

Clinical Report

Paternal Rights: The Ethics of Misunderstanding the “Legal Right to a Child”

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ABSTRACT

Establishment of paternal rights is an unseen and misunderstood process. Generally the establishment of maternal rights is clear, and paternal rights are thought to naturally fall to the person designated as the father. However, in practice there are some nuances that can lead to negative impacts towards partnering with parents. One of these nuances, the marital presumption, is not widely known. In the United States, the marital presumption of paternity can leave some nonmarried or spiritually or culturally married fathers finding themselves having to petition for paternity rights. This clinical report will discuss some relevant history of paternity that has influenced how paternal rights are viewed in the U.S. We provide a case example of how these nuances affect families, discuss the legal and ethical considerations, and provide guidance to clinicians who might face these complicated situations.

INTRODUCTION

Imagine that your partner goes into labor and delivers before you can make it into the hospital. Say you cannot make it to the hospital until a day later. You walk into the hospital excited to see the

child you and your partner have brought into the world. You step up to the desk and inquire to where they are. The person at the desk says you are not listed as a legal guardian. Puzzled, you tell them you are the child’s father. The person then says, “I’m sorry sir, you need to contact the child’s mother to sign a release of information allowing us to let you see your child and receive updates on how your child is doing.” And then, “You have no legal right to this child.”

How would you feel? What does it even mean? How can you be the father of a child and not have any legal right to the child?

ESTABLISHING PATERNITY

Legal parenthood is established differently for mothers and fathers in the United States.¹ Paternal rights are afforded through a marital presumption—the husband of the woman, at conception and/or at birth, is the father. Maternal rights, in nonsurrogate childbirth, are inherently presumed. This means that when a child is born to an unmarried woman, legal guardianship is granted to the mother only.

One can usually be certain of maternity; however, prior to DNA testing, biological paternity might have been uncertain. Different societies have developed different procedures and norms to assign paternity in the face of uncertainty. In the U.S., legal genetic paternity, outside of marital presumption,

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can be obtained through an acknowledgment of paternity by the father, or a legal petition for determination of paternity can be sought.²

Historically, there have been many approaches to the problem of what to do when biological maternity is known but biological paternity is not. In one example, paternity was based on establishment through paternal intention. This method of establishing paternity in cases of unmarried women dates back to the Roman Empire. In Roman times, as early as 400 BCE, children had to be accepted by the father, an intention to parent. The basic thought was that one could always be certain of who the mother of the child was, but there was not this same certainty for the father, and based on the notion of *patria potestas*—the father's will and power—the lives of children were defined by the fathers as their property; they could choose whether to accept the child.³ This was an era when unwanted children were often abandoned and either adopted, enslaved, or died. With child mortality high, children often did not receive a name until they were thought to have survived childhood.⁴

While the issue of paternal rights might not seem like a very pressing issue, that might be because many take it for granted. It also has the potential to negatively impact how pediatric clinicians partner with families. Hospitals and clinics have to work with established societal policies, and they need to provide some control of visitors. However, new fathers may not be aware of how to establish paternity until they are halted from entering the hospital to see their child. This process is probably one of the last things you think about when you are expecting a child, and sometimes even later on in life.

CASE EXAMPLE

A young adolescent was admitted for a significant infection that caused multiple complications that required a period of intubation and impacted her neurologic functioning, possibly long term. She was accompanied to the hospital by her father and his partner, who was not the patient's biological mother. The father explained that he and the patient's biological mother created an arrangement 10 years earlier that he would assume all responsibilities and care for their child, and she would have visitation at agreed-upon times. The biological mother was present at the hospital and began to inquire about assuming care of child, and asked about applying for various financial benefits for the child who might have had new medical needs or disabilities associated with that crisis. Dad was not only

concerned about his child's medical crisis, but also he learned that he could not stop the biological mom from assuming care for their child, as there was no legal aspect to their arrangement. Dad was concerned about how destructive this might be for his child as she recovered and was displaced from her known, supportive, family environment. Dad went to court during this hospital admission to attempt to establish paternal rights emergently and was denied. Fortunately, as the patient's recovery continued, her biological parents were able to agree that the patient would return to her dad's home, and Dad planned to pursue more definitive legal rights following his daughter's admission.

In this case, the father was the person who brought the child into the hospital, and was thus granted access by the hospital. This privilege was not necessarily policy, but was more of a practice. It was generally assumed that a parent who brought an ill child to the hospital had some connection to the child, and pragmatically this parent would be the only source of information about the child. In this case, suppose the child was brought into the hospital through emergency services, and her mother arrived first. According to many hospital admission processes, legal guardianship would have been established and updated in the child's chart. The father would have been stopped at the point of entry and likely denied access until he was granted access by the child's legal guardian, the child's mother. For many, this would seem like a procedural inconvenience, and one with good intentions, but for many fathers this would be a negative interaction that affects how they view their role in partnering with the healthcare team.

ETHICAL AND LEGAL PARENTAL RIGHTS

When people are fathers to expected children, they assume the role of fathers, and they take their obligation and responsibility from this social norm, and, with that, they expect the societal rights and privileges that will allow them to fulfill their paternal obligations. It's a natural process that we in society grant, based on the child being genetically linked to a particular parent. We even bestow this moral status on figures in a child's life who are not genetically related, but who have assumed the role through their agency and intentions. This role contains responsibilities that are separate from the law or the social institution of marriage. The important distinction is that there is a socially constructed and legally constructed right to parental authority. Even when there are questions around legal parental

rights, there is often still a consideration of parental inclusion in medical decisions, even when the state has the final say, sometimes even when parents are at risk of losing parental rights.

In Minnesota, the state where these authors practice, a father, along with a child's mother, have up to 10 months to make a declaration of parentage under oath in front of a notary.⁵ A "Recognition of Parentage" form can be filled out to establish a legal connection between a father and child, but this does not equate to legal custody. If recognition of parent-

ians who needed permission to visit their child. Visitor restriction policies varied between children's hospitals, but most policies restricted visitation to only two adults—often presumed to be a child's legal guardians. Some hospitals allowed those identified as caregivers to visit.⁸

There is a difference between a "legal" right and an "ethical" right. What is legal is not always ethical, and what is ethical is not always legal. The two domains are not synonymous. This is exactly why we continue to enact new laws and remove old ones.

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age does not happen, a father must go through the court process of paternal adjudication.⁶ This process can be initiated by the child, the mother, or the presumed father.

Parents can lose their parental rights through criminal action, be it abuse, negligence, or abandonment. Parents can also give up their parental rights, such as in an adoption. This is ethically different than not establishing parental rights legally. Fathers of newborn infants who have not established paternal legal rights should still be afforded the ethical right to exercise their parental duty to be involved in decision making. Fathers should be included in the care of their child, particularly when there are barriers to a formal declaration of paternity that involve visiting restrictions, reduced hours of visitation, transportation, and so on. Many of these barriers were heightened during the COVID-19 pandemic.

Accommodations can be made to create open communication with the medical team by having the child's mother sign a release of information form that allows the father to receive medical updates when the mother is not present, and even to create temporary legal ties to the child by having both parents sign a Delegation of Parental Authority (DOPA), which authorizes the father to consent for routine medical treatment and educational services.⁷

During COVID-19 visitor restrictions, there was a need to make "exceptions" for fathers who were not identified in the medical record as legal guard-

Many things that were once legal were certainly not ethical, and never were. Likewise, many things that were once illegal were completely ethical.

AVOIDING THE PITFALLS OF STRUCTURAL CONSTRAINTS TO ETHICAL PRACTICE

We have an ethical obligation to affirm and honor paternal interests when they are based on a well-established intention. This is particularly important when bias and structural racism exist as undercurrents in our society and our systems. It is easy to use a lack of legal connection as we would use a termination of parental rights.

We should caution ourselves from falling into the trap of relying on a legal nuance (or artifact) for practical or convenience purposes, such as designating fathers as "difficult" and using a nonlegally established paternity status to exclude them from the bedside. Fathers who have yet to declare paternity and are recognized as the father by the mother of the child, or even by the child, are not the same as fathers who have lost or refuse legal paternity. There are many "difficult" parents who have legal parental rights. Inappropriate interactions and behavior in the hospital are just as bad when a person is a parent with legal custody or a visitor; the person's behavior guides our response, not a legal loophole.

While recognition of legal paternity and its process might be practical (or expedient) from a gov-

ernmental perspective, it does impact issues in the hospital, and we should be wary of how we employ it, as clinicians. It is important to know the nuanced difference between termination of rights and unestablished paternity. In termination of rights, a burden of proof has been satisfied that a person may not have the rights of parenthood because extending such rights would be inconsistent with the best interest of the child. In the other case, to deny the person the rights of parenthood without proof is a serious harm to both the parent and child. Our presumption should be to honor parental interests, unless we've gone through a fair process, for good reason, to terminate that right. It is our obligation, and that of society, to meet the burden of proof prior to the exclusion or termination of parental rights. We also need to be aware of the nuances of a situation to ensure that we are not inadvertently being used to unfairly block fathers from being involved in their child's life.

Clinicians can feel caught within an imperfect system—working within social and legal policies, trying to control visitors, providing adequate infection control—but often must deal with incomplete information and slow or imperfect processes. It can be easy for either parent to exploit structural or systemic advantages when they are engaged in a relational conflict, and it can be easy for clinicians to accede to those forces. Some mothers may use their rights to exclude fathers who were involved in the pregnancy or the upbringing of the child when the relationship between the parents dissolves—and fathers may be unfairly removed from this process. There are certainly fathers who should be ethically and legally excluded for valid reasons, such as for the protection of the mother and child.

Clinicians can also explicitly or implicitly misuse a lack of legal paternity. It is important help both parents acknowledge that while there may be a history or dynamics that impact their relationship, they likely have a shared investment in what is best for their child, however difficult their relationship may be. We as clinicians must also be aware that we must not use a lack of legal paternity as a way to get to a decision or situation we might want, in the same way that it is wrong to use the threat of involving child protective services (CPS) to push a parent into a certain position. When we are faced with complexity and uncertainty, in non-ideal situations, it is best to look pragmatically at how to best go forward while we satisfy our many obligations to a child and family. Understanding the nuances, the hazards, and the perspectives of those affected can help us to establish better practices when we partner with families.

CONCLUSION

Since we work in a pluralistic society, familiarity with the nuances of legal policy may help us to avoid structural barriers to ethical practice. It may help us to avoid being inadvertently unethical. As members of healthcare institutions, we have a greater responsibility to overcome communication difficulties. We should think of the institutional power we wield and how a parent can be vulnerable and powerless against how we put our policies into practice, even when such consideration makes our job harder. Communication breakdowns happen with many families, with or without the involvement of their legal rights. Our ethical obligation is to join together with the parents and families of our patients, as caregivers, and not as agents of the state, even when this will be more difficult for us.

NOTES

1. 45 *CFR* § 303.5—“Establishment of paternity,” <https://www.govinfo.gov/content/pkg/CFR-2012-title45-vol2/pdf/CFR-2012-title45-vol2-sec303-5.pdf>.

2. *Ibid.*

3. A.R. Colón and P.A. Colón, *A History of Children: A Socio-Cultural Survey across Millennia* (Westport, Conn.: Greenwood Press, 2001).

4. *Ibid.*

5. “Parentage Act, 2021 Minnesota Statutes, Public Welfare and Related Activities, Chapter 257, Section 257.34,” <https://www.revisor.mn.gov/statutes/cite/257.34>.

6. “Parentage Act, 2021 Minnesota Statutes, Public Welfare and Related Activities, Chapter 257, Section 257.51,” <https://www.revisor.mn.gov/statutes/cite/257.51>.

7. “Delegation of Power by Parent or Guardian, 2021 Minnesota Statutes, Probate; Property; Estates; Guardianships; Anatomical Gifts. Chapter 524, Section 524.5-211,” <https://www.revisor.mn.gov/statutes/cite/524.5-211>.

8. A.J. Vance et al., “Visitor guidelines in US Children's hospitals during COVID-19,” *Hospital Pediatrics* 11, no. 6 (2021): e83-9.