil acts, except in cases in which the law authorizes juveniles to act themselves.

6. ***What special considerations are taken into account (if any) where the child's objection to a treatment or course of action is down to their religious beliefs?***

I don't think that there would be a special consideration for religious beliefs.

7. ***Are there any significant or landmark cases where a child's objection has outweighed medical advice? If so, please give an outline of those cases.***

I am not aware of any landmark decision.

8. What privacy can a child expect over their medical records and conversations they have with medical professionals (including mental health professionals and health care professionals in school)? Can a parent (ever) access that information? Are there any situations when a parent couldn't access that information?

Right to secrecy is permitted for the juvenile under article 1111-5 of the Public Health code (previously quoted and commented).

The minor is not allowed to consult his medical record by himself/herself. He/she may, however, request that his or her parents consult his or her file through the intermediary of a doctor and **deny them this access when he or she has requested the implementation of his or her right to secrecy** (art. L. 1111-5 et L. 1111-7 , al. 5 of PHC).

> Art. L. 1111-7 al. 5 of PHC :
> "*Subject to the objection provided for in Articles L. 1111-5 and L. 1111-5-1, in the case of a minor, the right of access shall be exercised by the holder or holders of parental authority. At the request of the minor, such access shall take place through the intermediary of a doctor.*"

9. What happens if there are issues as to the child's mental capacity to make decisions over their medical treatment?

The European Charter for Hospitalized Children, adopted by the Parliament in 1986, already affirmed "the right of the child to receive information appropriate to his or her age and degree of maturity, mental development, emotional and psychological state regarding all the treatment to which he or she is subject". The information that the child is likely to receive is determined by the doctor according to the maturity and condition of the person to whom it is addressed.

Then, if there is an issue regarding the child's mental capacity to make decisions over medical treatment, the doctor fulfil its information obligations to the child however, at the end, the decision always belong to the parents.

V. Genetically informed medicine and medical confidentiality

1. Does your jurisdiction recognise a duty to warn third parties of a familial risk of genetic disease? How does this sit with any principles regarding patient confidentiality?

Article L. 1111-7 of the Public Health Care states : "*In the event of a serious diagnosis or prognosis, medical secrecy does not prevent the family, relatives of the sick person or the trusted person defined in Article L. 1111-6 from receiving the necessary information to enable them to provide direct support to the sick person, unless the person concerned objects. Only a doctor is authorized to provide this information, or to have it provided under his responsibility.*"

Third parties such as family can be informed if the sick person does not object, only the doctor can disclose such information. Otherwise, medical confidentiality prohibits any doctor from communicating information about his patient to third parties.

2. ***Should parents be able to insist on genetic testing of their children as part of their "parental responsibility"? Is there a difference between tests (whether genetic or not) that screen for disorders and illness that can be treated successfully (e.g. type 1 diabetes) and those that cannot be treated (e.g. Huntingdon's disease)?***

The minor also has a **right of veto** with regard to the removal of bone marrow, which is reserved for the brothers and sisters of the child or, exceptionally, for the child's first cousin, uncle or aunt, nephew or niece (article L. 1241-3 of the PHC), and which may not take place if he refuses (article L. 1241-3 of the PHC).

The same applies to biomedical research (art. L. 1122-2 of the PHC), the doctor must inform the juvenile and seek her/his approval. However, the text is very clear: **"*In any event, their refusal or revocation of their acceptance cannot be disregarded*".**

3. ***Do children have a right "not to know"? Should they be allowed to make their own decision when they are considered competent (see case study 4) or when they are an adult?***

Article L.1122-2 of the PHC states : "*Unemancipated juveniles, protected adults or adults who are incapable of giving their consent and who are not subject to a legal protection measure shall, when their participation in research (biologic) involving the human person is envisaged, receive the information provided for in Article L. 1122-1 appropriate to their capacity to understand, both from the investigator and from the persons, bodies or authorities responsible for assisting them, representing them or authorizing the research, who themselves shall be informed by the investigator*". The child has a right to know, French law imposes to the doctor to inform the juvenile.

A juvenile can be able to take its own decisions regarding to his/her maturity and his/her ability to understand the situation. The doctor must give the juvenile all the information needed to him/her and to the parents. **Ultimately, the decision belongs to the child.**

4. ***In the case of separated parents, how would you approach a dispute between parents about the genetic testing or screening of their children? What principles / approach would your courts apply?***

The Courts will not consider that this is a usual act, where the consent of the other parent is presumed. For this reason, any decision relating to genetic testing or screening should be decided jointly between the parents and in case of disagreement, the most diligent parent can petition the family affairs judge, who will decide, taking into consideration the child's best interest.

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Delphine ESKENAZI
Associée

LIBRA
AVOCATS

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Medicine And Family Law

2

PART 1

Where parents disagree over medical treatment

French concept of Parental Authority :

Each parent has **Parental Authority** (« PA ») over their children.

Even after divorce or separation, they both will continue have PA.

All decisions regarding the children must be decided **jointly** by the parents regardless of the couple situation.

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Where parents disagree over medical treatment

If joint parental authority is the principle, one parent can be deprived of its PA exercise if it is in **the child interest**. Usually, parent must demonstrate that the other parent put the child at **danger.** The danger must be **obvious,** because of the action or inaction of the parent, and **cause a risk to the security of the child, health or morality of the child.**

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Where parents disagree over medical treatment

Disagreement

When separated parents disagree over medical treatment, they can petition a family affairs judge to obtain **a decision to resolve this dispute**.

When a parent is asking for a modification of the exercise of the PA, he/she must demonstrate to the court that **a change of circumstance occurred,** and such change shall affects the modalities of PA.

When deciding on the way PA is to be exercised, the judge shall take into consideration **the practice previously followed by the parents or the agreements they may have had previously.**

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Where parents disagree over medical treatment

Principle

If mandatory immunizations and treatments are given to the children, the Courts do not sanction parents regarding their choice as long as the best interests of the children are not at risk.

Family judge **cannot** choose for the parents, they must come to an agreement. Even in case of **emergency**, the ultimate decision always belongs to the parents.

Exception

However, the judge can intervein when it comes to **mandatory immunizations**, in such case, parents who refuse the immunization can be criminally charged (*art. L. 3111-2 of the Public Health Code*).

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PART 2

When doctors and parents disagree over treatment – religion

Medical treatments

According to the health code, **parents must decide on medical treatments** for their children, the decision belong to them. Parents must give a **written authorization** to the doctors in order to proceed with the medical treatment.

When parents **disagree with doctors** over medical treatment for their children the principle is the following: **if the doctor does not have the consent of the parents, he cannot proceed with the medical care.**

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When doctors and parents disagree over treatment – religion

Disagreement with doctors:

If parents disagree with doctors over medical treatment for their children, French law established two manners of dealing with such situation:

Emergency cases :

Doctors can overcome the refusal of the parents without petitioning the judge because health of the child is at risk.

Other cases :

When there is a **danger**, doctors can ask the Prosecutor to initiate a procedure called the "*assistance éducative*" before the juvenile judge.

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When doctors and parents disagree over treatment – religion

Religions

In France, secularism is a constitutional principle and according to it, **all religion shall be treated the same way.** All doctors must respect this fundamental principle (it does not matter if the doctors exercise in a public or private structure), otherwise, it is a **discrimination** based on religion according to French law.

Regarding medical decisions based on religious belif, the *Cour de cassation* ruled **that both parents should agree to it** *i.e circumscision.*

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PART 3

Where doctors and parents disagree over continuing life sustaining treatment

Life sustaining treatment decisions

The principle remains the same regarding to continuing life sustaining treatment: **decisions belong to the parents** (continuing or cessation).

If the parents are in dispute with the doctors regarding the treatment of their child, the decision will be ultimately made by a **college of doctors.** Doctors must consult parents to obtain their opinion when the child is a minor.

Parents can challenge the collegial decision before an Administrative Court through an emergency procedure called "*référé suspension*". Administrative Judge can order a second expertise and ultimately, he/she will ruled over the continuation or cessation of the life sustaining treatment.

The state cannot in any circumstance intervein in such decision.

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PART 4

Where a child patient does not consent to treatment or refuses treatment

Right to be informed

Doctors must inform the child based on his/her level of maturity and ability to understand the situation.

Consent

If the child consent must be sought, it is not required by the law that the juvenile actually agrees with the treatment. Decisions belong to the parents. 2 exceptions : prescription for contraceptive and abortion.

Medical record

The minor is not allowed to consult his medical record. Parents can have access to it through the doctor. However, the juvenile can exercise his/her right to secrecy to deny its access.

Right to secrecy

According to the provisions of this article, the juvenile can consult without the consent of his parent if it is "necessary to the safeguard" of his health.

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PART 5

Genetically informed medicine and medical confidentiality

Consent

Child has a right to veto on biomedical research and more generally on any genetically research.

Medical secret

Doctors must respect medical secret of their patients. Only third parties such as family are allowed to be informed on the medical condition of the sick person (if the person does not object).

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QUESTIONS

Delphine ESKENAZI
Libra Avocats
5, rue Récamier – 75007 Paris
+ 33 1 42 84 07 07
delphine@libra-avocats.com

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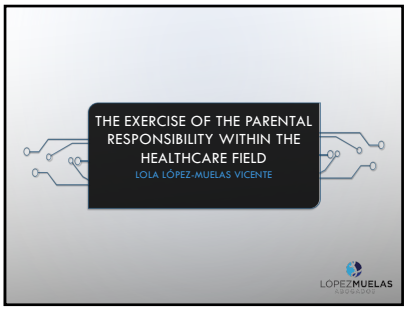
THE EXERCISE OF THE PARENTAL RESPONSIBILITY WITHIN THE HEALTHCARE FIELD
LOLA LÓPEZ-MUELAS VICENTE
LOPEZMUELAS

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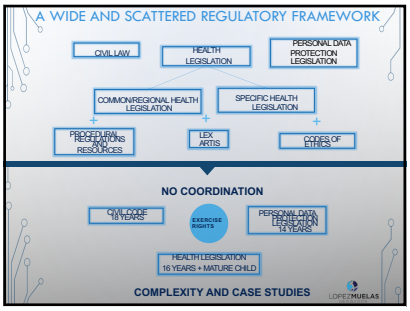
A WIDE AND SCATTERED REGULATORY FRAMEWORK
CIVIL LAW
HEALTH LEGISLATION
PERSONAL DATA PROTECTION LEGISLATION
COMMON/REGIONAL HEALTH LEGISLATION
SPECIFIC HEALTH LEGISLATION
PROCEDURAL REGULATIONS AND RESOURCES
LEX ARTIS
CODES OF ETHICS
NO COORDINATION
CIVIL CODE 18 YEARS
EXERCISE RIGHTS
PERSONAL DATA LEGISLATION 14 YEARS
HEALTH LEGISLATION 16 YEARS + MATURE CHILD
COMPLEXITY AND CASE STUDIES
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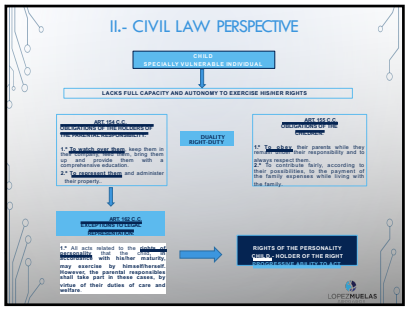
II.- CIVIL LAW PERSPECTIVE
CHILD
SPECIALLY VULNERABLE INDIVIDUAL
LACKS FULL CAPACITY AND AUTONOMY TO EXERCISE HIS/HER RIGHTS
DUALITY RIGHT-DUTY
RIGHTS OF THE PERSONALITY
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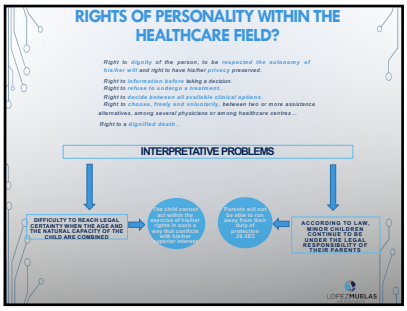
RIGHTS OF PERSONALITY WITHIN THE HEALTHCARE FIELD?
Right to dignity of the person, to be respected the autonomy of his/her will and right to have his/her privacy preserved.
Right to information before taking a decision.
Right to refuse to undergo a treatment.
Right to decide between all available clinical options.
Right to choose, freely and voluntarily, between two or more assistance alternatives, among several physicians or among healthcare centres...
Right to a dignified death...
INTERPRETATIVE PROBLEMS
DIFFICULTY TO REACH LEGAL CERTAINTY WHEN THE AGE AND THE NATURAL CAPACITY OF THE CHILD ARE COMBINED
The child cannot act within the exercise of his/her rights in such a way that violates his/her superior interest
Parents will not be able to run away from their duty of protection (Art. 39.3 EC)
ACCORDING TO LAW, MINOR CHILDREN CONTINUE TO BE UNDER THE LEGAL REPRESENTATION OF THEIR PARENTS
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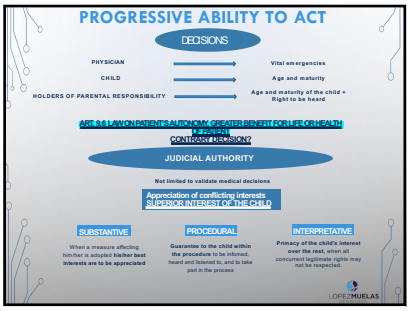
PROGRESSIVE ABILITY TO ACT
DECISIONS
PHYSICIAN
Vital emergencies
CHILD
Age and maturity
HOLDERS OF PARENTAL RESPONSIBILITY
Age and maturity of the child + Right to be heard
ART. 9.6 LAW ON PATIENT'S AUTONOMY, GREATER BENEFIT FOR LIFE OR HEALTH + DANGER
CONTROVERSIAL DECISION?
JUDICIAL AUTHORITY
Not limited to validate medical decisions
Appreciation of conflicting interests
SUPERIOR INTEREST OF THE CHILD
SUBSTANTIVE
When a measure affecting him/her is adopted his/her best interests are to be appreciated
PROCEDURAL
Guarantee to the child within the procedure to be informed, heard and listened to, and to take part in the process
INTERPRETATIVE
Primacy of the child's interest over the rest, when all concurrent legitimate rights may not be respected.
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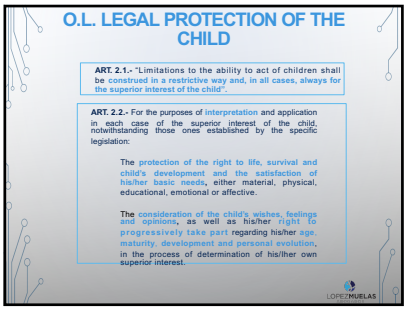
O.L. LEGAL PROTECTION OF THE CHILD
ART. 2.1.- "Limitations to the ability to act of children shall be construed in a restrictive way and, in all cases, always for the superior interest of the child".
ART. 2.2.- For the purposes of interpretation and application in each case of the superior interest of the child, notwithstanding those ones established by the specific legislation:
The protection of the right to life, survival and child's development and the satisfaction of his/her basic needs, either material, physical, educational, emotional or affective.
The consideration of the child's wishes, feelings and opinions, as well as his/her right to progressively take part regarding his/her age, maturity, development and personal evolution, in the process of determination of his/her own superior interest.
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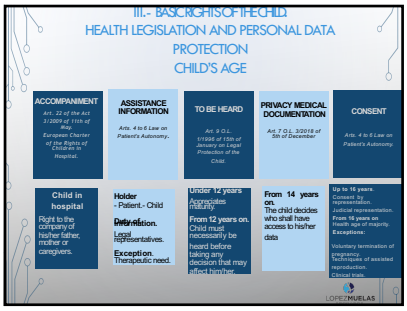
III.- BASIC RIGHTS OF THE CHILD.
HEALTH LEGISLATION AND PERSONAL DATA PROTECTION
CHILD'S AGE
ACCOMPANIMENT
Art. 22 of the Act 1/1996 of 11th of Jnuy. European Charter of the Rights of Children in Hospital.
ASSISTANCE INFORMATION
Arts. 4 to 6 Law on Patient's Autonomy.
TO BE HEARD
Art. 9 O.L. 1/1996 of 15th of January on Legal Protection of the Child.
PRIVACY MEDICAL DOCUMENTATION
Art. 7 O.L. 3/2018 of 5th of December
CONSENT
Arts. 4 to 6 Law on Patient's Autonomy
Child in hospital
Right to the company of his/her father, mother or caregivers.
Holder
- Patient.- Child
Exercise.
- Legal representatives.
Exception
Therapeutic need.
Under 12 years
Appreciates maturity.
From 12 years on.
Child must necessarily be heard before taking any decision that may affect him/her.
From 14 years on.
The child decides who shall have access to his/her data
Up to 16 years.
Consent by representation.
Judicial representation.
From 16 years on
Health age of majority.
Exceptions:
Voluntary termination of pregnancy.
Techniques of assisted reproduction.
Clinical trials.
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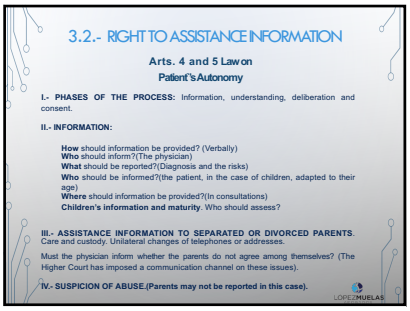
3.2.- RIGHT TO ASSISTANCE INFORMATION
Arts. 4 and 5 Law on Patient`s Autonomy
I.- PHASES OF THE PROCESS: Information, understanding, deliberation and consent.
II.- INFORMATION:
How should information be provided? (Verbally)
Who should inform?(The physician)
What should be reported?(Diagnosis and the risks)
Who should be informed?(the patient, in the case of children, adapted to their age)
Where should information be provided?(In consultations)
Children's information and maturity. Who should assess?
III.- ASSISTANCE INFORMATION TO SEPARATED OR DIVORCED PARENTS.
Care and custody. Unilateral changes of telephones or addresses.
Must the physician inform whether the parents do not agree among themselves? (The Higher Court has imposed a communication channel on these issues).
IV.- SUSPICION OF ABUSE.(Parents may not be reported in this case).
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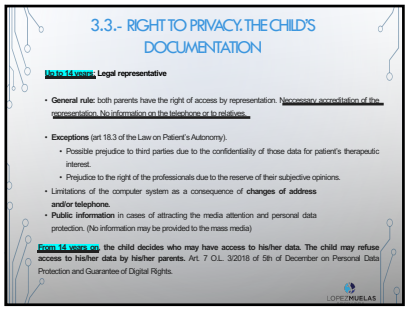
3.3.- RIGHT TO PRIVACY. THE CHILD'S DOCUMENTATION
Up to 14 years. Legal representative
General rule: both parents have the right of access by representation. Necessary accreditation of the representation. No information on the telephone or to relatives.
Exceptions (art 18.3 of the Law on Patient's Autonomy).
Possible prejudice to third parties due to the confidentiality of those data for patient's therapeutic interest.
Prejudice to the right of the professionals due to the reserve of their subjective opinions.
Limitations of the computer system as a consequence of changes of address and/or telephone.
Public information in cases of attracting the media attention and personal data protection. (No information may be provided to the mass media)
From 14 years on, the child decides who may have access to his/her data. The child may refuse access to his/her data by his/her parents. Art. 7 O.L. 3/2018 of 5th of December on Personal Data Protection and Guarantee of Digital Rights.
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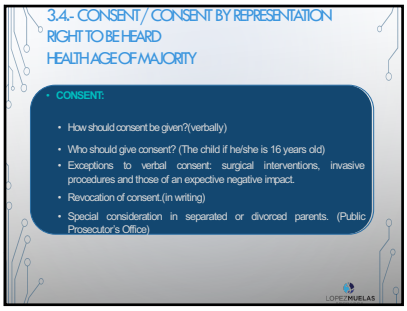
3.4.- CONSENT / CONSENT BY REPRESENTATION
RIGHT TO BE HEARD
HEALTH AGE OF MAJORITY
CONSENT:
How should consent be given?(verbally)
Who should give consent? (The child if he/she is 16 years old)
Exceptions to verbal consent: surgical interventions, invasive procedures and those of an expective negative impact.
Revocation of consent.(in writing)
Special consideration in separated or divorced parents. (Public Prosecutor's Office)
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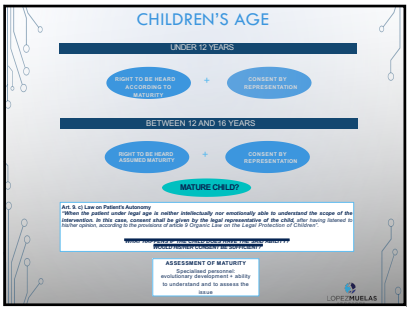
CHILDREN'S AGE
UNDER 12 YEARS
RIGHT TO BE HEARD ACCORDING TO MATURITY
+
CONSENT BY REPRESENTATION
BETWEEN 12 AND 16 YEARS
RIGHT TO BE HEARD ASSUMED MATURITY
+
CONSENT BY REPRESENTATION
MATURE CHILD?
Art. 9. c) Law on Patient's Autonomy
"When the patient under legal age is neither intellectually nor emotionally able to understand the scope of the intervention. In this case, consent shall be given by the legal representative of the child, after having listened to his/her opinion, according to the provisions of article 9 Organic Law on the Legal Protection of Children".
ASSESSMENT OF MATURITY
Specialised personnel: evolutionary development + ability to understand and to assess the issue
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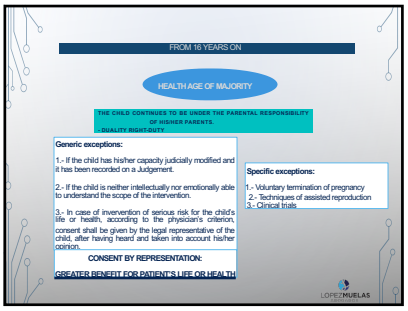
FROM 16 YEARS ON
HEALTH AGE OF MAJORITY
THE CHILD CONTINUES TO BE UNDER THE PARENTAL RESPONSIBILITY OF HIS/HER PARENTS.
- DUALITY RIGHT-DUTY
Generic exceptions:
1.- If the child has his/her capacity judicially modified and it has been recorded on a Judgement.
2.- If the child is neither intellectually nor emotionally able to understand the scope of the intervention.
3.- In case of inervention of serious risk for the child's life or health, according to the physician's criterion, consent shall be given by the legal representative of the child, after having heard and taken into account his/her opinion.
Specific exceptions:
1.- Voluntary termination of pregnancy
2.- Techniques of assisted reproduction
3.- Clinical trials
CONSENT BY REPRESENTATION:
GREATER BENEFIT FOR PATIENT'S LIFE OR HEALTH
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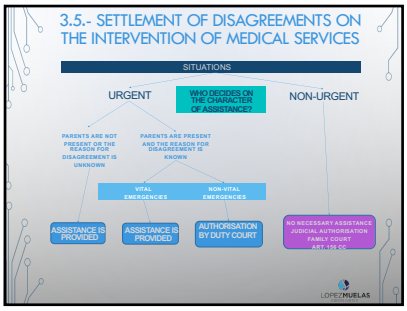
3.5.- SETTLEMENT OF DISAGREEMENTS ON THE INTERVENTION OF MEDICAL SERVICES
SITUATIONS
URGENT
WHO DECIDES ON THE CHARACTER OF ASSISTANCE?
NON-URGENT
PARENTS ARE NOT PRESENT OR THE REASON FOR DISAGREEMENT IS UNKNOWN
PARENTS ARE PRESENT AND THE REASON FOR DISAGREEMENT IS KNOWN
VITAL EMERGENCIES
NON-VITAL EMERGENCIES
ASSISTANCE IS PROVIDED
ASSISTANCE IS PROVIDED
AUTHORISATION BY DUTY COURT
NO NECESSARY ASSISTANCE JUDICIAL AUTHORISATION FAMILY COURT ART.156 CC
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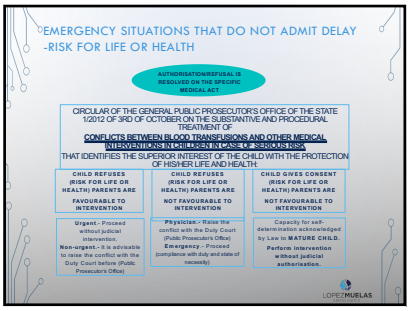
EMERGENCY SITUATIONS THAT DO NOT ADMIT DELAY
-RISK FOR LIFE OR HEALTH
AUTHORISATION/REFUSAL IS RESOLVED ON THE SPECIFIC MEDICAL ACT
CIRCULAR OF THE GENERAL PUBLIC PROSECUTOR'S OFFICE OF THE STATE 1/2012 OF 3RD OF OCTOBER ON THE SUBSTANTIVE AND PROCEDURAL TREATMENT OF
CONFLICTS BETWEEN BLOOD TRANSFUSIONS AND OTHER MEDICAL INTERVENTIONS IN CHILDREN IN CASE OF SERIOUS RISK
THAT IDENTIFIES THE SUPERIOR INTEREST OF THE CHILD WITH THE PROTECTION OF HIS/HER LIFE AND HEALTH:
CHILD REFUSES (RISK FOR LIFE OR HEALTH) PARENTS ARE FAVOURABLE TO INTERVENTION
CHILD REFUSES (RISK FOR LIFE OR HEALTH) PARENTS ARE NOT FAVOURABLE TO INTERVENTION
CHILD GIVES CONSENT (RISK FOR LIFE OR HEALTH) PARENTS ARE NOT FAVOURABLE TO INTERVENTION
Urgent - Proceed without judicial intervention.
Non-urgent.- It is advisable to raise the conflict with the Duty Court before (Public Prosecutor's Office)
Physician.- Raise the conflict with the Duty Court (Public Prosecutor's Office)
Emergency – Proceed (compliance with duty and state of necessity)
Capacity for self-determination acknowledged by Law to MATURE CHILD. Perform intervention without judicial authorisation.
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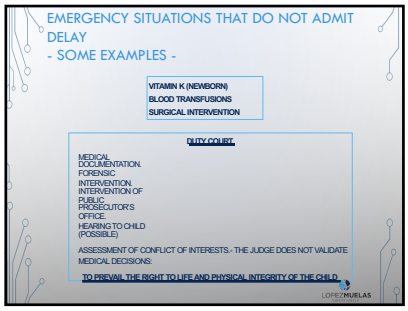
EMERGENCY SITUATIONS THAT DO NOT ADMIT DELAY
- SOME EXAMPLES -
VITAMIN K (NEWBORN)
BLOOD TRANSFUSIONS
SURGICAL INTERVENTION
DUTY COURT
MEDICAL DOCUMENTATION.
FORENSIC INTERVENTION.
INTERVENTION OF PUBLIC PROSECUTOR'S OFFICE.
HEARING TO CHILD (POSSIBLE)
ASSESSMENT OF CONFLICT OF INTERESTS.- THE JUDGE DOES NOT VALIDATE MEDICAL DECISIONS:
TO PREVAIL THE RIGHT TO LIFE AND PHYSICAL INTEGRITY OF THE CHILD.
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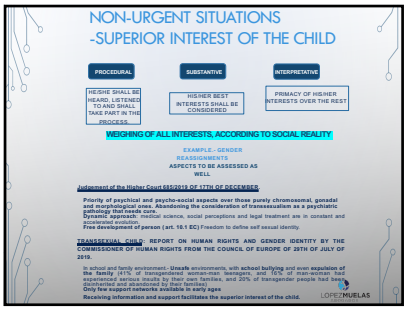
NON-URGENT SITUATIONS
-SUPERIOR INTEREST OF THE CHILD
PROCEDURAL
SUBSTANTIVE
INTERPRETATIVE
HE/SHE SHALL BE HEARD, LISTENED TO AND SHALL TAKE PART IN THE PROCESS
HIS/HER BEST INTERESTS SHALL BE CONSIDERED
PRIMACY OF HIS/HER INTERESTS OVER THE REST
WEIGHING OF ALL INTERESTS, ACCORDING TO SOCIAL REALITY
EXAMPLE.- GENDER REASSIGNMENTS
ASPECTS TO BE ASSESSED AS WELL
Judgement of the Higher Court 695/2019 OF 17TH OF DECEMBER:
Priority of psychical and psycho-social aspects over those purely chromosomal, gonadal and morphological ones. Abandoning the consideration of transexualism as a psychiatric pathology that needs cure.
Free development of person (art. 10.1 EC) Freedom to define self sexual identity.
TRANSSEXUAL CHILD: REPORT ON HUMAN RIGHTS AND GENDER IDENTITY BY THE COMMISSIONER OF HUMAN RIGHTS FROM THE COUNCIL OF EUROPE OF 26TH OF JULY OF 2019.
Receiving information and support facilitates the superior interest of the child.
LOPEZ MUELAS

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NON-URGENT SITUATIONS
SOME FREQUENTCASES
DISAGREEMENT IN CHOOSING THE PROFESSIONAL OR HEALTHCARE CENTRE. Principle of free election by the patient to choose, freely and voluntarily, between two or more assistance alternatives, among several physicians or among healthcare centres. (Art. 3 Law on Patient's Autonomy).
DISAGREEMENT ON THE TREATMENT OR INTERVENTION. DISAGREEMENT IN CASE OF SEVERAL ALTERNATIVES. SECOND OPINION. TREATMENTS OUTSIDE THE REGION OR THE COUNTRY.
DISAGREEMENT BEFORE NON-CONVENTIONAL ALTERNATIVE TREAMENTS OR PSEUDO-THERAPIES (Homeopathy, Reiki, acupuncture)
PETITION BY ONE PARENT OF CHANGE OF PHYSICIAN. Right of the child to receive individual attention always with the same reference professional (European Charter of the Rights of Children in Hospital).
DISAGREEMENT FOR THE PERFORMANCE OF DIAGNOSTIC TESTS.
INTERRUPTIONS OF TREATMENTS BY ONE OF THE PARENTS.
PROFESSIONAL RECOMMENDATION OF INTERRUPTION OF ASSISTANCE. NOT ACCEPTED BY THE PARENTS.
REFUSAL OF THE CHILD TO RECEIVE THE TREATMENT OR TO UNDERGO AN INTERVENTION. MATURITY.
SPECIAL REFERENCE TO EXPERIMENTAL TREATMENTS. TREATMENTS THAT DO NOT GUARANTEE THE CHILD'S IMPROVEMENT.
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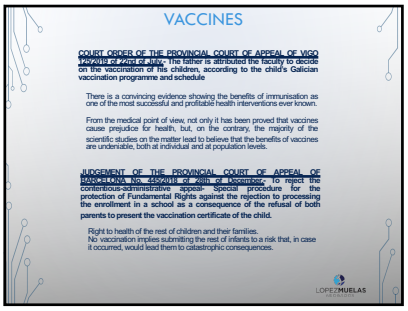
VACCINES
COURT ORDER OF THE PROVINCIAL COURT OF APPEAL OF VIGO (SECTION 2ND) OF 2016. The father is attributed the faculty to decide on the vaccination of his children, according to the child's Galician vaccination programme and schedule
There is a convincing evidence showing the benefits of immunisation as one of the most successful and profitable health interventions ever known.
From the medical point of view, not only it has been proved that vaccines cause prejudice for health, but, on the contrary, the majority of the scientific studies on the matter lead to believe that the benefits of vaccines are undeniable, both at individual and at population levels.
JUDGEMENT OF THE PROVINCIAL COURT OF APPEAL OF BARCELONA NO. 429/2021 OF 29TH OF DECEMBER: to reject the contentious-administrative appeal- Special procedure for the protection of Fundamental Rights against the rejection to processing the enrollment in a school as a consequence of the refusal of both parents to present the vaccination certificate of the child.
Right to health of the rest of children and their families.
No vaccination implies submitting the rest of infants to a risk that, in case it occurred, would lead them to catastrophic consequences.
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REL: June 2, 2020

ALABAMA COURT OF CIVIL APPEALS

OCTOBER TERM, 2019-2020

2190611 and 2190612

Ex parte R.H.

PETITION FOR WRIT OF MANDAMUS

(In re: Marshall County Department of Human Resources

v.

R.H.)

(Marshall Juvenile Court, JU-19-709.01 and JU-19-709.02)

MOORE, Judge.

R.H. ("the mother") has filed a petition for the writ of mandamus requesting that this court direct the Marshall

Juvenile Court ("the juvenile court") to vacate its order entered in case number JU-19-709.01 and in case number JU-19-709.02 granting Emery D. Massey the authority to execute a pediatric palliative and end-of-life ("PPEL") care order regarding K.H. ("the child").[1] We grant the petition.

Background

The child was adjudicated a dependent child by the juvenile court in 2019 in case number JU-19-709.01. The dependency judgment awarded temporary legal custody of the child to the Marshall County Department of Human Resources ("DHR"). DHR subsequently filed a complaint petitioning the juvenile court to terminate the parental rights of the mother; that action was assigned case number JU-19-709.02. The juvenile court appointed attorney Emery D. Massey as the guardian ad litem for the child in both cases.

On April 9, 2020, Massey filed in both cases a "motion for immediate court order to comply with requests of physicians." In that motion, Massey requested that the juvenile court enter an order allowing for the natural death

[1]This court assigned the petition separate case numbers corresponding to the separate actions below, and we have consolidated these mandamus proceedings ex mero motu.

of the child, who is suffering from an incurable illness known as Batten Disease and from an extremely painful condition known as toxic epidermal necrolysis. On April 10, 2020, the juvenile court, without conducting a hearing, granted the motion in case number JU-19-709.01 by entering an order providing, in pertinent part: "[The child]'s physicians may place an order to 'Allow Natural Death' in his file." Upon request by the mother, the juvenile court stayed enforcement of that order and set the matter for a hearing on May 4, 2020.

The mother did not provide this court with a transcript of the hearing. The order being challenged by the mother summarizes the hearing as follows. The parties called two attorneys to testify regarding the question whether the juvenile court had jurisdiction to enter a PPEL care order; one testified that the juvenile court lacked subject-matter jurisdiction and the other testified that the juvenile court had sufficient subject-matter jurisdiction. The juvenile court did not receive into evidence any further live testimony. Massey submitted a letter from the child's primary treating physician detailing the child's terminal condition, the efforts made to treat the child throughout his treatment

at a Birmingham hospital, and the recommendation that a PPEL care order allowing for the natural death of the child be placed in the child's medical records. In addition, the juvenile court accepted the following stipulations of the parties: that four other physicians who were also treating the child would testify similarly to the contents in the letter from the child's primary treating physician and that all four of those physicians agreed that the child should be allowed a natural death for the reasons set out in a letter by one of those physicians; that Massey would testify that it would be in the best interests of the child for a PPEL care order to be placed in the child's medical records; that the mother would testify that she had seen the child approximately 10 days earlier and that the child had said "Mama," which, the mother would assert, showed signs of the child's improvement; that the mother did not want a PPEL care order issued; and that the hospital social workers would testify that the visit the mother described had not occurred.

On May 8, 2020, the juvenile court entered an order ("the challenged order") in both cases, finding that it had jurisdiction over the controversy and authorizing Massey to

act as the representative for the child in executing a PPEL care order. The mother filed a single petition for the writ of mandamus in this court, referencing both cases, on that same date. The juvenile court has stayed enforcement of the challenged order pending this court's ruling on the petition.

Standard of Review

> "'Mandamus is an extraordinary remedy and will be granted only where there is "(1) a clear legal right in the petitioner to the order sought; (2) an imperative duty upon the respondent to perform, accompanied by a refusal to do so; (3) the lack of another adequate remedy; and (4) properly invoked jurisdiction of the court."'
>
> "Ex parte Ocwen Federal Bank, FSB, 872 So. 2d 810, 813 (Ala. 2003)(quoting Ex parte Alfab, Inc., 586 So. 2d 889, 891 (Ala. 1991)). Mandamus will lie to direct a trial court to vacate a void judgment or order. Ex parte Chamblee, 899 So. 2d 244, 249 (Ala. 2004)."

Ex parte Sealy, L.L.C., 904 So. 2d 1230, 1232 (Ala. 2004).

Analysis

I. Jurisdiction of the Juvenile Court

The mother initially argues that the juvenile court lacked jurisdiction to issue the challenged order. As explained above, the matter came before the juvenile court through a motion filed simultaneously in a dependency action

and a termination-of-parental-rights action, over which the juvenile court has statutory jurisdiction. See Ala. Code 1975, § 12-15-114(a) (setting forth the jurisdiction of juvenile courts in dependency actions), and § 12-15-114(b)(2) (setting forth the jurisdiction of juvenile courts in termination-of-parental-rights actions). Although recognizing the general subject-matter jurisdiction of the juvenile court in the underlying proceedings, the mother maintains that the juvenile court did not have the specific authority under the Alabama Juvenile Justice Act ("the AJJA"), Ala. Code 1975, § 12-15-101 et seq., to order the placement of a PPEL care order in the child's medical files. The mother argues further that the Natural Death Act ("the NDA"), Ala. Code 1975, § 22-8A-1 et seq., controls the question of jurisdiction over disputes concerning a child's PPEL care order and that the NDA does not grant such jurisdiction to juvenile courts. We consider the jurisdictional issue as a matter of first impression.

The NDA was enacted in 1981 to authorize physicians to follow the directives of adults regarding the withholding or withdrawal of life-sustaining treatment. See Act No. 81-722, Ala. Acts 1981. In 2018, the legislature passed the Alex

Hoover Act ("the AHA"), Act No. 2018-466, Ala. Acts 2018, which governs the application of the NDA in cases involving a "qualified minor," i.e., a minor "who has been diagnosed as a terminally ill or injured patient and whose diagnosis has been confirmed by at least one additional physician who is not the patient's attending physician." Ala. Code 1975, § 22-8A-3(17).[2] Section 22-8A-15(a), Ala. Code 1975, the operative section of the AHA, provides, in pertinent part:

> "The representative of a qualified minor may execute a directive with respect to the extent of medical treatment, medication, and other interventions available to provide palliative and supportive care to the qualified minor by completing and signing an Order for PPEL Care form. Once completed and signed by the representative, the attending physician may complete and sign the executed directive and enter the directive into the medical record of the qualified minor. Once properly entered and received into the medical record, the directive is deemed a valid Order for PPEL Care ...."

A PPEL care order is

> "[a] directive that, once executed by the representative of a qualified minor and entered into the record by the attending physician of the qualified minor in accordance with Section 22-8A-15, becomes the medical order for all health care providers with respect to the extent of use of

[2]The legislature has amended the NDA several times. However, only the amendments enacted pursuant to the AHA are generally at issue in this case.

> emergency medical equipment and treatment, medication, and any other technological or medical interventions available to provide palliative and supportive care to the qualified minor."

§ 22-8A-3(12).

The challenged order basically adjudicated a dispute among the parties arising under § 22-8A-15(a) by directing Massey to execute and to have placed in the child's medical records a PPEL care order. The mother claims that Ala. Code 1975, § 22-8A-9(e), required the parties to submit that controversy to the Jefferson Circuit Court.

Section 22-8A-9(e) provides, in pertinent part:

> "Nothing in [the NDA] shall impair or supersede the jurisdiction of the circuit court in the county where a patient is undergoing treatment to determine whether life-sustaining treatment or artificially provided nutrition and hydration should be withheld or withdrawn in circumstances not governed by [the NDA] or to determine if the requirements of [the NDA] have been met."

Section 22-8A-9(e) recognizes the jurisdiction of a circuit court in the county where the patient is undergoing treatment to adjudicate a dispute regarding, among other things, whether the requirements of the NDA have been met. Assuming, without deciding, that § 22-8A-9(e) applies in this case, the Jefferson Circuit Court would have jurisdiction to decide the

dispute among the parties regarding whether the requirements of the NDA have been met. However, § 22-8A-9(e) does not provide that the jurisdiction of that court shall be "exclusive."[3]

In Worley v. Jinks, 361 So. 2d 1082 (Ala. Civ. App.), writ quashed, 361 So. 2d 1089 (Ala. 1978), this court considered a similar situation. The Worleys commenced an adoption proceeding in the DeKalb Probate Court. The probate court eventually transferred the adoption proceedings to the

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[3]Section 22-8A-11(j), Ala. Code 1975, provides:

> "If any relative, health care provider who is involved directly in the care of the patient, or other individual who is involved directly in providing care to the patient desires to dispute the authority or the decision of a surrogate to determine whether to provide, withhold, or withdraw medical treatment from a patient, he or she may file an action for declaratory and injunctive relief in the circuit court for the county where the patient is under treatment. A health care provider who is confronted by more than one individual who claims authority to act as surrogate for a patient may file an action for declaratory relief in the circuit court for the county where the patient is under treatment."

Assuming, without deciding, that § 22-8A-11(j) applies to this case, that statute also does not vest "exclusive" jurisdiction in the circuit court to decide surrogacy disputes arising under the NDA.

DeKalb District Court, Juvenile Division, pursuant to Ala. Code 1975, § 12-12-35(a) ("Adoption proceedings, primarily cognizable before the probate court, may be transferred to the district court on motion of a party to the proceeding in probate court."). The Worleys argued that the DeKalb District Court could not exercise jurisdiction over the adoption proceedings because Article VI, § 144, of the Alabama Constitution of 1901 provides, in pertinent part: "There shall be a probate court in each county which shall have general jurisdiction of ... adoptions ...." This court rejected that argument, concluding that the constitutional provision granted probate courts "general," but not "exclusive," jurisdiction over adoption proceedings. 361 So. 2d at 1086. Under Worley, a statute vesting jurisdiction in one court, without specifying that the jurisdiction is "exclusive," does not divest another court of any concurrent jurisdiction that court has been granted over the same subject matter.

The mother maintains that the juvenile courts do not have concurrent jurisdiction over cases arising under the NDA because, she says, the legislature has not granted juvenile courts any statutory authority over PPEL care orders

concerning a dependent child. This argument actually does not concern the general subject-matter jurisdiction of the juvenile court; rather, it pertains to the separate jurisdictional question of the specific authority of the juvenile court to make a particular order in a case within its general subject-matter jurisdiction. "'The power to render the decree or judgment which the court may undertake to make in the particular cause, depends upon the nature and extent of the authority vested in it by law in regard to the subject-matter of the cause.'" Espinosa v. Espinosa Hernandez, 282 So. 3d 1, 12 n.9 (Ala. Civ. App. 2019) (quoting Cooper v. Reynolds, 77 U.S. (10 Wall.) 308, 317 (1870)). We therefore examine the AJJA to determine if the juvenile court had statutory authority to enter the challenged order.

Section 12-15-103(f), Ala. Code 1975, provides that "[t]he juvenile court shall have and exercise equity power," which includes the parens patriae power. See Ex parte Department of Mental Health, 511 So. 2d 181, 185 (Ala. 1987). The parens patriae power is the power of the state, acting as the sovereign parent, to assume custody and control of a dependent child in order to take all actions necessary to

protect the welfare and best interests of the child, see York v. Willingham, 18 Ala. App. 59, 60, 88 So. 218, 218 (1920), which includes, in appropriate circumstances, the power to issue orders relating to PPEL care orders regarding a "qualified minor" under the AHA.

> "The court has an equitable duty to protect the welfare of the children within its jurisdiction. 'The state has a "parens patriae interest in preserving and promoting the welfare of the child...."' (In re Sade C. (1996) 13 Cal. 4th 952, 989 [55 Cal. Rptr. 2d 771, 920 P.2d 716], quoting Santosky v. Kramer (1982) 455 U.S. 745, 766 [102 S.Ct. 1388, 1401, 71 L.Ed.2d 599].) The parens patriae power permits a court with jurisdiction over an individual under a disability to order withdrawal of his or her life-sustaining medical treatment. (In re Quinlan (1976) 70 N.J. 10 [355 A.2d 647, 665–666, 79 A.L.R.3d 205].) As the court explained in In re Quinlan, the first significant case considering the rights of the incompetent with respect to withdrawal of life-sustaining medical treatment, the courts have a nondelegable responsibility to make these decisions as a result of their inherent equitable powers. (Ibid.)"

In re Christopher I., 106 Cal. App. 4th 533, 557, 131 Cal. Rptr. 2d 122, 139 (2003), overruled by implication on other grounds by In re Zeth S., 31 Cal. 4th 396, 73 P.3d 541, 2 Cal. Rptr. 3d 683 (2003); see also Custody of a Minor, 385 Mass. 697, 434 N.E.2d 601 (1982) (holding that the issue whether to withhold medical treatment for a child in the care of a

welfare agency properly falls within the jurisdiction of the juvenile court insofar as that court is a statutory court charged with the care of dependent children).

The legislature has codified the parens patriae power of a juvenile court over a dependent child at § 12-15-314, Ala. Code 1975, which provides, in pertinent part, that,

> "[i]f a child is found to be dependent, the juvenile court may make any of the following orders of disposition to protect the welfare of the child:
>
> "....
>
> "... any other order as the juvenile court in its discretion shall deem to be for the welfare and best interests of the child."

§ 12-15-314(a). In In re K.I., 735 A.2d 448, 453 (D.C. 1999), the Court of Appeals for the District of Columbia considered a District of Columbia statute containing similar language to authorize the Family Division of the Superior Court, the District of Columbia's version of our juvenile court, to enter a do-not-resuscitate order regarding a neglected child.

The neglected child at issue in K.I., K.I., had been neurologically devastated and had become unresponsive. K.I.'s doctors believed that K.I. would inevitably succumb to the

injuries and therefore should not be subjected to painful resuscitation techniques. The District of Columbia's child-welfare agency had been awarded legal custody of K.I., but it excluded itself from making the decision to authorize a do-not-resuscitate order for the child. The mother and the father of K.I. disagreed as to the best course for the child. The controversy eventually went before the Family Division of the Superior Court, which authorized the do-not-resuscitate order. On appeal, the District of Columbia Court of Appeals relied on D.C. Code § 16-2320(a)(5) in determining that the Family Division of the Superior Court had been vested with the parens patriae power to enter the order. Section 16-2320(a)(5) provided the Family Division of the Superior Court the power to "'make such ... disposition [of a dependent child] as is not prohibited by law and as the Division deems to be in the best interests of the child.'"

The facts of K.I. bear a striking resemblance to those in this case in which the juvenile court received evidence indicating that the child suffers from a terminal illness that has blinded the child and has left the child unresponsive to any stimuli other than pain and discomfort. According to the

child's physicians, the child will, as his disease progresses, inevitably go into respiratory distress. The techniques that would be used to resuscitate the child, including chest compressions and placing the child on a ventilator, would themselves be painful and would only prolong the agony of the child. The medical experts involved opined that the child should not undergo those resuscitation techniques but should be allowed to die a natural death. DHR has been awarded legal custody of the child, but it asserts that it lacks the authority to make a decision regarding a PPEL care order for the child. Massey and the mother disagree as to the best course for the child. Like the Family Division of the Superior Court in K.I., the juvenile courts of this state are vested with the parens patriae power to make any order of disposition the court determines to be in the welfare and best interests of a dependent child. See Ala. Code 1975, § 12-15-314(a)(4). Following the reasoning in K.I., that grant of power gives juvenile courts of this state the statutory authority to determine whether a PPEL care order should be executed and placed in the medical file of a dependent child.

Contrary to the mother's contention, the absence of more specific statutory language authorizing juvenile courts to withhold medical treatment from a dependent child does not preclude a juvenile court from exercising its general parens patriae power to adjudicate issues involving a PPEL care order. Section 12-15-115(b)(1)[4] and § 12-15-130(f),[5] Ala. Code 1975, among other things, authorize juvenile courts to determine whether a dependent child requires medical care and to order appropriate and necessary medical care as the

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[4]Section 12-15-115(b)(1) provides:

> "(b) A juvenile court also shall have original jurisdiction in proceedings concerning any child in ... the following instances:
>
> > "(1) The child requires emergency medical treatment in order to preserve his or her life, prevent permanent physical impairment or deformity, or alleviate prolonged agonizing pain."

[5]Section 12-15-130(f) provides, in pertinent part:

> "Upon examination, if it appears that the child is in need of surgery, medical treatment or care, hospital care, or dental care, the juvenile court may cause the child to be treated by a competent physician, surgeon, or dentist or placed in a public hospital or other institution for training or care or in an approved private home, hospital, or institution, which will receive him or her for like purposes. ..."

circumstances require. As other jurisdictions have recognized,

> "the empowerment to determine medical care of a child includes the [c]ourt's power to enter [o]rders terminating those procedures. The mandate of juvenile courts to act in furtherance of the child's welfare provides the authority to make medical care decisions, including the entry of a DNR [Do Not Resuscitate] Order, where the child is in the custody of the state."

In re Truselo, 846 A.2d 256, 266 (Del. Fam. Ct. 2000) (citing In re C.A., 236 Ill. App. 3d 594, 603 N.E.2d 1171, 177 Ill. Dec. 797 (1992), and Custody of a Minor, supra) (footnotes omitted).

The Illinois Juvenile Court Act contained provisions authorizing the juvenile courts of that state to approve medical procedures necessary to safeguard the life or health of a dependent child in the temporary custody of the state, but the Act did not specify that the juvenile courts could also order the withholding or withdrawal of life-sustaining medical treatment. In construing those provisions, the Fourth Division of the Appellate Court of Illinois held:

> "In our view, these provisions support the guardian's general standing to petition the court for authority to consent to a medical judgment made by the ward's treating physicians, even when that judgment is to discontinue life-sustaining medical

treatment. The court is charged with ruling on all matters presented to it regarding the welfare of the child. Moreover, the Juvenile Court Act provides for court review of matters affecting the ward on a regular basis. For example, the guardian is required, periodically, to file reports in the court to ensure that case plans involving the wards are being implemented. See Ill. Rev. Stat. 1991, ch. 37, par. 802-28(2).

"In Illinois, no court of review has addressed whether the Juvenile Court Act provides judges with authority to consent to the placement of a DNR [do not resuscitate] order on a minor ward's medical chart. Other jurisdictions have accepted the authority of a juvenile court to approve such an order, however. In Custody of a Minor (1982), 385 Mass. 697, 434 N.E.2d 601, the child was suffering from a terminal cardiac condition with no known cure and was on a respirator. The hospital sought entry of a DNR order and the Massachusetts trial court found that it would be in the child's best interest not to be resuscitated if he went into cardiac or respiratory arrest. On appeal, the Supreme Judicial Court affirmed, holding that once a child in need of care and protection is committed to the Department of Social Services, the juvenile court has authority to make medical care decisions, including the one in question. See also In re Guardianship of Hamlin (1984), 102 Wash. 2d 810, 689 P.2d 1372 (Court held that court-appointed guardian of ward with mental age of one year had statutory authority to consent to termination of life support systems, even without court intervention, but that any interested party could file petition in court and court would intervene in cases of conflict between hospital, prognosis committee, attending physicians, or guardian); In re L.H.R. (1984), 253 Ga. 439, 321 S.E.2d 716 (Subject to certain safeguards, parents or legal guardian of terminally ill infant or incompetent adult in comatose state could consent to removal of life support without prior judicial

> intervention). See also Annot., Judicial Power To Order Discontinuance of Life-Sustaining Treatment (1986), 48 A.L.R. 4th 67.
>
> "Our juvenile court is charged with implementing its legislative mandate to care for those minors found to be in need of the State's protection. We believe that the court acted properly in hearing the petition and in concluding that C.A.'s guardian could consent to the placement of a DNR order on her charts under certain conditions."

In re C.A., 236 Ill. App. at 605–06, 603 N.E.2d at 1178, 177 Ill. Dec. At 804; see also In re Interest of Tabatha R., 252 Neb. 687, 695, 564 N.W.2d 598, 604, opinion amended on denial of reh'g, 252 Neb. 864, 566 N.W.2d 782 (1997) (holding that juvenile court had authority to decide whether to remove a dependent child from life-support measures and whether to resuscitate child as part of its statutory oversight power of "medical services" provided to dependent children).

In line with those cases, we hold that the provisions of the AJJA governing medical care for dependent children do not limit the juvenile courts' parens patriae power to authorize PPEL care orders. In so holding, we join the other courts that have considered essentially the same jurisdictional question under their respective statutes and have unanimously reached the same conclusion. See, e.g., In re Christopher I.,

supra; Lovato v. District Court In & For Tenth Judicial Dist., 198 Colo. 419, 424, 601 P.2d 1072, 1075 (1979); Hunt v. Division of Family Servs., 146 A.3d 1051, 1064 (Del. 2015); In re Truselo, supra; In re K.I., supra; D.K. v. Commonwealth of Kentucky ex rel. Cabinet for Health & Family Servs., 221 S.W.3d 382 (Ky. Ct. App. 2007); In re C.A., supra; In re P.V.W., 424 So. 2d 1015 (La. 1982); Custody of a Minor, supra; and In re AMB, 248 Mich. App. 144, 640 N.W.2d 262 (2001). Therefore, we reject the mother's contention that the juvenile court lacked jurisdiction to enter the challenged order.

II. Alleged Violations of the NDA

A. Alleged Violation of PPEL Care Order Format

The mother next argues that the challenged order does not comport with the NDA because, she says, the juvenile court did not fill out an "Order for PPEL Care Form" approved by the Alabama Department of Public Health and signed by the representative of the child and the child's attending physician, as required by § 22-8A-15(a). The mother contends that the challenged order also does not comply with the rules and requirements promulgated by the Alabama Department of Public Health, which establish the specific PPEL Care Order

Form and the protocol for filling out and placing the form in the qualified minor's medical file. See Regulation 420-5-19-.03, Ala. Admin. Code (Dep't of Public Health), and Appendix III to Regulation 420-5-19-.03. Based on those alleged violations, the mother contends that the juvenile court did not effectively enter a PPEL care order.

The mother misapprehends the substance of the challenged order. The juvenile court did not purport to make a PPEL care order itself. Instead, the juvenile court appointed Massey as the representative of the child to execute the PPEL care order form for placement in the child's medical file. The challenged order specifically requires Massey to follow the pertinent regulations and to execute and submit the form promulgated by the Alabama Department of Public Health. We find no merit in the mother's argument that the juvenile court improperly circumvented § 22-8A-15(a) and the regulations and procedures for making an effective PPEL care order.

B. Appointment of Guardian Ad Litem As Representative

Finally, we judicially notice that the challenged order appoints Massey, a guardian ad litem, as the representative of

the child for the purpose of executing the PPEL care order. A "representative of a qualified minor" is defined as

> "[a]ny of the following:
>
> > "a. A parent of a qualified minor whose medical decision-making rights have not been restricted.
> >
> > "b. A legal guardian of a qualified minor.
> >
> > "c. A person acting as a parent, as the term is defined in [Ala. Code 1975, §] 30-3B-102, of a qualified minor."

Ala. Code 1975, § 22-8A-3(18) (emphasis added). A guardian ad litem is not a legal guardian. See Ala. Code 1975, § 26-2A-20(7) (defining "guardian" to exclude "one who is merely a guardian ad litem"), and § 12-15-102(17) (defining "legal guardian" to exclude a guardian ad litem). A guardian ad litem also is not a parent or a person acting as a parent under Ala. Code 1975, § 30-3B-102.[6]

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[6]Section 30-3B-102(13), Ala. Code 1975, defines "person acting as a parent" as:

> "A person, other than a parent, who:
>
> > "a. Has physical custody of the child or has had physical custody for a period of six consecutive months, including any temporary absence, within one year immediately before the commencement of a child custody proceeding; and

The members of this court disagree as to whether the mother argued in her mandamus petition that the juvenile court violated § 22-8A-3(18) by improperly appointing a guardian ad litem, Massey, as the child's representative. Regardless, the mother has failed to present any materials showing that she raised this issue in the juvenile-court proceedings. The materials attached to the mandamus petition and the answers do not reference any such argument. None of the parties attached the mother's motion to set aside the April 10 order or the transcript of the May 4 hearing, which would have revealed to this court the exact arguments made before the juvenile court. See Rule 21(a)(1)(F), Ala. R. App. P. (requiring parties to append to the mandamus petition and answer "any order or opinion or parts of the record that would be essential to an understanding of the matters set forth in the petition"). The challenged order itself does not indicate that the parties questioned the capacity of Massey to act as a representative of the child under § 22-8A-3(18) or that they submitted that question to the juvenile court for adjudication.

> "b. Has been awarded legal custody by a court or claims a right to legal custody under the law of this state."

Ordinarily, when a petitioner has not raised a point in support of the issuance of a writ of mandamus before the lower court, that point is not preserved for the appellate court's consideration. See State v. Reynolds, 887 So. 2d 848, 851–52 (Ala. 2004) ("This Court will not ... issue a writ of mandamus commanding a trial judge to rescind an order[] based upon a ground asserted in the petition for the writ of mandamus that was not asserted to the trial judge, regardless of the merits of a petitioner's position in the underlying controversy."). Furthermore, an appellate court cannot consider issues not argued by a petitioner, which are considered to be waived. See Braxton v. Stewart, 539 So. 2d 284, 286 (Ala. Civ. App. 1988) ("An appeals court will consider only those issues properly delineated as such, and no matter will be considered ... unless presented and argued in brief."). However,

> "'[a]n exception to the rule that an unpreserved issue will not be considered on appeal exists where the interests of minors or incompetents are involved. [...] The duty to protect the rights of minors and incompetents has precedence over procedural rules otherwise limiting the scope of review and matters affecting the rights of minors can be considered by this court ex mero motu.'"

Berry v. Berry, 2018 Pa. Super. 276, 197 A.3d 788, 797 (2018) (quoting South Carolina Dep't of Soc. Servs. v. Roe, 371 S.C.

450, 463, 639 S.E.2d 165, 172 (2006)); see also In re J.E.G., 144 Vt. 309, 313, 476 A.2d 130, 133 (1984) (addressing unpreserved issue because of "protective nature" of juvenile hearings).

In Stevens v. Everett, 784 So. 2d 1054, 1055 (Ala. Civ. App. 2000), overruled on other grounds by Ex parte Fann, 810 So. 2d 631 (Ala. 2001), this court recognized that exception by stating:

> "Although [Becky Stevens] did not specifically raise the [Alabama Custody and Domestic or Family Abuse Act] in the trial court or on appeal, and although Judge Robertson is correct in stating that this court generally does not review on appeal arguments not raised either in the trial court or in the appellant's brief, a case involving child custody is not the 'general' case. Alabama courts have historically held that when a trial 'court has acquired jurisdiction of a child as to the child's custody and control, the child becomes a ward of the court and the parties to the suit are of secondary importance.' Thorne v. Thorne, 344 So. 2d 165, 168 (Ala. Civ. App. 1977) (citation omitted). In addition, our supreme court has held that '[t]he question of the custody of infant children is not an adversary proceeding between parents in the eyes of the law, but is a matter within the peculiar discretion of the [trial court] as to the welfare of wards of the court.' Stephens v. Stephens, 253 Ala. 315, 319-20, 45 So. 2d 153, 157 (1950)."

Although in Ex parte Fann, 810 So. 2d at 635, our supreme court criticized Stevens, the court did not overrule that part of this court's decision recognizing that the interests of minors may in some cases justify addressing an issue not otherwise preserved for appellate review.[7] In Pritchett v. Dixon, 222 Ala. 597, 600, 133 So. 283, 285 (1931), Doss v. Terry, 256 Ala. 218, 218, 54 So. 2d 451, 452 (1951), and Citizens Walgreen Drug Agency, Inc. v. Gulf Insurance Co., 282 Ala. 648, 213 So. 2d 814 (1968), the supreme court itself held that it could, ex mero motu, notice and correct an irregularity in the proceedings involving the failure to appoint a guardian ad litem for a minor child.

In this case, the juvenile court committed an indisputable error of law in appointing Massey as the representative of the child because Massey is not within the

[7]In Ex parte Fann, our supreme court did not reject the entirety of the main opinion in Stevens. The supreme court criticized this court only for acting sua sponte to reverse a judgment for a purported error that the court determined was not error at all, namely, the omission of an express finding regarding the impact of domestic violence in a child-custody case. 810 So. 2d at 635. The supreme court did not express any opinion in Ex parte Fann that this court could never raise an issue sua sponte in order to correct an actual legal error harming the best interests and welfare of a child.

class of persons eligible to act as a representative for a qualified minor under § 22-8A-3(18). That error has far more profound implications than a mere irregularity in the proceedings. The challenged order allows Massey to execute a PPEL care order designed to withhold life-sustaining treatment from the child although Massey does not have any custodial power over the child. That error directly impacts the fundamental right of the child to life. See United States Constitution, amend. V ("No person shall be ... deprived of life ... without due process of law ...."), and amend. XIV, § 1 ("... nor shall any State deprive any person of life ... without due process of law ....). The child lacks any capacity, legal or actual, to raise this issue on his own. His fundamental rights should not be disregarded based on the failure of the mother to comply with technical procedural rules for preserving issues for mandamus review. To prevent an injustice of such magnitude, this court exercises its limited discretion to correct the error sua sponte.

We understand that Massey and the juvenile court were attempting to provide relief that they deemed to be in the best interest of the child in dire circumstances, but the AHA

controls the manner in which a PPEL care order may be effected. The AHA mandates that only a "representative" of a qualified minor may execute a PPEL care order, Ala. Code 1975, § 22-8A-15(a), and restricts the class of persons who may be appointed a representative of a qualified minor. Ala. Code 1975, § 22-8A-3(18). The juvenile court was required to adhere to those specific statutory requirements. Because the juvenile court deviated from the AHA and NDA by appointing Massey as the representative of the child and authorizing Massey to execute a PPEL care order for the child, the challenged order is due to be vacated.

III. Conclusion

Although the mother is not entitled to the relief she seeks based on the alleged lack of jurisdiction of the juvenile court to enter the challenged order and on the juvenile court's alleged error in failing to follow the regulations and procedures governing PPEL care orders, we nonetheless grant the petition on the basis that the juvenile court erred in appointing Massey as the representative of the child and authorizing Massey to execute a PPEL care order for

the child, and we order the juvenile court to vacate the challenged order for that reason.

2190611 -- PETITION GRANTED; WRIT ISSUED.

2190612 -- PETITION GRANTED; WRIT ISSUED.

Thompson, P.J., and Donaldson, J., concur.

Hanson, J., concurs in part and concurs in the result, with writing.

Edwards, J., concurs in the result, with writing.

HANSON, Judge, concurring in part and concurring in the result.

I concur in the main opinion with one limited exception. I do not agree that Stevens v. Everett, 784 So. 2d 1054 (Ala. Civ. App. 2000), is in any way authoritative as to the question whether an appellate court considering a petition for a writ of mandamus may properly reach a ground that was not first asserted in the tribunal to which the writ is to be directed. Our supreme court, in Ex parte Fann, 810 So. 2d 631 (Ala. 2001), overruled Stevens and quoted with approval Presiding Judge Robertson's dissent criticizing the fundamental flaw of the main opinion in that case: undertaking "'a sua sponte search for error [in violation of] the fundamental precepts of appellate procedure.'" 810 So. 2d at 635 (quoting Stevens, 784 So. 2d at 1056 (Robertson, P.J., dissenting)). Because the main opinion in Stevens was rejected 19 years ago in Ex parte Fann, I do not believe it should be now invoked in order to reach "plain error" that was not raised in the juvenile court, and I thus do not join Part

II(B) of the main opinion (although I have no quarrel with that opinion's reading of Ala. Code 1975, § 22-8A-3(18)).[8]

[8]I do not express any opinion regarding the potential availability of surrogacy procedures set forth in Ala. Code 1975, § 22-8A-11.

EDWARDS, Judge, concurring in the result.

I disagree with much of the analysis in the main opinion. Nevertheless, I concur in the result.

Emery D. Massey, the guardian ad litem for K.H. ("the child"), sought and obtained two orders from the Marshall Juvenile Court ("the juvenile court") -- the April 10, 2020, order and the May 8, 2020, order -- that authorized the implementation of orders to withhold life-sustaining treatment from the child without obtaining the consent of R.H. ("the mother"). See Ala. Code 1975, § 22-8A-3(10) (defining "life-sustaining treatment" as including "assisted ventilation [and] cardiopulmonary resuscitation").[9] Massey sought those orders

[9]Based on the letter submitted to the juvenile court from Dr. Lauren Nassetta, the child's physicians do not want to resuscitate the child when his respiratory system eventually fails; there is no issue concerning whether palliative care should be administered or whether nutrition and hydration or life-sustaining treatment should be withdrawn. Dr. Nassetta's letter states:

> "[W]e know that [the child's] respiratory system will eventually fail. An 'Allow Natural Death' order will prevent him from having to receive painful chest compressions and be [placed] on mechanical ventilation machine[, from which he had developed severe complications in the past]. ... [W]e will continue the antibiotics that are treating his current infection and start new antibiotics if he needs them in the future. We will also continue

purportedly under the authority of certain provisions of the Natural Death Act ("the NDA"), Ala. Code 1975, § 22-8A-1 et seq., and at the request of the child's physicians, who were "asking those who are legally able to make decisions for [the child] to allow his physicians to place an order to 'Allow Natural Death'" in the child's medical file.

In the May 2020 order, the juvenile court expressly authorized the use of an "order for pediatric palliative and end of life care" ("a PPEL care order"), as defined in Ala. Code 1975, § 22-8A-3(12), to facilitate the result sought by Massey. See Ala. Code 1975, § 22-8A-15.[10] The May 2020 order stated that Massey

> "and treating physicians shall fill in the appropriate form provided for [a PPEL care] order.

> nutrition through his IV and the therapies that help him stretch and prevent painful contractures of his joints."

[10]The parties apparently agree that a PPEL care order may include the same subject matter as a "do not attempt resuscitation (DNAR) order," as defined in § 22-8A-3(7), and provisions for withholding or withdrawing "artificially provided nutrition and hydration," as defined in § 22-8A-3(2), and "life-sustaining treatment," as defined in § 22-8A-3(10). Because the specific contours of a PPEL care order are not at issue in the present petition for the writ of mandamus, I will assume that the parties' position is correct.

> "This Order and forms once applied shall be placed in the child's medical file and will go with the child at any hospital, medical facility, nursing home, hospice, or doctor where the child may be located and shall govern an end of life situation."

The NDA clearly provides that a PPEL care order may be executed by

> "a. A parent of a qualified minor whose medical decision-making rights have not been restricted.
>
> "b. A legal guardian of a qualified minor.
>
> "c. A person acting as a parent, as the term is defined in [Ala. Code 1975, §] 30-3B-102, of a qualified minor."

§ 22-8A-3(18) (defining "representative of a qualified minor" for purposes of a PPEL care order); see also § 22-8A-15(a) ("The representative of a qualified minor may execute a directive with respect to the extent of medical treatment, medication, and other interventions available to provide palliative and supportive care to the qualified minor by completing and signing an Order for PPEL Care form.").[11] The

[11]In appropriate circumstances in dependency proceedings and termination-of-parental-rights proceedings, a juvenile court has the power to appoint a person who might qualify as "[a] person acting as a parent, as the term is defined in [Ala. Code 1975, §] 30-3B-102[(13)] ...." § 22-8A-3(18)c.; see also Ala. Code 1975, § 30-3B-102(13) (defining a "person acting as a parent" as "[a] person, [which includes an individual and a governmental agency,] other than a parent, who: ... [h]as physical custody of the child ... and ... [h]as

NDA makes no provision for a PPEL care order to be executed by a guardian ad litem. In other words, the May 2020 order does not reflect an authorization to execute a PPEL care order that complies with the NDA; the May 2020 order reflects an authorization to execute a PPEL care order that would allow the child's physicians to withhold life-sustaining treatment

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been awarded legal custody by a court or claims a right to legal custody under the law of this state"). In the May 2020 order, however, the juvenile court determined that the Marshall County Department of Human Resources was not "a person acting as a parent," and neither the mother nor the Marshall County Department of Human Resources has contested that determination.

Also, in appropriate circumstances in a dependency proceeding or termination-of-parental-rights proceeding, a juvenile court might restrict a parent's "medical decision-making rights," as that term is used in § 22-8A-3(18)a. However, such a decision would merely restrict the exercise of particular parental rights, not automatically result in the appointment of another person with those rights, and whether such a restriction would be proper in the present case and what procedures must be followed in order to properly impose such a restriction are not issues that are before us. The juvenile court cannot appoint a legal guardian as described in § 22-8A-3(18)b.; appointment of a legal guardian is a matter that is within the exclusive jurisdiction of the probate court, see Ala. Code 1975, § 26-2A-31(c).

from the child without complying with the NDA.[12] The April 2020 order likewise was not in compliance with the NDA.

Regarding subject-matter jurisdiction, the NDA specifically states that the circuit court in the county where a patient is receiving treatment has jurisdiction over cases "to determine if the requirements of [the NDA] have been met" and "to determine whether life-sustaining treatment or artificially provided nutrition and hydration should be withheld or withdrawn in circumstances not governed by [the

[12]The May 2020 order potentially places the child's physicians at legal risk. It is compliance with the NDA that provides protection from civil liability, criminal prosecution, and ethical sanction when certain decisions are made that may have the secondary result (presumably not directly intended) of causing an innocent parties' death. See Ala. Code 1975, § 22-8A-7(d) ("Any health care provider or health care facility acting within the applicable standard of care who is signing, executing, ordering, or attempting to follow the directives of an Order for PPEL Care in compliance with [the NDA] shall not be subject to criminal or civil liability and shall not be found to have committed an act of unprofessional conduct."); see also Ala. Code 1975, § 22-8A-10. The guardian ad litem did not represent the child's physicians, although he purportedly sought the PPEL care order on their behalf. Under the circumstances, it is at least arguable that the April 2020 and May 2020 orders should be vacated on the ground that the physicians' interests "may, as a practical matter," be impeded by Massey's obtaining an order that was not in compliance with the NDA but purportedly authorized the physicians to withhold life-sustaining treatment. See Rule 19(a)(ii), Ala. R. Civ. P.

NDA]." Ala. Code 1975, § 22-8A-9(e). The present circumstance, authorizing a person to execute an order to withhold life-sustaining treatment without complying with the requirements of the NDA, qualifies as a circumstance "not governed by [the NDA]." Thus, jurisdictional-conflict issues aside, arguably the Jefferson Circuit Court (the circuit court with jurisdiction in the county where the child is hospitalized) would have jurisdiction to consider whether the law permitted a PPEL care order to be executed by a person other than a representative of a qualified minor. Nevertheless, the fact that the Jefferson Circuit Court might have jurisdiction to consider the type of case at issue does not mean that the juvenile court might not also have jurisdiction over that type of case. The NDA does not expressly state that the circuit court has exclusive jurisdiction over such cases.

The main opinion concludes that the juvenile court has subject-matter jurisdiction over the type of case at issue and that the mother otherwise has made an inadequate argument to support granting her petition based on the juvenile court's lack of jurisdiction. Regarding the former, I do not agree

that the jurisdiction of the juvenile court is as broad as the main opinion suggests, and I see no need for the dicta regarding the purportedly expansive nature of the juvenile court's equity jurisdiction regarding health-care decisions impacting the death of a child.[13] The juvenile court has subject-matter jurisdiction over the underlying dependency proceeding and termination-of-parental-rights proceeding, and Massey's motion concerns issues within that jurisdiction, namely, (1) whether certain unquestionably medical interventions (resuscitation measures) should be administered to a dependent child when those interventions might briefly prolong a child's life but also will purportedly cause substantial harm to the child and (2) who is authorized, by law, to make the decision regarding whether to administer such interventions to the dependent child.

Regarding the mother's argument, the issues before us involve matters of first impression under the NDA, and the pertinent facts are undisputed and are straightforward. The mother has focused primarily on the issue of the juvenile

[13]Indeed, I question whether the duty to provide medical care that is in the best interest of a child is equivalent to the power to withhold, withdraw, or terminate life-sustaining medical care for that child.

court's purported lack of subject-matter jurisdiction, but even within that issue she has emphasized concern about the basis on which a juvenile court could "enter an order and or disposition 'allowing natural death' for a child in [the Department of Human Resources'] custody ... over the objection of a mother whose rights have not been terminated." (Emphasis added.) See Espinosa v. Espinosa Hernandez, 282 So. 3d 1, 12 n.9 (Ala. Civ. App. 2019) (noting the ambiguity of the concept of jurisdiction, including regarding those questions of authority that may be "implicit in the concept of subject-matter jurisdiction [and those that are] beyond 'the nature and extent of authority vested in [a particular court] by law' ...." Quoting Cooper v. Reynolds, 77 U.S. (10 Wall.) 308, 317 (1870).). Also, the mother has posited the issue whether, "even if the juvenile court has jurisdiction, ... the order allowing natural death comports with [the NDA]." And the mother has correctly noted that "[t]he issue of whether the [juvenile] court entered an order in compliance with [the NDA] is a matter of law and is reviewed de novo."

The Marshall County Department of Human Resources has filed an answer in support of the mother's petition for the

writ of mandamus and likewise has questioned the juvenile court's authority to issue an order granting Massey's request over the objection of the mother. DHR argues that it has been awarded only "temporary legal custody" of the child,[14] that the mother's parental rights have not been terminated, that the mother had the "right to give or withhold consent to medical treatment for her child ... and to authorize pediatric palliative and end of life care ... pursuant to Ala. Code [1975,] § 22-8A-3(12)," and that "[the mother] has not authorized medical personnel caring for [the child] to proceed with the 'allow death naturally' protocol." Also, Massey has stated in his answer to the mother's petition for a writ of mandamus that the mother "argues that the [NDA] should apply and was not properly followed." Massey takes the position not only that the juvenile court properly applied the NDA but also that he, as a guardian ad litem, had the legal right and legal responsibility to make decisions regarding the best interest of the child and that the NDA does not "impair or supersede" his rights and responsibilities.

[14]DHR sought and obtained from the juvenile court an order to approve a tracheostomy for the child in October 2019 and two orders approving separate surgeries for the child in January 2020.

Unlike the main opinion, I do not believe that this court must adopt plain-error review in order to address the mother's argument, nor do I believe that the mother failed to raise the issue whether the juvenile court's jurisdiction extended so far as to allow that court to violate the law governing a PPEL care order -- or to judicially legislate into existence a fourth category of representative of a qualified minor -- by appointing Massey to execute such an order when the mother refused to consent to such an order before the juvenile court and DHR took the position that it had no statutory authority to execute the order. In my opinion, the mother adequately raised the issue whether the NDA authorized the juvenile court to appoint Massey to execute a PPEL care order under the circumstances presented to that court, and this court has the discretion to address that issue based on the petition, answers, and supporting materials before us.[15] There simply

[15]In the present case, the decision whether to execute a PPEL care order for this child has arisen in a manner that likely precludes appellate review of the decision because, at this time, the mother's rights to the child have not yet been terminated and no final judgment exists. Thus, I am even more inclined to exercise our discretion to seek to resolve this issue on the merits as opposed to denying the petition based on technical infirmities as to which reasonable jurists might differ.

is no basis in the NDA for a guardian ad litem to exercise such authority, much less over the objection of a parent whose parental rights have not been terminated, and, given the condition of the child and the likelihood that the child will die when the guardian ad litem's PPEL care order is followed, it is likewise clear that the mother will have no viable remedy by way of appealing from a final judgment in the dependency proceeding or the termination-of-parental rights proceeding. Accordingly, I conclude that the mother has a clear legal right to a writ of mandamus directing the juvenile court to vacate the April 2020 order and May 2020 order. See Ex parte Integon Corp., 672 So. 2d 497, 499 (Ala. 1995).