IN THE UNITED STATES DISTRICT COURT
DISTRICT OF COLUMBIA

VICTOR M. BOOTH, *et al*,	)	
Plaintiffs,	)	
vs.	)	**Civil Action No. 21-01857 (TNM)**
MURIEL BOWSER, *et al*,	)	
Defendants.	)	

PLAINTIFFS' CONSOLIDATED MEMORANDUM OF POINTS AND AUTHORITIES OPPOSING DEFENDANTS' MOTION TO DISMISS AND SUPPORTING PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

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INTRODUCTION

The Defendants present the Minor Consent Act as a passive mechanism, which "simply acknowledges the longstanding ability of mature minors to determine for themselves whether or not to seek certain medical care." Defendants' Memorandum, Dock. 16 at 26 ("Def. Mem."). Whether these minors choose to discuss the matter with their parents is their own affair. *Id.* at 30.

This mischaracterization of the Act may be more palatable, but it is not accurate. Try as they might to clothe the Act in a veneer of passivity, the defendants cannot change the fact that the *primary* purpose of the Act, from the beginning, was to secretly subvert parents' lawful exemptions. The Committee on Health's report, cited by defendants, makes this plain: the Act was "needed" to grant minors the right to consent to vaccines "despite their parents refusal of consent or objection to immunization." Council of the District of Columbia, Committee on Health, Report on Bill 23-0171 at 2, *https://tinyurl.com/4cuty3af* (accessed Aug. 19, 2021).

This mischaracterization colors every facet of the defendants' argument, but especially their view of standing. Defendants characterize the "injury" as a "many-linked chain[] of what-ifs," ending with the plaintiffs' children "possibly elect[ing] to receive a vaccine." Def. Mem. 8-9. *Actually* administering a vaccine to a child, in secret, when the District *knows* that doing so will violate a parent's lawful exemption, is undoubtedly an injury. But that injury would be in *addition* to the injuries already inflicted: the loss of a lawful exemption, interference with their fundamental right as parents to direct the medical care of their children, and the immense and growing pressure on the children in the crucible of their public schools.

Critical to all of this are the plaintiffs' lawful religious exemptions, which the defendants all but ignore. The District offers parents the lawful authority to exempt their children from vaccine requirements on religious grounds with one hand, then surreptitiously strips them of that lawful authority with the other. The loss of this statutory right, and the resulting interference in

the parent-child relationship, are themselves injuries. As the Ninth Circuit Court of Appeals recognized, "The government's interest in the welfare of children embraces not only protecting children from physical abuse, but also protecting *children's interest* . . . in the *lawfully exercised authority of their parents*." *Calabretta v. Floyd*, 189 F.3d 808, 820 (9th Cir. 1999) (emphasis added). The plaintiff parents have exercised lawful authority to exempt their children from childhood vaccines. They should be confident that when they make lawful choices on behalf of their children, the government will not only respect those choices but will also protect their *children's interests* in the lawfully exercised authority of their parents.

The Minor Consent Act does the opposite. Instead of respecting parents' lawful exemptions, it bypasses them in secret. Meanwhile, the District has ratcheted up the pressure on children whose parents have opted out of vaccines. Both DCPS and the Department of Health have publicly and vocally encouraged children to be vaccinated. So have the plaintiffs' local schools. And since the complaint was filed, the defendants have opened additional vaccine clinics in schools, including at least one of plaintiffs' schools.

Meanwhile, the plaintiffs' children are left to navigate these competing forces—their parents who have claimed a lawful exemption, and their school staff, teachers, and peers pressuring them to be vaccinated—in the unique setting of public schools. As the Supreme Court recognized in *Lee v. Wiseman*, the official actions of school officials (in that case, an official invitation to pray at a graduation) can have unforeseen, substantial, and even coercive effects on the consciences of students. "The *undeniable fact* is that the school district's supervision and control of a high school graduation ceremony places public pressure, as well as peer pressure, on attending students to stand as a group or, at least, maintain respectful silence during the Invocation and Benediction. This pressure, though subtle and indirect, can be *as real as any*

overt compulsion." *Lee v. Wiseman*, 505 U.S. 577, 592-593 (1992) (emphasis added). An adult may be able to distinguish between "coercion" and "encouragement," but "for the dissenter of high school age, who has a reasonable perception that she is being forced by the State to pray in a manner her conscience will not allow, *the injury is no less real*." *Id.* (emphasis added).

While the plaintiffs do not advance an establishment clause claim, *Wiseman'*s observations about the experiences of students in public schools captures exactly the pressures that the plaintiffs' children have experienced, and will continue to experience as long as the Act remains in effect. This increasingly coercive environment—combined with the parents' ongoing loss of their right to lawfully exempt their children—are injuries that have occurred; are ongoing; and will only be exacerbated as the defendants continue their efforts to have all school-age children vaccinated, and open school vaccine clinics to accomplish that goal. These are real injuries, they constitute violations of federal law, and they are redressable by this Court.

The defendants' motion to dismiss should be rejected, and the Act should be enjoined.

ARGUMENT

I. The Plaintiffs have standing.

"The law's concept of the family rests on the presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions." *Parham v. J.R.*, 442 U.S. 584, 602 (1979). The defendants concede this, but argue that "plaintiffs description of [this right] is overbroad," Def. Mem. 26, and that "plaintiffs cannot show that *any* injury is certainly impending." *Id.* at 8 (emphasis in original). This is incorrect.

A. The Minor Consent Act has injured and continues to injure the plaintiffs.

The Minor Consent Act has already injured the plaintiffs in at least two respects: it has secretly subverted the parents' lawful exemptions, and in doing so has exerted a pressure on the children "as real [to them] as any overt compulsion" would be. *Wiseman*, 505 U.S. at 592-593.

1. The Minor Consent Act has and continues to deprive parents of their lawful authority to direct the medical care of their children.

"[T]he loss of constitutional freedoms, 'for even minimal periods of time, unquestionably constitutes irreparable injury.'" Plaintiffs' Statement of Points and Authorities, Dock. 2-3 at 32 ("Pl. Mem."), *quoting Mills v. District of Columbia*, 571 F.3d 1304, 1312 (D.C. Cir. 2009). "[T]he same is true of rights afforded under the RFRA." Pl. Mem. 32, *quoting Capitol Hill Baptist*, 496 F. Supp. 3d 284, 301 (D.D.C. 2020).

The Act thwarts the lawful exemptions of parents at several turns, and does so easily. Section 2 creates a new category of medical decisions over which the child's parents can exercise absolutely no control, or even direction. If an eleven year old "consents" to receive a vaccine recommended by the ACIP, he or she can receive it—even if the child's parent has expressly *refused* to consent. Nothing more is required; that is the end of the matter.

This is a sea-change. "[T]he interest of parents in the care, custody, and control of their children" is "perhaps the oldest of the fundamental liberty interests recognized by this Court." *Troxel v. Granville*, 530 U.S. 57, 65 (2000). And it includes a "right to make decisions about the child's medical care." *P.J. v. Wagner*, 603 F.3d 1182, 1197 (10th Cir. 2010). As the Second Circuit has held, "the constitutional liberty interest of parents in the 'care, custody, and management of their child,' though not 'beyond limitation,' includes a *significant* decision-making role concerning medical procedures sought to be undertaken by state authority upon their children." *Van Emrik v. Chemung County Dep't of Social Services*, 911 F.2d 863, 867 (2d Cir. 1990) (emphasis added).

This "significant decision-making role" is entirely absent in the Minor Consent Act, but it is a prominent feature in almost all District law regarding medical care in schools. Students are permitted to self-administer medication only if the student's "responsible person"—such as a

parent—"has submitted a valid medication action plan to the school" allowing for self-administration. D.C. CODE § 38-651.02(a)(1); *see* D.C. CODE § 38-651.01(4) (defining "responsible person," "in the case of a student under 18 years of age," to be "a parent . . . or other adult charged with the ongoing care and supervision of the student"). There are exceptions, of course, but only in "emergency circumstances." *See* D.C. CODE § 38-651.05(b)(1) (use of "epinephrine auto-injectors in emergency circumstances). And even in emergencies, schools are required to tell the child's parents that medications were administered "as soon as practicable."[1] Significant parental direction over a child's medical needs is the *norm*, not the exception.

The defendants rejoin that the District has a history of "permitting minors 'of any age' to consent to certain medical procedures." Def. Mem. 3, *citing*, *inter alia*, 22-B DCMR §§ 600, 600.7. Setting aside the fact that the District's laws cannot override constitutional protections, *see* U.S. CONST. Art. VI, cl. 2, the defendants overstate these regulations, while understating how far the Act departs from them.

As an initial matter, none of the provisions of 22-B DCMR § 600, *et seq.*, allow children "of any age" to consent to medical treatment in the absence of an emergency. The default rule, established in § 600.1, is that persons who are "eighteen (18) years of age or older may consent to the provision of services for himself or herself." There are a few exceptions, but none are as broad as the Minor Consent Act. One is limited to minors who are "seventeen (17) years of age," and does not involve "medical treatment." *See* § 600.2 (voluntary blood donations). Two more involve reproductive health, where minor women have heightened constitutional protections. *See*

[1] *See* D.C. Code § 38-651.05(d)(4) ("*As soon as practicable* following the administration of medication pursuant to this section, the public school *shall* inform the student's responsible person that the medication was administered") (emphasis added); *see also* D.C. CODE § 38-651.10 (in cases where a student who self-administers medication misuses the medication, "[t]he school shall promptly notify the responsible person of any disciplinary action imposed").

§ 600.7(a) ("pregnancy or its lawful termination"); § 600.7(c) ("prevention, diagnosis, or treatment" for a "sexually transmitted disease"). The others all involve emergency circumstances, where "the delay that would result from attempting to obtain parental consent would substantially increase the risk to the minor's life, health, mental health, or welfare." § 600.4.[2] Those exceptions are entirely consistent with the well-recognized—and carefully limited—doctrine that "[i]n an *emergency medical situation*, the County may proceed with medically necessary procedures without parental notice or consent to protect the child's health." *Mann v. Cty. of San Diego*, 907 F.3d 1154, 1163 (9th Cir. 2018). At the other end of the spectrum, there are situations where "self-consent of minors shall not apply." *See* § 600.8 (sterilization); *see also* D.C. CODE § 38-651.01, *et. seq*. (student medications).

The lone outlier is § 600.9—the Minor Consent Act. It applies to "any" "minors who want to receive vaccines and who are capable of providing informed consent themselves," "regardless of their parents' fitness or beliefs," and regardless of whether they "could not previously obtain such vaccines because of their parents' objections or simply because of logistical difficulties." Def. Mem. 33. It is not limited to emergency situations, *see* Pl. Mem. 21-24, 38-39, and the decision to be vaccinated does not enjoy heightened constitutional protection.

The latter point distinguishes abortion cases like *Planned Parenthood of Central Miss. v. Danforth*, 428 U.S. 52 (1976), which the defendants cite for the proposition that "Plaintiffs' asserted broad right to control their children's medical care has been squarely rejected by the Supreme Court." Def. Mem. 27. It is true that *Danforth* struck down the portion of Missouri's abortion statute that required "the written consent of a parent or person *in loco parentis*" of the

[2] *See also* § 600.5 (permitting "emergency service of first aid" when "the only alternative to probable death or serious physical or mental damage"); § 600.5(b) (substance abuse).

woman was under the age of 18. *Danforth*, 428 U.S. at 72. But the Court did *not* reject the time-honored role that parents have over their children's medical care. Instead, *Danforth* applied an interest-balancing approach. And the interest-balancing that occurs in an abortion case is unique, because where conflicts occur in those cases, they pit the fundamental rights of parents against the equally-fundamental right of the woman over her pregnancy. Since neither right is absolute, they have to be weighed against each other, and that weighing occurs within the factual context of each case. *See Danforth*, 48 U.S. at 60-61 (noting that *Roe v. Wade* "emphatically rejected . . . the proferred argument' that the woman's right is absolute . . ."), *id.* at 75 (noting that "[m]inors, as well as adults, are protected by the constitution and possess constitutional rights").

The lesson is simple: where that fundamental conflict arises, those competing interests must be balanced against each other. *Anspach v. City of Philadelphia*, also heavily relied on by defendants, involved the same weighing of competing rights. *See Anspach v. City of Philadelphia*, 503 F.3d 256, 261 (3d Cir. 2007) ("parental interests must be balanced with the child's right to privacy, which is also protected under the Due Process Clause"). And of course, interest-balancing is a prominent feature in *Danforth*'s successor. *See Planned Parenthood v. Casey*, 505 U.S. 833, 874 (1992) (holding that because "not every law which makes a right more difficult to exercise is, *ipso facto*, an infringement of that right," courts should determine whether "state regulation imposes an undue burden on a woman's ability to make this decision").

Here, however, there is no conflict between competing fundamental rights. *Danforth* did not "reject" any parent's "broad right to direct their children's medical care." Def. Mem. 27. Rather, it held that Missouri's statute failed the interest-balancing test by infringing on the fundamental right of women in a specific, particular way—imposing "a blanket provision" that

gave parents "an absolute, and possibly arbitrary, veto," "regardless of the reason for withholding the consent." *Id.* at 74.

Ironically, the Minor Consent Act falls prey to the same design flaws that doomed the statute in *Danforth*: it, too, eschews any sort of interest balancing. As much as the defendants protest now, one of the Act's express purposes was "to grant minors, who are concerned for their health and safety, protection and the right to consent to a vaccination recommended by US Advisory Committee on Immunization Practices (ACIP) and a trained physician, *despite their parents refusal of consent or objection to immunization*." Health Committee Report at 2 (emphasis added). To accomplish that purpose, the District enacted a "blanket provision" that gives "an absolute, and possibly arbitrary, veto," "regardless of the reason for withholding the consent." *Danforth*, 428 U.S. at 74. Here, the *parent* is vetoed; but that is the only difference.

Nor does the Minor Consent Act involve a decision where children stand on equal footing with their parents, or where the interests of parents are arguably weaker. The Act does not cover abortion-related procedures. Nor is it limited to circumstances where the life or health of the child is at risk. On the contrary, if the person administering a vaccine believes the child is "mature," and can provide "informed consent," the vaccine can be administered, full-stop. Even if the parent is fit. Even if the parent has claimed a lawful exemption. Even if the provider *knows* the parents have a lawful exemption. None of that factors into the equation. There is no interest balancing. There is no weighing of interests. There is only a blanket override.

In sum, "the *real* goal of the Minor Consent Act is not to react to a global pandemic, but to bypass the decisions of religious parents who object to *any* ACIP-recommended vaccines, whether pre- or post-pandemic." Pl. Mem. 24. With one hand, the District has given parents the lawful authority to exempt their children from vaccinations. On the other hand, it has publicly

and notoriously communicated to children through the Act that they may ignore their parents, and that the District will abet them in doing so—even to the point of hiding the facts from the parents. The harm is not exclusively caused by a vaccination at the end of the chain of events listed by the defendants (although that would of course *further* injure them); the harm has already been caused by authorizing parents to exempt their children on the one hand, then abrogating that lawful right on the other hand. That harm has already occurred, is ongoing, and will only be exacerbated at each of the steps listed by defendants.

2. The Minor Consent Act has and continues to deprive children of their right to rely on the lawful authority of their parents.

The defendants extensively cite *Anspach* for a second proposition: that rights are only violated "where the government 'compel[s] interference in the parent-child relationship.'" Def. Mem. 28. The Minor Consent Act, they argue, "is permissive and does not compel, coerce, or prohibit any action." *Id.* at 30. But the Third Circuit emphasized that the public health center in *Anspach* "had no authority over Melissa, nor did Center staff become involved in [the child's] reproductive health decisions without invitation." *Anspach*, 503 F.3d at 266. The Court noted that a public health clinic was "a facility that, *unlike a public school*, does not require attendance or exercise authority over its visitors." *Id.* at 271 (emphasis added).

This distinguished *Anspach* from *Lee v. Wiseman*, where the Supreme Court found that "circumstances endemic to a high school graduation" created a sense of compulsion, which "coerced those attending to join in the prayer whether or not doing so violated their personal religious beliefs." *Id.* at 264. "The *undeniable fact*," *Wiseman* held, "is that the school district's supervision and control of a high school graduation ceremony places public pressure, as well as peer pressure, on attending students to stand as a group or, at least, maintain respectful silence

during the Invocation." *Wiseman*, 505 U.S. at 593 (emphasis added). "This pressure, though subtle and indirect, can be *as real as any overt compulsion*." *Id*. (emphasis added)

The defendants try to avoid *Wiseman* by restricting the Act's reach just to clinics and medical providers.[3] And they are largely dismissive of the fact that plaintiffs' children have faced "intense peer pressure" to receive vaccines. Def. Mem. 5. The plaintiffs, they argue, "do not allege this pressure came from District employees or officials," *id.*, and in any event, the children "have not been persuaded in the past five months to seek out the vaccine." *Id.* at 10.

This misses the point. Whether or not a child *actually succumbs* to peer pressure is irrelevant to whether the child feels coerced. As *Wiseman* noted, "there are heightened concerns with protecting freedom of conscience from *subtle coercive pressure* in the elementary and secondary public schools." *Wiseman*, 505 U.S. at 592 (emphasis added). Adults may be able to appreciate the distinction between rising as a sign of "simple respect for the views of others" and rising as "an expression of participation" in an activity. *Id.* But "for the dissenter of high school age, who has a reasonable perception that she is being forced by the State to pray in a manner her conscience will not allow, the injury is no less real." *Id.* at 593.

While the plaintiffs do not advance a claim under the Establishment Clause, the Supreme Court's observations about the "subtle coercive pressures" in schools are as true of the plaintiffs' children as they were of Deborah Wiseman. Those pressures take on an added dimension when the thing that a child is being pressured to do is something they know their parents disagree with. For many children, including the plaintiffs', that raises an issue of conscience. And pressuring a child's conscience causes real injury.

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[3] *See*, *e.g.*, Def. Mem. 9 (arguing that plaintiffs' "alleged injuries" "depend upon pure speculation" that "a *medical provider* would find the children capable of providing informed consent") (emphasis added); *see also id.* at 11, 12, 21, and 22.

More fundamentally, placing children in such a position, and encouraging them to defy their parents' wishes, is the opposite of respect for the parent-child relationship. The government has an "interest in the welfare of children," but children also have an "interest in . . . the lawfully exercised authority of their parents." *Calabretta*, 189 F.3d at 820. That authority is subverted when the state overrides the decisions of parents. "There is not much reason to be concerned with the privacy and dignity of the three year old whose buttocks were exposed," the Ninth Circuit observed. "But there is a very substantial interest, which forcing the mother to pull the child's pants down invaded, in the mother's dignity and authority in relation to her own children in her own home." *Id.* at 820. "An essential aspect of the privacy of the home is the parent's and the child's interest in the privacy of their relationship with each other," and the same is true of the "children's interest in the privacy and dignity of their homes and in the lawfully exercised authority of their parents." *Id.*

Here, the plaintiff parents have exercised their lawful authority to claim a religious exemption. Absent some sort of emergency, the government's only legitimate role is to protect the children's interest in that lawfully exercised authority. "The right to family association includes the right of parents to make important medical decisions for their children, and of children to have those decisions made by their parents *rather than the state*." *Wallis ex. rel. Wallis v. Spencer*, 202 F.3d 1126, 1141 (9th Cir. 1999) (emphasis added). Parents should be able to send their children to school with confidence, knowing that the government will protect their *children's interests* in the lawfully exercised authority of their parents. The Minor Consent Act does the opposite; it has done so for months; and the pressure on the children will intensify even more when mandatory, in-person instruction resumes in eleven days.

B. The Minor Consent Act is not "passive" towards the parent-child relationship, nor is the District a "passive" participant in the Act.

The defendants mischaracterize the Minor Consent Act as a purely passive force. It may "authorize[] healthcare providers to provide a service under certain circumstances," they argue, but it "does not require plaintiffs or their children to do anything," Def. Mem. 11, much less "compel interference with the parent-child relationship." *Id.* at 30. This is wrong.

1. The primary purpose of the Act, from the beginning, was to subvert the lawful exemptions of parents.

The purpose of the Minor Consent Act, from the very beginning, was to provide a legal mechanism for overriding the objections of parents, and to do so without the parents finding out. This is evident from the Committee on Health's initial report, which stated that "Bill 23-0171 is needed to grant minors, who are concerned for their health and safety, protection and the right to consent to a vaccination recommended by US Advisory Committee on Immunization Practices (ACIP) and a trained physician, *despite their parents refusal of consent or objection to immunization*." Committee on Health Report at 2 (emphasis added). Tellingly, the defendants twice quoted this same sentence in their memorandum—and twice omitted the italicized language. *See* Def. Mem. 3, 32.

There were other indicators, too. On the following page, the Committee on Health recounted executive testimony suggesting that "if the bill proceeds, the District would need to ensure an alternative source of payment in order to keep the service confidential, as using a third-party payer would *lead to a guardian or parent being notified* of the vaccination via an Explanation of Benefits." Committee on Health Report at 3 (emphasis added). Paragraph 74 of the complaint alleges the same. Ver. Compl. ¶ 74 (introducing an amendment, which was passed, to prevent insurers from "send[ing] an explanation of benefits for the vaccination to the minor's house"). And then there are paragraphs 62, 63, and 66, where the Act's sponsor and the

Chairman of the Committee of the Whole described the Act as a way to "alter certain behaviors" and to "reduce any and all barriers to these treatments" posed by parents who are "choosing not to vaccinate their children based on" the "anti-science belief[]" that "vaccines may cause autism or other harmful health effects." Ver. Compl. ¶¶ 62-63, 66; *see also* Pl. Mem. 4-5, 36.

Of course, the plaintiffs' children are not exempt because they hold "anti-science beliefs"; they are exempt because they have *sincere religious beliefs* against childhood vaccines, and because the District has created a lawful exemption precisely for parents with sincere religious beliefs against childhood vaccines. Ver. Compl. ¶¶ 24, 31, 38, 44, 156-159. The defendants do not challenge the sincerity of these beliefs. Def. Mem. 38 ("[T]he sincerity of plaintiffs' religious belief against vaccinating their minor children is not in dispute").

Nor, for that matter, do they offer any legal arguments about the religious exemption. In fact, defendants' memorandum mentions the religious exemption only six times, and none of them are substantive arguments. Two merely restate the fact that the plaintiffs have claimed the exemption. *See* Def. Mem. 1, 4. Two more are quotations from the plaintiffs' Complaint. *Id.* at 9, 20. The final two are summaries of the facts of *other* cited cases, not this one. *Id.* at 37. The plaintiffs, in stark contrast, have extensively discussed both the exemption and how the Act subverts it. *See* Ver. Compl. 11, 13-14, 16, 53-54, 56, 58-60, 76-77, 79, 90, 94, 96, 100-101, 129, 155-166, 179, 197-200, 212, 214, 220, 222, 224, 226; Pl. Mem. 2-5, 14, 18-20, 23, 25, 28-29, 30, 31-33, 38. The defendants' reticence to engage this issue—which is central to all three of the plaintiffs' claims—is unfortunate, and could carry future consequences.[4]

[4] *See Anspach*, 503 F.3d at 258 ("Absent compelling circumstances not present here, failure to raise an argument in one's opening brief waives it").

Instead, the defendants bring forth other scenarios. "[T]he Act," they suggest, "can be constitutionally applied to at least help competent minors whose only impediment to vaccination before the Act went into effect was the logistics of getting to the doctor *with* their parents to obtain desired vaccines. Now they can do it on their own." Def. Mem. 15.

Perhaps someone has adopted a law designed to accomplish that goal, but that someone is not the District and that law is not the Minor Consent Act. Nothing in the text limits the Act's sweep to that scenario, or suggests it was ever intended to be so limited. Indeed, entire subsections of the Act make no sense in the defendants' hypothetical context. If a parent *wants* their child to obtain a vaccine, and the "only impediment" is the "logistics of getting to the doctor *with* their parents," there is no reason to keep the fact of vaccination from the parent. On the contrary, telling a parent—whose life is filled with "competing priorities," *id.* at 15 n. 5—would be *advantageous*. The parent could watch for potential side effects, avoid scheduling an appointment for a duplicative vaccine, and could rectify any billing issues with the provider and insurance. But of course, the Act expressly *bars* insurers from sending an explanation of benefits to the child's home. 22-B DCMR § 600.9(d)(1)-(2). And that blanket bar applies to everyone—even the parents in defendants' hypothetical. It has no "plainly legitimate sweep." Def. Mem. 15.

2. The Minor Consent Act was designed to subvert the lawful exemptions of parents in secret.

The fact that the Minor Consent Act divests parents of their lawful exemptions in *secret* underscores the injury. There are at least four provisions which overtly do this. And contrary to the defendants' assertions that the Act is merely "permissive," *see* Def. Mem. 26 n. 15, 29 n. 17, all four are mandatory and compulsory.

We begin with subsection (d)(1), which states that "Providers who administer immunization under the authority of this subsection *shall* seek reimbursement, *without parental*

consent, directly from the insurer . . ." § 600.9(d)(1) (emphasis added). Subsection (d)(2) further directs that "Insurers *shall not* send an Explanation of Benefits for services provider." § 600.9(d)(2) (emphasis added). The defendants, in passing, liken the *effect* of these sections to HIPPA, but otherwise do not defend them. *See* Def. Mem. 31.

The third provision is D.C. CODE § 38-602(a), which contains several mandates: health care providers *shall* submit the immunization records directly to the school, while leaving part 3 of that record blank, and schools *shall* keep the immunization record confidential. Both provisions are compulsory, *see Citizens for Responsibility & Ethics v. FEC*, 993 F.3d 880, 892 (D.C. Cir. 2021) (distinguishing the "mandatory 'shall'" from the "discretionary 'may'"), and were *intended* to be compulsory. *See* Committee on Health Report at 3; Ver. Compl. ¶ 74.

The defendants argue that "part 3 of the immunization record" refers to the DC Health Universal Health Certificate, which they distinguish from a person's "permanent medical record." Def. Mem. 21. As we discuss below, that distinction is questionable. *Infra* at @@30-31. More importantly, it again misses the point. Whether or not a Universal Health Certificate is a "permanent medical record" under the National Vaccine Act, it remains a medical record for a child that the District has *mandated* be kept from the child's parents.

Finally, subsection (e) states that "A minor who receives services provided under the authority of this subsection *shall* have access to the minor's immunization records *without parental consent*." § 600.9(e) (emphasis added). The contrast in mandates could not be starker: minors shall get information, and their parents shall not.

Again, all of this was intentional. The Act was designed to subvert the lawful exemptions of parents. Telling parents that their children have received a vaccine—through an explanation of benefits or a Universal Health Certificate—would thwart that goal. That is why the executive

suggested that the Council amend the bill to prevent situations where "a third-party payer would lead to a guardian or parent being notified of the vaccination via an Explanation of Benefits," Committee on Health Report at 3, and why the Council acted on that suggestion. Ver. Compl. ¶ 74. The Act's compulsory measures have injured and continue to injure the plaintiffs.

C. While the plaintiffs have been and continue to be injured by the Act, the defendants' subsequent conduct threaten additional, imminent injuries.

Finally, while the defendants misapprehend the *principle* injuries inflicted by the Act, they are also wrong that the future risk of being *vaccinated* "depend[s] upon many-linked chains of what-ifs" that are "too speculative to support standing." Def. Mem. 10. The "chain" is not so long as the defendants suggest; and in the last month they have removed some links.

While the Minor Consent Act subverts the lawful exemptions of parents in all places where it applies, the plaintiffs have focused primarily on its application in schools because that is where the *current* injuries are most severe—particularly for the children—and because that is where the *future* risk of actually being vaccinated is most likely. Again, from the beginning, the Minor Consent Act was envisioned as a mechanism to get more children vaccinated, "despite their parents refusal of consent or objection to immunization." Committee on Health Report at 2. Even before it was passed, the Council recognized that it could be deployed as a method of distributing vaccines to children. As Council Member Allen stated, "we're certainly going to be having a conversation sometime next year [2021] when there's another vaccine that's going to be critically important, that's gonna see widespread distribution and we're gonna want to make sure that we're taking the right steps." Ver. Compl. ¶ 69.

"Next year" has come, and the defendants are taking those steps. Since May, when the FDA and ACIP expanded the emergency use of the COVID-19 vaccine for children ages 12-15, *id.* at ¶¶ 84-85, DCPS has upped the ante in the crucible of schools by stressing the importance

of being vaccinated, *id*. at ¶¶ 86-89, updating its immunization policy with an increased focus on "identify[ing] students that are non-compliant," and disseminating information about "the critical public health need for immunizations" within the new context of the Minor Consent Act. *Id.* at ¶¶ 93, 95-96. These efforts have already placed tremendous pressure on the plaintiffs and their children, and will only intensify when in-person classes resume August 30th. *Id.* at ¶¶ 103-105.

The emergency use authorization also coincided with the efforts of DCPS and DC Health to open vaccine clinics in schools. The FDA issued the authorization on May 10, and ACIP recommended the vaccine on May 12. *Id.* at ¶¶ 84-85. Two days later, Chancellor Ferebee told all DCPS families, "[w]e are collaborating with local health officials to host vaccination clinics at our schools. More details are forthcoming." *Id.* at ¶ 89. On June 1, four walk-in vaccine clinics opened in DCPS schools. *Id.* at ¶ 99. Given these facts, the plaintiffs alleged that more would be coming, *id.* at ¶ 100, and that they were the intended targets. *Id.* at ¶ 101-105, 220, 222, 224, 226.

The defendants object to all this "theorizing," Def. Mem. 10, but they especially object to the allegations about clinics. "[E]ven assuming that the existence of an on-site clinic would somehow render imminent the vaccination of their children," they argue, "DCPS does not offer vaccines in any of the plaintiffs' schools." *Id.* They dismiss the "assumption" for the same reason they are dismissive of the "peer pressure" the plaintiffs' children are facing: a failure to appreciate the "undeniable fact" of just how unique—and coercive—the high school environment can be. *Wiseman*, 505 U.S. at 593. But their factual assertion—that there are no vaccine clinics in the plaintiffs' schools—is also wrong, and perhaps even misleading.

In support of this claim, the defendants point the Court to DCPS's "Vaccinations for Students" webpage, *https://tinyurl.com/hfamyt7t*. Def. Mem. 10. The central feature of that page

is a list of "School Immunization Clinics" operated by the District. At the time the complaint was filed, this list included only four schools. *See* Compl. ¶ 99. Now, there are twenty.

One of those schools is Hardy Middle School, in Ward 2, where Shameka's child K.G. is enrolled. *See* Ver. Compl. ¶¶ 2, 27, 30. Hardy's clinic has been open since August 10, and offers both the COVID-19 vaccine and childhood immunizations. Before the clinic opened, Shameka was already afraid to send her child back to Hardy, and had already been contacted by her local school to get K.G.'s vaccines "up to date." Ver. Compl. ¶ 103. Both she and K.G. had already faced pressure to get the vaccine. *Id.* Those fears have only become more concrete since the complaint was filed, and that fact is entirely attributable to the acts of the defendants.

While the plaintiffs suspected—and alleged—that this would happen, they had no reason to know about the vaccine clinic at Hardy Middle School when they filed their complaint. At the time, the district's website did not list Hardy Middle School as a clinic location. *See* Ver. Compl. ¶ 99. Nor had the District communicated the existence of the clinic to them when the complaint was filed on July 12 (almost a month before the clinic opened). On the contrary, Hardy Middle School's official twitter account announced the clinic on August 2, 2021, well after the complaint was filed. *See* @HardyMiddleSchool, Twitter (Aug. 23, 2021, 3:23 p.m.) *https://twitter.com/HardyMSHawks/status/1422640203152470018* (accessed Aug. 18, 2021).

The same may not be true of the defendants, who filed their memorandum on August 5. While the defendants claim is not technically false—Hardy was not *yet* "offer[ing] vaccines" to students in any of the plaintiffs' schools, Def. Mem. 10—it is at best incomplete, given that it was made two days after Hardy's announcement, and would cease to be true four days later. It is possible the defendants were unaware of this clinic when they submitted their memorandum, but that also seems unlikely given that Hardy encouraged students to pre-register for vaccines on

August 2, and DC Health handles pre-registrations. *See* DCPS, "Vaccinations for Students" ("To pre-register for a vaccinations, please click the button above to complete the required questionnaire so that *DC Health* can gather information for your child's vaccine appointment").[5] Furthermore, DCPS has publicized the existence of these vaccine clinics. As Chancellor Ferebee wrote in an e-mail to all DCPS families on August 11, "DCPS is proud to host COVID-19 vaccination clinics at many of our schools across the District. Visit *dcpsreopenstrong.com/ vaccines/* to see locations and times." DCPS, "Important Health and Safety Update on COVID-19 Vaccines" (Aug. 11, 2021), *https://dcpsreopenstrong.com/ chancellor/important-health-and-safety-update-on-covid-19-vaccines/* (accessed Aug. 18, 2021). To the extent defendants are merely attempting to *persuade* parents to have their children vaccinated, there is no issue. But if their efforts at persuasion fail, they cannot override the parent's lawful exemptions.

Whatever the defendants knew or didn't know on August 5, the fact remains that DCPS and DC Health are *currently* operating vaccine clinics in at least twenty schools, and at least one of those clinics is in one of plaintiffs' schools—exactly as they predicted.[6] Because the

[5] The underscored text is a hyperlink, which redirects the user to *https://vras-dc.powerappsportals.us/en-US/* (accessed Aug. 18, 2021). That webpage, entitled "Pediatric Vaccination Pre-Registration" asks the user to "please fill in the required questionnaire so that DC Health can gather information for your child's vaccine appointment," and is branded with the logos for DC Health and the "Government of the District of Columbia, Muriel Bowser, Mayor." DCPS's "Vaccinations for Students" website also says students can "call the Vaccination Call Center at 1-855-363-0333 to make an appointment," which is operated by DC Health.

[6] We note in passing that Victor and Shanita have children who attend Kipp DC Will Academy. Ver. Compl. ¶¶ 1, 3, 21-23, 34. While Kipp DC is not included on DCPS's list of walk-in school clinics, the school's "Healthy Operations" webpage states that "We encourage all staff and eligible students to take the COVID vaccine. *In the coming weeks, we'll be hosting COVID Vaccine clinics at our schools to increase access to our communities*." Kipp DC, "Healthy Operations" *https://www.kippdc.org/healthy-operations/* (accessed Aug. 18, 2021) (emphasis added). The same message is repeated in a video published on Kipp DC's official YouTube channel on July 23, 2021. Kipp DC, YouTube, "2021 Back to School Health & Safety Framework," *https://www.youtube.com/watch?v=JEhLzQ5ilpo* (accessed Aug. 18, 2021).

defendants have raised a motion to dismiss under Rule 12(b)(1), the Court may consider materials outside the pleadings "to assure itself of its own subject matter jurisdiction," *Settles v. U.S. Parole Comm'n*, 429 F.3d 1098, 1107 (D.C. Cir. 2005), *quoting Haase v. Sessions*, 835 F.2d 902, 908 (D.C. Cir. 1987), and must construe the complaint liberally to afford all possible inferences favorable to the pleader on allegations of fact. *Settles*, 429 F.3d at 1106. The complaint, combined with the materials beyond the pleadings cited by the defendants—in particular, DCPS's "Vaccinations for Students" webpage—place the Court's subject matter jurisdiction on firm ground. The plaintiffs have standing.

II. The complaint sufficiently pleads three claims for relief.

The defendants urge this court to dismiss the complaint under Rule 12(b)(6), arguing that it does not state a claim upon which relief can be granted. As the defendants note in passing, Def. Mem. 7, while this Court is "not bound to accept as true a legal conclusion couched as a factual conclusion," *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 556 (2007), it "must accept as true all of the factual allegations contained in the complaint." *Swierkiewicz v. Sorema N.A.*, 534 U.S. 506, 508 (2002). At this stage, the claim to relief need only be "plausible on its face," *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). Rule 12(b)(6) "does not countenance . . . dismissals based on a judge's belief of a complaint's factual allegations," and a well-pled complaint "may proceed even if it appears that a recovery is very remote and unlikely." *Twombly*, 550 U.S. at 556.

A. The Minor Consent Act substantially burdens the free exercise rights of parents under the Religious Freedom Restoration Act.

1. The Minor Consent Act substantially burdens parents' free exercise rights.

The defendants' memorandum identifies only one allegation as a "legal conclusion cast as a factual allegation": the "plaintiffs' characterization that the potential for their child to receive a vaccine against their wishes is a 'substantial burden.'" Def. Mem. 38, *citing* Pl. Mem.

28-29. This objection is easily dealt with. Setting aside the fact that the language complained of is in a memorandum of points and authorities (not a complaint),[7] and deals with the plaintiffs' Fifth Amendment claim (not whether there is a "substantial burden" under RFRA), the plaintiffs did in fact recount the specific factual allegations in the complaint that formed the basis of their legal arguments: "Victor, Shameka, Shanita, and Jane are all fit parents." "They have used their own maturity, experience, and capacity for judgment to decide whether to vaccinate their children." "They have decided that vaccinating their children would be contrary to their sincere religious beliefs." "And they have expressed that decision to the District by filing a religious exemption, which they have a statutory right to do. . . ." Pl. Mem. 28. These facts support the conclusion: "As fit parents, the Fifth Amendment presumes that their decisions are in the best interests of their children. The Minor Consent Act takes the opposite approach. . . ." *Id.*

The complaint contains sufficient *factual* allegations for the other claims, too. The current and ongoing injuries that give the plaintiffs standing are also "substantial burdens" under RFRA. "The District has recognized a legal right of parents to claim a religious exemption from vaccinations, by filing an objection in good faith and in writing a statement . . . that vaccinations would violate the parent's religious beliefs." Ver. Compl. ¶ 155. The Minor Consent Act did not eliminate the religious exemption. *Id.* at ¶ 160. All four of the plaintiffs have claimed that exemption. *Id.* at ¶¶ 156-159. All four have children who are enrolled in DCPS schools. *Id.* at ¶¶ 23, 30, 37, 43. Those schools will resume mandatory in-person instruction on August 30th. *Id.* at ¶¶ 18-19, 23, 30, 37, 43, 83. In May 2021, DCPS began pushing for the vaccination of all students, updated its Immunization Attendance Policy to include the Minor Consent Act, and announced its intent to "partner[] with local health officials to host vaccination clinics at our

[7] *Twombly* applies only to legal conclusions in a complaint. *Twombly*, 550 U.S. at 556.

schools." *Id.* at ¶¶ 89, 95-96. The following month, it did just that in four schools. *Id.* at ¶ 99. The plaintiffs alleged, on information and belief, that there would be more, *id.* at ¶ 100, and that they would be used to "authorize the vaccination of students whose parents have claimed a religious exemption." *Id.* at ¶ 101. At least one of those predictions has already come to pass.

The plaintiffs also alleged that they feared they cannot send their children back to those schools on August 30th without jeopardizing their lawful exemptions. *Id.* at ¶¶ 102-105. And some of the plaintiffs have already felt intense pressure from their schools to have their children vaccinated, even before their students have returned to the crucible of public school. *Id.* at ¶¶ 103-105. *See also* Pl. Mem. 19 ("Here, the plaintiffs have sincere religious beliefs against vaccinating their minor children," "they have acted on those beliefs by claiming a religious exemption," and "several District Council members have expressed their disagreements publicly" with those beliefs"). These are not legal conclusions posing as facts; they are facts. And once one pairs them *with* legal conclusions, the substantial burdens become clear.

Creating an exemption for parents who have sincere religious beliefs about vaccines, and then designing a mechanism to secretly subvert the same parents who claim that exemption, inflicts more than a "*de minimis* inconvenience[]." *Kaemmerling v. Lappin*, 553 F.3d 669, 678 (D.C. Cir. 2008). Indeed, the entire reason these parents object to the Act is precisely *because* they have a religious exemption, and that puts them in a different position *vis-à-vis* the Act from any other category of parents. Parents whose children already have all the vaccines recommended by ACIP have nothing to fear. Nor does the Act infringe on the hypothetical parents defendants have proposed: those who don't object to vaccines, but whose lives are filled with too many "competing priorities" to accompany the child to the doctor. Def. Mem. 15 n. 5. Parental consent is a non-factor for children who are abandoned or orphaned. Parents who object

to vaccines, but choose not to claim an exemption, may eventually have to make that choice; but until they do so, their decision has not been challenged and devalued like the plaintiffs' decisions have been. Even parents with medical exemptions are treated differently: their decisions are not "singled out," nor are they "targeted" like parents who claim a religious exemption or an HPV exemption. *See* Pl. Mem. 24, 30, *citing* D.C. CODE § 38-602(a)(2).

The Act uniquely burdens only one subset of parents: the parents who file exemptions. The plaintiffs' exemptions are religious. The sincerity of their beliefs is undisputed. Def. Mem. 38. The Act has exerted "substantial pressure on [the plaintiffs and their children] to modify [their] behavior and to violate [their] beliefs." *Kaemmerling*, 553 F.3d at 678. And that pressure is only increasing. *See* Ver. Compl. ¶¶ 103-105, 83, 89, 99-101; Pl. Mem. 4-5, 20, 37; DCPS, "Vaccinations for Students." The Act imposes substantial burdens.

2. The Minor Consent Act, as applied to the plaintiffs, does not further a compelling interest.

The defendants assert a "compelling interest in stemming the spread of deadly communicable diseases." Def. Mem. 32. The problem with this argument is two-fold. First, the leading case cited by the defendants held that "[s]temming the spread of *COVID-19* is unquestionably a compelling interest." *Roman Catholic Dioces of Brooklyn v. Cuomo*, 141 S.Ct. 63, 67 (2020) (emphasis added). But the Minor Consent Act is not a pandemic measure. At the time the Act was drafted and passed, the list of vaccines that could be administered did *not* include the vaccine for COVID-19. And nothing in the Act references pandemics generally, or the COVID-19 pandemic specifically. *See* Pl. Mem. 23-24.

Second, the "compelling interest" put forth by the District is far too broad. One can acknowledge that "the state's wish to prevent the spread of communicable diseases" is a compelling interest. But unless the District *also* proves that it has a compelling interest in

applying the Act *to the particular plaintiffs*, it "cannot rely on its generalized interests in protecting public health or combating the COVID-19 pandemic, critical though they may be." *See* Pl. Mem. 21-22, *quoting Capitol Hill Baptist*, 496 F. Supp. 3d at 298; *see also* Pl. Mem. 31, *quoting Franz v. United States*, 707 F.2d 582, 607 (D.C. Cir. 1983) (requiring the government to "promote, *in a particular case*, compelling governmental interests" before it infringes on fundamental rights) (emphasis added).

The defendants offer general concerns about herd immunity and transmission rates. Those concerns may be true. But it is also true that those concerns aren't yet enough to prompt the District to *mandate* the COVID-19 vaccine for all school-age children 12 and up. *See* Def. Mem. 8-9, 11. That being so, it is difficult to see how the same general concerns are sufficient to justify interfering with the lawful, religious exemptions of parents.

The fact that religious exemptions "are generally rare in the District" also complicates the defendants' case. Ver. Compl. ¶ 94. Yes, *Jacobson* affords legislatures latitude to prevent the spread of contagious diseases. Def. Mem. 33 n. 21. But as we pointed out earlier, *Jacobson*—which does not control RFRA cases—centered on carefully balancing the "acknowledged power of a local community to protect itself against an epidemic" against the "necessities of the case"—the practical need to curtail individual freedom. Pl. Mem. 22-23, *quoting Jacobson v. Massachusetts*, 197 U.S. 11, 30-31 (1905). The defendants make no effort to show that under the "necessities of the case," imposing special burdens on the "rare" subset of parents with religious exemptions is necessary to for the community to "protect itself against an epidemic." *Id.* at 30-31. Yet that "rare" subset of parents are the ones most injured and burdened by the Act.

Instead, the defendants' arguments focus largely on *other* parents: the parents of children who "are capable or providing informed consent," Def. Mem. 9, or parents who don't object to

vaccines but cannot get to the doctor with their children. *Id.* at 15. Quite simply, this is not how the analysis works. *Anspach* didn't reach whether the school board had a compelling interest; but even it discussed at length the particulars of the public health clinic, *Anspach*, 503 F.3d at 264, 266, *Melissa*'s participation in that clinic (and why it did not burden *her parents*' protected rights), *id.* at 264-265, 271, *and* the particulars of the parties in several cited cases.[8]

If the government takes away fundamental rights, it must defend that decision in the unique circumstances *of each case*. That burden is particularly difficult to shoulder here because the plaintiffs are not seeking some new remedy: they are simply asking that their lawful exemptions once again be respected, not subverted. The defendants offer no explanation for how retaining the religious or HPV exemptions on the one hand, and then creating a subjective class of cases where it doesn't apply on the other, furthers any of the interests they have asserted.

3. The Minor Consent Act is not narrowly tailored.

The generalized interests invoked by the defendants create an additional problem. If the Minor Consent Act was truly aimed at "prevent[ing] the spread of communicable diseases," there are myriad ways to accomplish that aim without subverting the lawful exemptions of parents.

In the last year, we have become all too familiar with measures to stop the spread of communicable diseases: masks, social distancing, good hygiene, limited social gatherings, and the like. Likewise, we have become more aware of and comfortable with technologies that allow us to accomplish remotely what we would normally have done in person: "telemedicine," online video conferences, and encrypted technologies for transmitting sensitive documents. Any of them could have been used to make it easier for parents to consent to the vaccines they *want* (if

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[8] *See Anspach*, 503 F.3d at 262-269 (discussing the "rap session" in *Doe v. Irwin*, 615 F.2d 1162 (6th Cir. 1980), the particulars of "Jane Doe" and the school guidance counselor in *Arnold v. Board of Education*, 880 F.2d 305 (11th Cir. 1989), and the particulars of the mother, daughter, and swim coach in *Gruenke v. Seip*, 225 F.3d 290 (3rd Cir. 2000)).

they can't accompany their child in person to the doctor's office, for example), without stripping parents of their lawful right to exempt their children from vaccines they do *not* want.

The defendants' memorandum is light on this point. While the phrase "narrowly tailored" appears several times, they make only two substantive arguments. First, they chide the plaintiffs for "provid[ing] no reasoned basis . . . for how a fitness determination would operate as a 'reasonable way' for the District to achieve the stated goals of the act 'with a lesser burden on constitutionally protected activity.'" Def. Mem. 33, *citing* Pl. Mem. 31, 33. Setting aside the fact that under strict scrutiny, the *government* has the burden of proving its measures are narrowly tailored to further compelling governmental interests (not the plaintiffs), *see Johnson v. California*, 543 U.S. 499, 505 (2005), the suggestions outlined seem like reasonable alternatives for preventing the spread of communicable diseases, or alleviating the burden on parents whose lives are filled with "competing priorities." Def. Mem. 15 n. 5. After all, the District has adopted and used many—if not all—of the measures outlined above.

The defendants' second argument is that the law *is* narrowly tailored, because it is restricted to a discrete "class of person" ("minors who are 'able to comprehend the need for, the nature of, and any significant risks ordinarily inherent in the medical care'"), while excluding other discrete classes of persons (such as minors who are "incapable" of appreciating those needs or risks). Def. Mem. 34. It is true that the District could have drawn the Act more broadly. But that is true of almost any law—and it is *not* what makes a law "narrowly tailored." Rather, as the D.C. Circuit noted in *Franz*, the essence of the "narrowly tailored" analysis is that "[i]f there are other, reasonable ways to achieve those goals *with a lesser burden on constitutionally protected activity*, a State may not choose the way of greater interference. If it acts at all, it must choose 'less drastic means.'" Pl. Mem. 31, *quoting Franz*, 707 F.2d at 607 (emphasis added).

Yes, extending the Minor Consent Act to *all* minors without the language about informed consent would broaden its scope, while restricting the Act to minors who are 17 years old or above would limit it. But in both cases, the Act would still *burden* the *constitutionally protected activity* at issue by preventing the parents of those children—whoever they may be—from lawfully exempting them from vaccines. The alternatives suggested above are "narrower" in the proper sense: they are directed to the same "compelling interests" raised by the defendants, while avoiding its burdens. The Minor Consent Act is not narrowly tailored.

B. The Minor Consent Act violates the National Vaccine Act.

The Minor Consent Act also conflicts with the National Vaccine Act. Federal law preempts lower law when "the operation of federal and state law clash in a way that makes 'compliance with both state and federal law . . . impossible,'" or when a law "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Sickle v. Torres Advanced Enter. Sols., LLC*, 884 F.3d 338, 347 (D.C. Cir. 2018).

The Minor Consent Act does both. It contains counter-mandates that make compliance with both federal law and District law impossible, and these counter-mandates thwart the primary purpose of the Act primary purpose. When it comes to limiting the risk of unavoidable vaccine injuries, parents are the front-line of defense. The Act was designed to deprive parents of access to accurate medical information, and any meaningful opportunity to assess the risks before their child is vaccinated. This does not *decrease* the risks for children; it *increases* them.

1. <u>The Minor Consent Act thwarts Congress's purposes by mandating the creation of inaccurate health records, while barring parents from accessing accurate records.</u>

We begin, briefly, with familiar ground: the Minor Consent Act mandates that if vaccines are administered to the children of parents who have a lawful religious exemption, "the health care provider *shall* leave blank part 3 of the immunization record," and the "school *shall* keep

the immunization record . . . confidential." D.C. CODE § 38-602(a)(2) (emphasis added); *see also* Ver. Compl. ¶¶ 54, 57, 96, 118, 162; Pl. Mem. 24, 30. Both provisions, like the ban on sending parents an explanation of benefits, further the District's primary goal of subverting the lawful exemptions of parents by erecting barriers to prevent them from discovering that their children have been vaccinated. *See* Committee on Health Report at 2; *see also* Pl. Mem. 14-15.

Both provisions also conflict with 42 U.S.C. § 300aa-25(a), titled "Recording and Reporting of Information." Beginning with the "leave blank" requirement, Congress has mandated that "[e]ach health care provider who administers a vaccine set forth in the Vaccine Injury Table to *any* person *shall* record, or ensure that there is recorded, in such person's permanent medical record (or in a permanent office log or file to which a legal representative shall have access upon request) with respect to each such vaccine" its "date of administration," its "manufacturer and lot number," the name, address and title of the provider administering the vaccine, and "any other identifying information on the vaccine" required by the Secretary's regulations. § 300aa-25(a) (emphasis added). In other words, the record cannot be left blank.

The defendants' response is that Congress was talking about "permanent medical records," while the Minor Consent Act refers to a portion of "the DC Health Universal Health Certificate." Def. Mem. 21, *citing* D.C. CODE § 38-502 *and* 5-A DCMR § 130.4.[9] One page later, they argue that the "immunization record" to be left "blank" in § 38-602 also refers to the "Universal Health Certificate." *Id.* at 22. Since "permanent medical records" and the Universal Health Certificate are "different systems entirely and do not overlap," *id.* at 21, the defendants see "no conflict at all" between the Minor Consent Act and the National Vaccine Act. *Id.* at 22.

[9] Defendants also cite, without explanation, 5-E DCMR § 5300.2, which deals with free appropriate public education (FAPE) for children with disabilities. Def. Mem. 21.

On the contrary, they argue, "the Act does not prohibit providers from recording certain information in patients' medical records" (although the defendants cannot quite bring themselves to say that parents could access the child's permanent records). *Id.* at 12, 21.

This dodge is too clever by half. As an initial matter, whether the "immunization records" to be left blank are a "permanent medical record," part of the "Universal Health Certificate," or both, is not resolved by the sources the defendants cite; whether these documents are the same or distinct is, at best, ambiguous.[10] But even if the defendants were correct, the reach of the National Vaccine Act is not limited to just "permanent medical records." "[P]ermanent medical records" cannot be left blank, but neither can "permanent office log[s]," or a "file to which a legal representative shall have access to." § 300aa-25(a).

The defendants cite to 5-A DCMR § 130.4, presumably to bolster their claim that the Universal Health Certificate is a distinct record (even though the regulation does not explicitly say that). But the form described in that section sounds a lot like a "permanent office log." Licensees are to "maintain a record for each enrolled child" in "one central location at the Facility," § 130.1, which contains among other things "health information and records," § 130.2(m), and a "[c]hild's significant health history." § 130.4(g). Critically, this record must also contain "*specific immunizations* received by month, day, and year," § 130.4(h), and must be made "*immediately available* to . . . the child's parents . . . upon request." § 130.1. The National Vaccine Act explicitly applies to all "file[s] to which a legal representative shall have access to,"

[10] Section 38-602 uses the term "immunization record," but that term only appears in subsection (a)(2), which was created by the Minor Consent Act. The preexisting sections used a different term—"certificate of health"—which fits the Universal Health Certificate. *C.f.* Dock. 16-3 *with* § 38-602(a)(1) (designed for school-age children), § 38-602(c)(2)(B) (completed by licensed medical professional), *and* § 38-602(c)(2)(C) (includes information for accessing health insurance and contacting school nurses). Section 38-502 further complicates matters by introducing a *third* term: "certification of immunization." None of these terms are defined.

where vaccine information is recorded. § 300aa-25(a). If the Universal Health Certificate and the record in § 130.4 are one and the same, then even the District's Certificate is subject to the National Vaccine Act, *cannot* be left blank, and *must* be accessible by the child's parents. The Minor Consent Act mandates otherwise, creating an irreconcilable conflict.

2. The Minor Consent Act thwarts Congress's purposes by depriving parents of any meaningful opportunity to assess the risks before their children are vaccinated.

Congress also requires that Vaccine Information Sheets (VISs), developed by the Secretary of Health and Human Services to comply with carefully-crafted standards, must be distributed "by healthcare providers to the legal representatives [parents] of any child or to any other individual receiving a vaccine set forth in the Vaccine Injury Table." 42 U.S.C. § 300aa-26. Here, there is no doubt that the plaintiff parents are their children's "legal representatives." *See* 42 U.S.C. § 300aa-33(2). As such, the National Vaccine Act mandates that they shall be provided with *the Secretary's* official VISs. Those VIS's shall be given to them by *the healthcare provider* who is about to administer a vaccine to their child. And that VIS shall be "supplemented with visual presentations or oral explanations," if needed. § 300aa-26(d). In other words, this required transmission of information between provider and parent is meant to occur with the provider, before any vaccines are administered.

The Minor Consent Act makes all of this impossible, by allowing minors to be vaccinated without their parents' knowledge, and by going out of its way to keep these vaccinations secret from parents. It is hard to have a conversation with your child's provider when the law says your consent is not needed, and no provider is allowed to tell you that this meeting ever took place.

The defendants attempt to dodge this, too, arguing that when Congress said VISs must be provided "to the legal representatives of any child *or* to *any other individual to whom such provider intends to administer such vaccine*," the "or" means that the provider can give the VIS's

to the parents of a child *or* directly to the child (because the child "qualifies as 'any other individual' to whom a healthcare provider intends to administer a vaccine"). Def. Mem. 18.

The defendants misread the statute. Not one provision in the National Vaccine Act contemplates a role for children that is independent of their parents. Indeed, the Act uses the word "child" only twice. They are both in this section, and they are both used in the phrase, "the legal representatives of *any child*." § 300aa-26(a), (d). The "or" does *not* distinguish "parents of children" from "children who get a vaccine." It distinguishes "children" (whose *parents* have to be provided with the VIS) from "any other individual" who are *not children*. This is confirmed by the legislative history of the National Vaccine Act. As originally passed, § 300aa-26 did not include the phrase "or to any other individual receiving a vaccine." National Childhood Vaccine Injury Act of 1986, 100 Stat. 3775, 3776-3777 (Nov. 14, 1986). This language was added as part of an omnibus amendment in 1993, as Congress prepared to add adult vaccinations to the Injury Table under 42 U.SC. § 300aa-14. Preventative Health Amendments of 1993, 107 Stat. 2226, 2242 (Dec. 14, 1993). The defendants' argument is a non-starter.[11]

The Minor Consent Act also mandates the creation of "one or more age appropriate alternative vaccine information sheets." 22-B DCMR § 600.9(c). The defendants do not contend that these "alternative" VISs will be created by the U.S. Secretary for Health and Human Services; rather, they argue in conclusory fashion that "[w]hile the use of the word "alternative" here may have been imprecise, it cannot carry the weight plaintiffs place on it—it does not conflict with federal requirements." Def. Mem. 20. The District may have been imprecise in

[11] Additionally, the defendants' theory is at odds with common law doctrines like the "Rule of Sevens." *See, e.g., Carwell v. Bechtol*, 724 S.W.2d 739, 745 (Tenn. 1987) ("The rule of capacity has sometimes been known as the Rule of Sevens: under the age of seven, no capacity; between seven and fourteen, a rebuttable presumption of no capacity; between fourteen and twenty-one, a rebuttable presumption of capacity").

choosing the word "alternative," but the meaning of that word is quite clear: it denotes choosing between "one or the other of two things."[12] The defendants claim the Minor Consent Act creates a "both-and" situation. But "alternative" denotes "either-or." Mandating that providers distribute an *alternative* VIS conflicts with federal law.

3. <u>By thwarting Congress's purposes, the Minor Consent Act puts children at risk.</u>

Defendants also contend the VISs are really irrelevant because the plaintiffs already have them, and thus "there is little if any likelihood that plaintiffs would suffer any harm as a result of the alleged *future* violations of the NCVIA." Def. Mem. 11-12, *citing* Ver. Compl. Exh. A. This assumes that the only point of the VIS is to get them into someone's hands, like sandwiches in a Subway store. But that is not the goal Congress had in mind. The "point" of a VIS is not to give parents something to read, but to give them a meaningful *opportunity* to learn about vaccines, what risks they may pose to their child, what adverse reactions to watch out for, and—critically—to bring any questions they have to their provider. That is why Congress mandated both that the *provider* "distribute" the sheets to parents, and that the sheets be "supplemented with visual presentations or oral explanations" if needed. § 300aa-26(d).

The sheets themselves also drive this point home. The VIS for the DTaP Vaccine, referenced by the defendants, instructs the reader to "[t]ell your provider if the person getting the vaccine" has had certain medical conditions or allergic reactions. Ver. Compl. Exh. A at 1. It tells the reader that "your child's health provider can give you more information" about situations where a DTaP vaccination should be postponed. *Id.* It directs the reader to "call 9-1-1 and get the person to the nearest hospital" if there are signs of severe allergic reactions, and to

[12] Pl. Mem. 11, *quoting* The Law Dictionary; *see also* Def. Mem. 20 n. 10, *quoting* Merriam-Webster Dictionary (same).

"call your health care provider" for "other signs that concern you." *Id.* at 2. And if the reader wants to learn more, the sheet directs him or her to "ask your health care provider." *Id.* The other VISs contain similar instructions. *See* Ver. Compl. Exh. A.

To be sure, having the sheet gives parents *some* information. But Congress doesn't merely require that parents "get information." It requires that specific information, carefully crafted by the Secretary, be provided to parents by the provider *so that* parents can act on that information, and seek out additional information is needed, before a vaccine is actually administered to their children. The Minor Consent Act deprives parents of *that* opportunity. Whether the plaintiffs might independently read the VISs on their own is irrelevant; it is not the same thing, and not what Congress mandated.

4. <u>The Minor Consent Act thwarts Congress's comprehensive scheme, undermining its carefully calibrated provisions and putting children at risk.</u>

As should be evident, the National Vaccine Act was a colossal, sweeping act that continues to touch the life of every American child. It governs vaccine research, development, safety, testing, licensing, production, procurement, distribution, evaluations, coordination between governmental and non-government activities, and funding for all the above. And that is just in 42 U.S.C. § 300aa-2. It creates a compensation program, § 300aa-10, defines the jurisdiction of courts and the nature of actions, §§ 300aa-11 to -17, -21, -31, and of course controls the creation, distribution, recording, and reporting of vaccine information. §§ 300aa-25, -26. Implied preemption is clear, given "the substantive nature and reach of the federal regulatory scheme." *Crosby v. National Foreign Trade Council*, 530 U.S. 363, 388 (2000).

The defendants view these mandates essentially as "add-ons." The District can do what it likes, so long as it *also* does not *expressly* violate anything Congress says (or does what it wants *and* what Congress commands). Providers can leave a "Universal Health Certificate" blank, so

long as all the required information goes into some "permanent health record." The District can bar parents from accessing immunization records if that record is a "Universal Health Certificate," not a "permanent medical record." It can imprecisely require providers to issue "alternative" VISs that have not been vetted by the Secretary; it just cannot *explicitly* bar those same providers from distributing the official VISs, too. And it can distribute those VISs directly to a child, even if the child has a legal representative—a parent.

Congress probably did not anticipate evasions like this in 1986; but they are undoubtedly obstacles to accomplishing the "full purposes and objectives" of Congress. *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941). The National Vaccine Act and Compensation Program were created because vaccine injury is "unavoidable." *Bruesewitz v. Wyeth*, 562 U.S. 223 (2011). The defendants seem unconcerned with the possibility of a child having duplicate vaccine records, some of which contain accurate information and others of which are blank. But accurate vaccine records—containing the date of administration, manufacturer, lot number, information about the provider, and "any other identifying information on the vaccine"—were incredibly important to Congress. 42 U.S.C. § 300aa-25(a). And they are *essential* to determining whether claims have been timely filed under the National Vaccine Act. *Shalala v. Whitecotton*, 514 U.S. 268 (1995). Congress had excellent reasons to mandate that *all* records of vaccinations to be accurate. Duplicate records—where some record a vaccine and others do not—turn what should be a simple factual matter into a quagmire.

Likewise, Congress envisioned parents as the first line of defense against unavoidable vaccine injuries. Again, this makes perfect sense: parents know not only their child's medical history, but that of their extended family as well. That is why Congress requires that accurate, complete records be accessible to parents, § 300aa-25(a), why VISs must be provided to parents

in advance, § 300aa-25(d), why the provider must supplement those VISs with visual presentations and oral explanations when necessary, *id.*, and why the sheets themselves *repeatedly* encourage parents to ask questions, disclose risk factors, and watch for adverse reactions. Ver. Compl. Exh. A. The Minor Consent Act overrides Congress's judgments, and thwarts its purposes. In the face of such conflicts, it must yield.

Finally, the Minor Consent Act thwarts the ability of vaccine injured children in the district to receive compensation. Because the National Vaccine Act exists, the plaintiffs no longer have a right to access courts of law for vaccine injuries. Their only remedy is through the Compensation Program, and to raise a claim under the program they *must* recognize vaccine injuries in a timely fashion. And they can only do that if they have access to the accurate records regulated in § 300aa-25 and § 300aa-26. That is why Congress so heavily regulates the creation, content, and distribution of those records.

These mandates serve procedural purposes; but they are more than just procedural hurdles. They are carefully calibrated to reduce the risk of unavoidable vaccine injuries, and to save children. As the U.S. District Court for the Northern District Court of New York observed, "a failure to comply with the pre-vaccination procedural requirements of § 300aa-26 could do more than deprive Plaintiffs of their right to receive an 'HPV vaccine VIS' prior to a health care practitioner administering the vaccine to their children. Rather, it could in fact directly interfere with Plaintiffs' constitutional right to make informed medical decisions for their children because § 23.4 could ultimately deprive them of the ability to guide and assist their children with respect to their decision whether to receive the vaccine," and "could not counsel their children about any adverse reactions they might experience after its administration." *Cole v. Zucker*, 2019 U.S. Dist. LEXIS 31714, *20-21 (N.D. N.Y. 2019) (UNPUBLISHED).

C. The Minor Consent Act violates the Fifth Amendment.

1. The fundamental right of parents to direct the "care" of their children includes the right to consent to medical treatment in non-emergency circumstances.

Defendants' principally argue that granting relief to the plaintiffs will "break new ground in [the] field" of substantive due process. Def. Mem. 25, *quoting Abigail Alliance for Better Access to Developmental Drugs v. von Eschenbach*, 495 F.3d 695, 702 (D.C. Cir. 2007). The Supreme Court, they argue, has "never specifically defined the scope of a parent's right to direct her child's medical care," Def. Mem. 27, *quoting P.J. v. Wagner*, 603 F.3d 1182 (10th Cir. 2010), while "[h]istory and tradition" confirm a "right of mature minors to consent to medical care." Def. Mem. 27, *citing Bonner v. Moran*, 126 F.2d 121 (D.C. Cir. 1941).

While some parental rights may not be as settled as the defendants would like, this one is. There is a clear difference between suggesting that "terminally ill patients have a fundamental right to experimental drugs that have passed Phase I clinical testing," *von Eschenbach*, 495 F.3d at 701, and arguing as the plaintiffs do here that "the interest of parents in the care, custody, and control of their children," "perhaps the oldest of the fundamental liberty interests recognized by this Court," *Troxel*, 530 U.S. at 65, includes a "right to make decisions about the child's medical care." *P.J.*, 603 F.3d at 1197. As the Second Circuit has held, "the constitutional liberty interest of parents in the 'care, custody, and management of their child,' though not 'beyond limitation,' includes a significant decision-making role concerning medical procedures sought to be undertaken by state authority upon their children." *Van Emrik*, 911 F.2d at 867.

The defendants' reliance on two "mature minor" cases—*P.J.* and *Bonner*—is curious. While *P.J.* did say that "[t]he Supreme Court has . . . never specifically defined the scope of a parent's right to direct her child's medical care," the defendants have ripped that quoted out of context. In the paragraph immediately before, the Tenth Circuit said that "although we have

never specifically recognized or defined the scope of a parent's right to direct her child's medical care, *we do not doubt* that a parent's general right to make decisions concerning the care of her child includes, to some extent, a more specific right to make decisions about the child's medical care." *P.J.*, 603 F.3d at 1197 (emphasis added). The next paragraph includes the defendants quote, plus some other things, too. The entire passage reads as follows:

> The Supreme Court has similarly alluded to, but never specifically defined the scope of a parent's right to direct her child's medical care. Indeed, the Court has recognized that "[m]ost children, even in adolescence, simply are not able to make sound judgments concerning . . . their need for medical care or treatment," and that our legal system presumes "that natural bonds of affection lead parents to act in the best interests of their children." Therefore, this precedent reasonably suggests that the Due Process Clause provides some level of protection for parents' decisions regarding their children's medical care.

P.J., 603 F.3d at 1197 (brackets and ellipses in original, internal citations omitted).

Similarly, defendants cite *Bonner* for the proposition that history and tradition confirm a "right of mature minors to consent to medical care." Def. Mem. 27, *citing Bonner*, 126 F.2d at 122. Nothing on that page—or in *Bonner* as a whole—supports their position. In fact, a third "mature minor" case cited by defendants (which actually involved an infant) described the *Bonner* passage as "dicta." *Kozup v. Georgetown University*, 851 F.3d 437, 439 (D.C. Cir. 1988).

Bonner's actual holding began with "the general rule" "that the consent of the parent is necessary for an operation on a child." *Bonner*, 126 F.2d at 122 (citing authorities in Michigan, Texas, Oklahoma, West Virginia, and Massachusetts). The was "whether the consent of a boy 15 years of age dispenses with the necessity of consent by his parents." *Id*. The trial court decided it did, relying on a passage from the Restatement of the Law of Torts that said, "if the child is capable of appreciating the nature, extent, and consequences of the invasion, his assent prevents the invasion from creating liability, even though the assent of the parent is expressly refused." *Id.*

The Court of Appeals reversed the trial court's decision, expressing skepticism about the Restatement, which was "bottomed on the principle that the very nature of rights of personality is freedom to dispose of one's own person as one pleases." *Id.* at 123. *Id.* Even if there were such a rule, the trial court "overlook[ed] the infancy exception to such a rule. In deference to common experience, there is general recognition of the fact that many persons by reason of their youth are incapable of intelligent decision, as the result of which public policy demands legal protection of their personal as well as their property rights." *Id.* at 122. The "universal law" was that minors could not be held liable on personal contracts, contracts for the disposition of property, or to marry without the consent of their parents. "Hence, it is *not at all surprising* that, generally speaking, the rule has been considered to be that a surgeon has no legal right to operate upon a child without the consent of his parents or guardian." *Id.* (emphasis added).

Bonner acknowledged some exceptions to this rule, but none of them help the defendants or apply to the plaintiffs' children: "cases of emergency, when obviously an operation is necessary," "cases in which the child has been emancipated, or where the parents are so remote as to make impracticable the obtaining of their consent in time to accomplish proper results." *Id.* But even "in all such cases," the Court critically held, "the basic consideration is whether the proposed operation is for the benefit of the child and is done with a purpose of saving his life or limb." *Id.* at 123. In other words, the situations where children can consent to medical treatment on their own are the *exception*, not the *rule*; and those exceptions require that the treatment in question be *necessary* to save the child's life or limb.

2. The Minor Consent Act does not give special weight to the decisions of fit parents, does not further a compelling interest, and is not narrowly tailored.

Medical decisions are among the most private of family decisions, and "so long as a parent adequately cares for his or her children (*i.e.*, is fit), there will normally be no reason for

the State to inject itself into the private realm of the family to further question the ability of that parent to make the best decisions concerning the rearing of that parent's children." *Troxel*, 530 U.S. at 68-69. For this reason, "[s]ubstantial governmental burdens on family integrity are subject to strict scrutiny review, and they survive only if the burden is narrowly tailored to serve a compelling state interest." *De Nolasco v. United States Immigration & Customs Enforcement*, 319 F. Supp. 3d 491, 500 (D.D.C. 2018).

The Minor Consent Act fails strict scrutiny under the Fifth Amendment for the same reasons it fails under RFRA: the "compelling interests" put forth by the defendants are far too general, the defendants make no effort to show how those *general* interests justify application of the Act to the *specific* plaintiffs, and there are myriad alternatives to accomplish those general interests without stripping parents of their lawful authority to exempt their children from vaccines. These demands are not mere surplusage. There is a reason why *Troxel* requires—as a constitutional *minimum*—that the state afford "special weight" to the determinations of parents, *see* Pl. Mem. 30, and why both this Court and the D.C. Circuit apply the heightened strict scrutiny to violations of parental rights. *See* Pl. Mem. 31-32. It is to ensure that the government, which does *not* stand on the same footing as fit parents, cannot override a parent's decision based on "nothing more than a simple disagreement" between the District and parents. *Troxel*, 530 U.S. at 60; *see also* Pl. Mem. 27-30. And until the District shoulders that burden, its views on herd immunity or transmission rates amount to nothing more than a disagreement.

This brings us to the heart of the matter.

3. <u>This Court should reject defendants' invitation to break new ground in substantive due process by placing children on the same legal footing as their parents when it comes to routine medical decisions.</u>

Ironically, it is the defendants who "break new ground," repeatedly contrasting the "longstanding ability of mature minors to determine for themselves whether or not to seek

certain medical care" with the "broad right [of parents] to control their children's medical care" that the Supreme Court has "never specifically defined." Def. Mem. 26-27. Though they never come out and say it directly, one cannot help but think that if a "mature minor" and his or her parents were to come into conflict—a conflict the Minor Consent Act fans into flame—the *District* would side with the minor's decision over the parents. And there is no question the Minor Consent Act would do so.

A closer look at the facts of *Bonner* provide some important rejoinders, and offers a sobering reminder of why the law affords special protection to the decisions of fit parents—and why removing the "safety net" of parents from their "mature minors" is so fraught with peril. In *Bonner*, a fifteen year old child was persuaded by his aunt to engage in a series of skin grafts for his cousin. *Id.* at 121. The ordeal, which ultimately proved unsuccessful, lasted two months and left the boy in considerable pain. The boy's actions were no doubt commendable: "the operation was entirely for the benefit of another and involved sacrifice on the part of the infant." *Id.* at 123. But that didn't change the fact that the procedure caused him "serious physical pain" "involving anesthesia, blood letting, and the removal of skin from his body, with at least some permanent marks of disfigurement." *Id.* Such a procedure "require[d] a mature mind to understand precisely what the donor was offering to give." *Id.*

Because there was no threat to the child's life or limb, *Bonner* held that "[t]he circumstances in the instant case are wholly without the compass of any of these exceptions," and the "the court below should, in the circumstances we have outlined, have instructed that the consent of the parent was necessary." *Id.* It failed to do so, and that failure was reversible error. Nor was this an anomalous approach—the Tenth Circuit did the same thing in *P.J.* After concluding that the general right of parents to direct the care of their children included "a more

specific right to make decisions about the child's medical care," *P.J.*, 603 F.3d at 1197, the court engaged in the same balancing of interests as the D.C. Circuit did in *Bonner*: "when a child's *life or health* is endangered by her parents' decisions, in *some circumstances* a state may intervene without violating the parents' constitutional rights." *Id.* at 1198 (emphasis added).

Bonner distinguished another case defendants cite—*Bakker v. Welsh*, 144 Mich. 632 (1906)—for the same reason. *See* Def. Mem. 28 (citing *Bakker* as a case where the court "reject[ed] liability of medical providers for failure to obtain parental consent where a 'young fellow almost grown into manhood' sought surgery"). *Bonner* rejected the defendant's invitation to follow *Bakker*, which involved a boy who "was 17 years old," was "accompanied to the surgeon's office by his aunt and two sisters, all adults," and—critically—where "it did not appear that the father would have refused his consent." *Bonner*, 126 F.2d at 123. The *Bakker* Court—in a ruling that predated parental rights cases like *Meyer v. Nebraska*, 262 U.S. 390 (1923), and *Pierce v. Society of Sisters*, 268 U.S. 510 (1925)—did refuse to hold the physician liable for the surgery. But it was not because the patient was a "mature minor." Rather, the Court noted that the young man not only went to the physician with his adult aunt and sisters, but that he went "back to his father with an agreement." *Bakker*, 144 Mich. at 635. There was "nothing in the record to suggest that, if the consent of the father had been asked, it would not have been given"; indeed, "there is nothing in the record to indicate to the doctors, before entering upon the operation, that the father did not approve of his son's going with his aunt and adult sisters, and consulting a physician as to his ailment, and following his advice." *Id.* at 635-636.

The truth is that *Bakker* is a case about constructive parental consent, not about "mature minors." Here, of course, there is no confusion as to the plaintiffs' position on vaccines. *See* Ver. Compl. ¶¶ 25, 32, 39, 45, 156-159. And as the D.C. Circuit noted in *Bonner*, the Michigan

Supreme Court declined to follow *Bakker* in a subsequent case where the child's "parents had repeatedly indicated that they did not want the boy's tonsils removed," and "neither of his parents were with him at the time of the operation, or came to the hospital with him." *Zoski v. Gaines*, 271 Mich. 1, 10 (1935). To "allow consent to be implied in such situations" would "go far beyond the law as laid down in the authorities cited and examined." *Id.*

In truth, the defendant's arguments are no different from those advanced—and rejected—in *Parham v. J.R.* There, the state tried to argue that the decision of parents to have a child admitted to a mental hospital "must be subjected to an exacting constitutional scrutiny, including a formal, adversary, pre-admission hearing." *Parham*, 442 U.S. at 603. But that argument swept too broadly. "Simply because the decision of a parent is not agreeable to a child or because it involves risks," the Supreme Court held, "does not automatically transfer the power to make that decision from the parents to some agency or officer of the state." Indeed, "[t]he same characterizations can be made for a tonsillectomy, appendectomy, or other medical procedure," none of which the Court would have found sufficient to override the parents' choice. *Id*.

Certainly, children may hold views that are different from their parents. But that does not change the fact that "[m]ost children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment." *Id.* That is why "[p]arents can and must make those judgments." *Id.* The outcomes of *Meyer v. Nebraska* and *Pierce v. Society of Sisters* would not have been different "if the children there had announced a preference to learn only English or a preference to go to a public, rather than a church, school." *Id.* at 603-604. The same is true of medical decisions: "The fact that a child may balk at hospitalization or complain about a parental refusal to provide cosmetic surgery does not diminish the parents' authority to decide what is best for the child." *Id.* at 604.

The lesson is clear: as a general rule, parental consent is needed for medical treatment; and while there are some narrow exceptions to that rule, they arise only in cases of necessity, where the child's life or health are threatened. In all other cases—including cases involving "mature minors"—parents have a fundamental right not only to "control," but to "direct" the care of their children. They direct that care when children are infants by making all decisions for them, not just the medical ones. As children grow and develop, the role of parents changes. But until the child becomes an adult, parents continue to provide critical direction to their children.

To direct a child—especially a "mature" child—a parent must know what the child is going through, and must have a voice in the conversations the child is having. The Minor Consent Act changes the nature of that conversation: *Your parents don't know what's best—in fact, they're putting you at risk. You know better. And you don't have to stand for it anymore.* And then it does its best to cut parents out that conversation entirely.

Parents are suited to counsel their children because they "possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions." *Parham*, 442 U.S. at 602. Their contribution cannot be discarded so lightly. Nor should it.

III. Absent relief from this Court, the plaintiffs will continue to suffer irreparable, imminent, and redressable injuries.

Lastly, the defendants object to the issuance of a preliminary injunction. Their principal argument—that "plaintiffs will not suffer irreparable harm . . . because they have not shown they are likely to suffer any injury," Def. Mem. 39—is subject to the same defects as their arguments on standing. The Minor Consent Act has already injured the plaintiffs by subverting their lawful exemptions; it continues to do that even now; the plaintiffs' children have and will continue to face immense pressure to violate their parents wishes in the crucible of public high schools; and

DC Health is operating vaccine clinics in DCPS schools, including schools where the plaintiffs' children are enrolled.

"It has long been established that the loss of constitutional freedoms, 'for even minimal periods of time, unquestionably constitutes irreparable injury.'" *Mills v. District of Columbia*, 571 F.3d 1304, 1312 (D.C. Cir. 2009), *quoting Elrod v. Burns*, 427 U.S. 347, 373 (1976). Those losses have occurred and are occurring. And as we argued in our prior memorandum, the injuries feared in *Mills* were arguably less imminent than the injuries the plaintiffs feared when they filed their complaint. *See* Pl. Mem. 36-37. The plaintiffs in *Mills* had a temporary reprieve from NSZ checkpoints; the Minor Consent Act is currently on the books. The plaintiffs in *Mills* did not know when the District would resume the checkpoints; the plaintiffs know DCPS and DC Health are operating clinics, and when they will threaten their children (August 30th). Pl. Mem. 32-37. Those threats are even more imminent now that at least one clinic is in plaintiffs' schools.

Finally, the defendants make objections rooted in generalized concerns about public health. Def. Mem. 42-43. They invoke the community's "right to protect itself," but offer no explanation for why restoring the religious exemptions that the District created, and which the plaintiffs had before the Act was adopted, would put the community at risk. In contrast, the burden on the plaintiffs' rights is severe and ongoing.

As this Court held in *Capitol Hill Baptist*, "[w]hile the public clearly has an interest in controlling the spread of disease, the public also has an interest in honoring protections for religious freedom in accordance with the laws passed by Congress." *Capitol Hill Baptist*, 496 F. Supp. at 302-303. Where "the government has failed to show a compelling interest" in applying a law to the plaintiffs, "the public has little interest in the 'uniform application' of the

regulations. The public interest instead weighs in favor of the plaintiffs." *Tyndale House Publishers, Inc. v. Sebelius*, 904 F. Supp. 2d 106, 130 (D.D.C. 2012).

The balance of interests favors the plaintiffs. The Minor Consent Act should be enjoined.

CONCLUSION

For the foregoing reasons, the plaintiffs' motion for preliminary injunction should be granted. In the alternative, the plaintiffs should be permitted to amend their complaint.

Respectfully submitted this 19th day of August, 2021:

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