No. 26A325

IN THE

Supreme Court of the United States

M.W.,
APPLICANT,

v.

SUPERIOR COURT OF CALIFORNIA, COUNTY OF LOS ANGELES,
RESPONDENT,
N.G. AND O.A.,
REAL PARTIES IN INTEREST

On Application for a Stay of the Order Issued by the Superior Court of California, County of Los Angeles

BRIEF *AMICI CURIAE* OF THE AMERICAN ASSOCIATION OF PRO-LIFE OBSTETRICIANS AND GYNECOLOGISTS AND AMERICAN COLLEGE OF PEDIATRICIANS IN SUPPORT OF APPLICANT'S EMERGENCY APPLICATION FOR ADMINISTRATIVE STAY AND STAY PENDING PETITION FOR CERTIORARI

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INTEREST OF *AMICI CURIAE*[1]

The American Association of Pro-Life Obstetricians and Gynecologists ("AAPLOG") is a nonsectarian professional medical organization that represents approximately 8000 life-affirming medical professionals from all 50 states. The American College of Pediatricians ("ACPeds") is a national organization of pediatricians and other health care professionals dedicated to the health and well-being of children, including the sanctity of human life from conception to natural death. Amici support petitioner's argument that the Fourteenth Amendment's Due Process Clause limits a state's ability to find that a litigant has consented to its jurisdiction. Amici respectfully submit that the decision below presents another due-process concern: it was rendered without a guardian ad litem or other representative to protect a medically vulnerable pre-born child's independent interests. Amici thus offer this brief to assist the Court in evaluating the medical, ethical, and child-welfare consequences of the judgment below.

The additional due-process problem arose when the challenged decision was made: Baby G's diagnosis already presented difficult, time-sensitive medical judgments about delivery planning, immediate neonatal stabilization, surgery, and future staged care. Those complexities warranted a guardian ad litem or other

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[1] Under Rule 37.6, no counsel for any party authored this brief, in whole or in part, nor did counsel for any party or either party make a monetary contribution intended to fund this brief in whole or part. No person or entity other than Amici and counsel for Amici contributed monetarily to this brief's preparation or submission.

representative for the child's independent interests before authority over those decisions was allocated. Later orders by a different court in Texas directing post-birth medical care and appointing a guardian ad litem (App. 9) confirm the need for such representation. Yet the earlier defective judgment continues to exclude M.W., the surrogate mother who carried and birthed Baby G, from his life, parenting, and ongoing medical care. Were it not for the California judgment under review, M.W. would have been declared his mother under Texas law. *See* Tex. Fam. Code §§ 160.762(a) (providing that unvalidated gestational agreement is unenforceable), 160.201(a)(1) (establishing mother-child relationship through birth). Instead, a Texas court gave full faith and credit to the defective California judgment, prompting the need for this Court's urgent attention.

Amici have a strong institutional interest because this case sits at the intersection of law, medicine, medical ethics, and vulnerable human life. Amici can offer a medical and ethical perspective recognizing that a child with serious ongoing medical needs may benefit from continuity of care, stable caregiving relationships, and the involvement of the woman who gave birth to him and seeks to support his treatment. That perspective is especially useful where the requested relief is narrow: preserving review before a pre-birth California judgment becomes the practical reason that M.W. is barred from any continuing role in Baby G's time-critical care and upbringing, even if another court has separately protected some of his immediate medical needs.

The organizations' members are also affected by rulings that define how courts treat children with known medical needs, enforce safeguards in assisted-reproduction arrangements, and allocate parental authority after birth. Clear and administrable rules matter because uncertainty can affect counseling, treatment planning, advocacy, and the willingness of caregivers to pursue continuing care for children facing difficult diagnoses. Here, the most pressing question is no longer whether Baby G will receive any immediate post-birth intervention; it is whether a judgment entered without adequate safeguards may be used to cut off a willing caregiver from the child's crucial follow-up surgeries, care, and family life.

Amici do not ask the Court to resolve disputed medical facts, decide ultimate parentage, or announce a broad rule governing every surrogacy case. They merely offer their experience and perspective to aid the Court in preserving meaningful review before the California judgment ossifies into a continuing barrier to M.W.'s involvement in Baby G's life and medically complex treatment.

SUMMARY OF ARGUMENT

I. The medical complexity at issue existed when the challenged decision was made and warranted special protections in the interest of due process. Baby G's known cardiac diagnosis required difficult judgments about birth planning, immediate neonatal care, surgical options, and future staged treatment. Amici agree with petitioner that the California court's exercise of jurisdiction in this case raised serious due-process concerns. But due process should have also required a guardian ad litem or other representative for the child's independent interests before a court allocated legal authority over those decisions. A Texas court's later order directing

care and appointing a guardian ad litem confirms that need; it does not retroactively cure the California judgment or its current use to exclude M.W. from Baby G's life, parenting, and ongoing medical care.

That problem is especially acute because Baby G is not an abstraction and his needs did not end at delivery. He has been born with a serious cardiac condition, has received initial post-birth treatment pursuant to the later court order, and will require ongoing monitoring, staged surgeries, and caregiving decisions. A judgment that forecloses M.W. from participating in those decisions necessarily affects the child's concrete interests, not merely the adults' competing claims to parentage. When courts confront medical decisions of this kind, the child's interests should require independent representation. Belated representation after another court intervened cannot answer whether the California judgment was entered through a process adequate for a child whose known condition made medical decision-making complex from the outset. Those defects matter because the judgment is now being used not merely to allocate formal parentage, but to bar the woman who gave birth to Baby G from any involvement in his continuing care and life. Tellingly, she is the only one of the adults involved in the parentage dispute who fought for him to receive that care while she was pregnant with him.

II. Those considerations also support the stay analysis. If M.W. is right that the California judgment was entered without jurisdiction, then allowing it to remain operative risks irreparable consequences before review can occur. That concern is only amplified by a decision rendered without adequate statutory

safeguards. The harm is not merely the impending denial of immediate lifesaving treatment upon birth; another court has addressed that emergency. The harm is the ongoing exclusion of M.W. from Baby G's life and future medical care based on a judgment whose validity remains seriously disputed. The Court should intervene to ensure that Baby G's interests are not jeopardized.

ARGUMENT

Baby G was prenatally diagnosed with hypoplastic left heart syndrome ("HLHS"), a serious cardiac condition requiring coordinated delivery planning, immediate post-birth stabilization, and a sequence of difficult treatment decisions beginning at birth and extending well beyond it. That was the posture when the challenged California decision was made, and which the California Supreme Court has allowed to stay in place. The need for an independent representative was therefore not a hindsight lesson from later events; it was apparent from the medical complexity already before the court. Just before birth, a Texas court appointed a guardian ad litem and entered an order directing that Baby G receive medical care after delivery at a facility specializing in the baby's condition. (App. 9.) That court also entered an order restraining M.W. from any contact or involvement in Baby G's care. (App. 9–10.)

These orders may change the nature of the emergency posture, but they also confirm grave due-process concerns: a child facing these medical choices should have had someone charged with protecting his interests when legal authority over his care was first adjudicated. A Texas court has subsequently given full faith and credit to the California judgment, blocking M.W.'s rights. (App. 10.) The resulting

problem is that the California judgment continues to serve as the legal foundation for rulings prohibiting M.W.—the surrogate mother who carried and birthed Baby G—from having any involvement in his care, parenting, or life.

Amici offer their medical, ethical, and child-protection expertise to emphasize that this continuing exclusion matters. A child with HLHS does not merely need a one-time order authorizing treatment at birth. He needs ongoing medical follow-up, staged surgical planning, caregiving continuity, and adults willing to advocate for his welfare over months and years. M.W. alleges that she is willing to support that care and relieve the intended parents of parental and financial obligations. A judgment that bars her from that role therefore affects more than litigation; it may affect the child's practical access to a willing caregiver and advocate throughout a medically complex childhood. More broadly, it may impact the decisions of women in medically complex surrogacy cases who may not have originally intended to become the baby's parent, but do not wish to see the baby intentionally killed.

The existence of a guardian ad litem does not answer whether a defective California judgment may be used to eliminate M.W.'s caregiving and parental involvement altogether. The point is that Baby G's long-term welfare may include an interest in preserving access to a willing birth mother who seeks to participate in his care, subject to lawful adjudication. From a medical ethics and child protection standpoint, when the practical effect of a decree is to decide whether the woman who carried and birthed a medically fragile child (and was the sole adult advocating for his right to medical care throughout the pregnancy) may have any contact with

him or role in his ongoing care, the law's ordinary concern for adversarial fairness becomes indispensable. The appointment of a guardian ad litem for treatment-related proceedings is important, but it does not cure defects in the California judgment or justify using that judgment to foreclose M.W.'s future relationship with Baby G before meaningful review.

Nor does the existence of a legal parentage framework eliminate the need to consider the consequences of enforcing the California judgment in this procedural posture. In *Michael H. v. Gerald D.*, this Court confirmed that States have constitutional authority to define and allocate parental rights through recognized legal-parentage rules. 491 U.S. 110, 130 (1989). But that principle cuts against viewing the California court's judgment in isolation: once a court-recognized parentage determination carries legal force, the decisionmaker's authority over the child's welfare becomes constitutionally significant, particularly where the order is being used to exclude a willing birth mother from future care and parenting. Given the time-sensitive nature of Baby G's care and treatment, only a stay from this Court can prevent the irreparable harm of interfering with Baby G's parental relationship while this case proceeds.

I. Due Process Cannot Permit a Disputed Parentage Judgment to Serve as the Basis for Cutting Off a Birth Mother's Ongoing Involvement in a Medically Fragile Child's Life.

Due process requires a procedure adequate to protect the concrete interests affected by a judgment, and here the concrete interests were apparent in this surrogacy dispute before Baby G was born. The California court was asked to allocate authority over a child already known to require life-preserving medical decisions

involving delivery timing, neonatal stabilization, surgical-pathway selection, and future staged care. Those are not ordinary incidents of parentage litigation. They are precisely the sort of complex, child-specific medical interests that necessitate a guardian ad litem or other representative before the State gives binding legal effect to one set of adult litigants' preferred allocation of authority. The Texas court's order directing treatment and appointing a guardian ad litem confirms that representation was necessary—as Amici's experience shows, the pre-born child was effectively the "second patient" alongside his mother. Because the California judgment was entered without representation for Baby G, Amici respectfully submit that it stands on this additionally infirm ground and cannot fairly be used to block M.W.'s involvement in Baby G's life as his birth mother.

A. The Fourteenth Amendment established the need for representation at the time of the California decision.

Due process is concerned with the reliability and fairness of the process used before the State imposes binding legal consequences. The Fourteenth Amendment provides that "a person cannot be deprived of his legal rights in a proceeding to which he is not a party." *Martin v. Wilks*, 490 U.S. 755, 759 (1989). Baby G is now a newborn child whose future care and family relationships are being shaped by court orders. M.W. is the woman who carried and birthed him and seeks to remain involved in his life and care. A judgment that bars that involvement before the objections to it are meaningfully reviewed imposes consequences that cannot be undone.

The appointment of a guardian ad litem in Texas underscores rather than eliminates the due-process problem. It confirms that Baby G's interests were not identical to any adult litigant's position and that the medical choices surrounding his birth and treatment required an independent voice. But a later guardian ad litem cannot retroactively participate in the California proceeding, test the medical assumptions before that court, or ensure that Baby G's interests were considered when the parentage judgment first allocated authority over care. Nor does the later appointment decide the parentage question, cure defects in the California proceedings, or justify excluding a willing birth mother from the child's life altogether.

That principle is narrow. Amici do not suggest that every parentage dispute requires emergency federal intervention, nor do they challenge the authority of a court to appoint a guardian ad litem or order necessary medical care for a newborn. The concern arises here because Baby G has known continuing medical needs, M.W. brought him safely to birth and seeks to support his care (while it is not apparent that the intended parents do), and the California judgment is functionally prohibiting her from involvement in his ongoing life. *See* Tex. Fam. Code §§ 160.762(a), 160.201(a)(1). More simply, the judgment is risking the baby's life. Babies with HLHS require a series of surgeries and monitoring; without this, they die. In that light, preserving review is the minimum safeguard needed to prevent a disputed judgment from becoming practically irreversible.

That conclusion is also consistent with longstanding decisions treating the form of a minor's representative as a matter of procedural regularity rather than a

jurisdictional prerequisite. *See Colt v. Colt,* 111 U.S. 566, 578 (1884) (holding representation of infant defendants by general guardian rather than guardian ad litem, in accordance with local practice, did not defeat state court's jurisdiction or invalidate its decree). The point here is not that any particular label is constitutionally required in every case; it is that some representative must be responsible for the child's concrete medical interests when the judgment will control life-preserving care.

B. The medical context shows why representation was required when the challenged decision was made.

Baby G's medical condition makes the due-process defect concrete rather than abstract. At the time of the California decision, the court was not merely assigning formal parentage in a routine case. It was allocating authority over a child already known to face a medically complex course of treatment, including immediate stabilization after birth, selection among surgical strategies, interstage monitoring, and later operative decisions. Those choices involved medical uncertainty, ethical judgment, and potentially divergent adult interests. That is why the child needed a guardian ad litem or other representative then—not only after another court later intervened.

HLHS is a congenital heart defect involving underdevelopment of left-sided heart structures, including the left ventricle, the mitral and aortic valves, and the

ascending aorta.[2] In a normally formed heart, the left ventricle pumps oxygenated blood systemically while the right ventricle pumps blood to the lungs. In HLHS, the left ventricle is often too underdeveloped to function as the systemic pump, so staged surgeries instead repurpose the right ventricle as the systemic ventricle and route venous blood passively to the lungs without a subpulmonary ventricle.

Newborns with HLHS depend on the ductus arteriosus, a developmental structure that normally closes shortly after birth, remaining patent so that oxygenated blood can reach the heart and body. For that reason, affected newborns must receive a prostaglandin infusion as soon as possible after birth.[3] Prenatal diagnosis can improve the preoperative condition and reduce neurological complications by enabling timely prostaglandin initiation.

Without surgical intervention, HLHS is uniformly fatal. Neonates with HLHS are typically treated through a three-stage surgical sequence that progressively separates pulmonary from systemic circulation and ultimately achieves passive pulmonary blood flow, known as Fontan physiology.[4]

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[2] *See generally* S.M. Hoenig et al., *Seventy Years Managing Hypoplastic Left Heart Syndrome—What has been Learned and What Remains to be Learned*, 38 SEMINARS IN THORAC. & CARDIOVASC. SURG. 59 (Aug. 18, 2025), https://doi.org/10.1053/j.semtcvs.2025.07.004.

[3] S. Akkinapally et al., *Prostaglandin E1 for Maintaining Ductal Patency in Neonates with Ductal-dependent Cardiac Lesions*, 2018(2) COCHRANE DATABASE SYST. REV. CD011417 (Feb. 27, 2018), https://doi.org/10.1002/14651858.CD011417.pub2.

[4] K. Stout et al., *2018 AHA/ACC Guideline for the Management of Adults With Congenital Heart Disease: A Report of the American College of*

The first stage is traditionally the Norwood procedure, typically performed within the first week of life. That procedure involves open-heart surgery with aortic reconstruction, atrial septectomy, and creation of a source of pulmonary blood flow through either a modified Blalock-Taussig shunt or a right-ventricle-to-pulmonary-artery shunt. Alternatively, some infants undergo a hybrid procedure combining bilateral pulmonary-artery banding and ductal stenting through a catheter-based approach, deferring aortic reconstruction until Stage II. More than 90% of infants survive the Norwood procedure to hospital discharge.[5] During the outpatient inter-stage period between Norwood and Stage II, mortality is 4% to 15%, making close home monitoring of weight and oxygen levels critical.[6]

Stage II is the bidirectional Glenn or Hemi-Fontan procedure, typically performed at 3 to 6 months of age. These procedures convert pulmonary blood flow from a high-pressure arterial source to a passive venous source, reducing volume load on

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Cardiology/American Heart Association Task Force on Clinical Practice Guidelines, 139 CIRCULATION e698 (Aug. 16, 2018), https://www.ahajournals.org/doi/10.1161/CIR.0000000000000603.

[5] R. Ohye et al., *Current Therapy for Hypoplastic Left Heart Syndrome and Related Single Ventricle Lesions*, 134 CIRCULATION 1265, 1266 (Oct. 25, 2016), https://www.ahajournals.org/doi/10.1161/circulationaha.116.022816.

[6] R. Ohye et al., *Comparison of Shunt Types in the Norwood Procedure for Single-Ventricle Lesions*, 362 N. ENGL. J. MED. 1980, 1981 (May 27, 2010), https://www.nejm.org/doi/full/10.1056/NEJMoa0912461.

the single right ventricle.[7] They are considered relatively low-risk operations.[8] Stage III is Fontan completion, typically performed at 2 to 4 years of age, in which complete separation of the circulations is performed. It may be done with either an extracardiac conduit, usually after a bidirectional Glenn, or a lateral tunnel, typically after hemi-Fontan, routing inferior vena cava blood to the pulmonary arteries.[9]

Outcomes have improved substantially thanks to these treatments. Hypoplastic-left-heart-related infant mortality declined by 43% from 2007 to 2021, from 7.4 to 4.2 per 100,000 births, and in-hospital neonatal mortality fell from 25.3% to 20.6% when comparing 1998–2005 with 2006–2014.[10] Experienced centers report hospital survival greater than 90% after Norwood surgery, with 5-year survival of 60% to 70% after Fontan surgery. Current estimates suggest that about 70% of neonates born with HLHS today will reach adulthood, and 31% of patients with HLHS survived without a cardiac transplant at age 35.[11] Because outcomes have improved

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[7] J. Feinstein et al., *Hypoplastic Left Heart Syndrome: Current Considerations and Expectations*, 59 J. AM. COLL. CARDIOL. S1, S16–S17 (Jan. 3, 2012), https://pmc.ncbi.nlm.nih.gov/articles/PMC6110391/pdf/nihms-983456.pdf.

[8] Ohye et al., *supra* note 5, at 1265.

[9] Stout et al., *supra* note 4, at e763.

[10] J. Mantena & R. Vidavalur, *Trends and Regional Disparities in Hypoplastic Left Heart Syndrome Prevalence and Mortality in the USA: A Nationwide Study*, 185 EUR. J. PEDIATR. 493 (2026), https://link.springer.com/article/10.1007/s00431-026-07165-1.

[11] J. Gaynor et al., *Long-Term Survival and Patient-Reported Outcomes After Staged Reconstructive Surgery for Hypoplastic Left Heart Syndrome*, 85 J. AM. COLL. CARDIOL. 2386, 2390 (June 16, 2025), https://www.jacc.org/doi/10.1016/j.jacc.2025.04.028.

significantly over the past four decades, survival rates are likely even higher for children born in 2026.

Treatment strategies also continue to evolve. A team of physicians from Children's Health in Dallas published a 2025 paper describing the modern evolution of perinatal counseling and the broadening group of babies considered candidates for biventricular repair.[12] The only truly corrective treatment options for HLHS are heart transplantation or, in cases of borderline left-heart hypoplasia, biventricular repair. Some teams, however, including those at Children's Health in Dallas, now use a standard single-ventricle palliation strategy while performing adjunctive procedures that promote left-ventricular loading and growth, with eventual biventricular conversion. In the mildest cases, primary neonatal biventricular repair may be an option, avoiding the three-stage palliation strategy altogether.

Many people who survive HLHS repair report a good quality of life. Adults with HLHS have reported good to excellent general health and better general quality of life than the general population.[13] Although some children with HLHS at age 6 have lower behavioral, quality-of-life, and functional-status measures than population norms, the vast majority of study subjects—between 80.3% and 96.7%—had

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[12] L. Murguia et al., *Redefining Biventricular Repair Feasibility in Prenatal Counseling: A Review of Fetal Echocardiograms in Patients Selected for Complex Biventricular Repair*, 47 PEDIATR. CARDIOL. 2067 (Aug. 21, 2025), https://pmc.ncbi.nlm.nih.gov/articles/PMC13144223/.

[13] Gaynor et al., *supra* note 11, at 2391, 95.

scores within the normal range.[14] In a recent large cohort study evaluating long-term survival and patient-reported outcomes after staged reconstructive surgery for HLHS, more than 85% of patients reported that their overall health was good, very good, or excellent, and surveyed patients reported statistically significantly higher quality of life than the comparative general population.[15]

Additionally, there are published medical studies demonstrating improved outcomes when the baby's mother is directly involved. It is well known that while *in utero* the developing baby hears his mother's voice. When born prematurely, intentional exposure to the mother's voice has demonstrated improvements in neurodevelopment and feeding.[16] Other studies have demonstrated that term infants who have been exposed to opiates *in utero* have decreased symptoms of withdrawal when treated using the Eat/Sleep/Console protocol[17]— mothers holding and nursing their babies (including those who still have issues with addiction) improve their baby's

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[14] C. Goldberg et al., *Behavior and Quality of Life at 6 Years for Children With Hypoplastic Left Heart Syndrome*, 144 PEDIATRICS 1 (2019), https://pmc.ncbi.nlm.nih.gov/articles/PMC6856798/pdf/PEDS_20191010.pdf.

[15] Gaynor et al., *supra* note 11, at 2391.

[16] M. Mukerji et al., *Role of Maternal Sound Stimulation in the NICU: Improving Outcomes for Newborns and Their Families*, 14 FRONT. PEDIATR. 1764698, at 3 (Mar. 20, 2026), https://www.frontiersin.org/journals/pediatrics/articles/10.3389/fped.2026.1764698/full; M. Filippa et al., *Maternal Singing and Speech Have Beneficial Effects on Preterm Infant's General Movements at Term Equivalent Age and at 3 Months: An RCT*, 16 FRONT. PSYCHOL. 1536646, at 7 (Jan. 28, 2025), https://www.frontiersin.org/journals/psychology/articles/10.3389/fpsyg.2025.1536646/full.

[17] *See generally* L. Young et al., *Eat, Sleep, Console Approach or Usual Care for Neonatal Opioid Withdrawal*, 388 N. ENGL. J. MED. 2326 (Apr. 30, 2023), https://www.nejm.org/doi/pdf/10.1056/NEJMoa2214470.

outcomes by being involved.[18] Medical literature demonstrates what most mothers intuitively know: babies benefit from involvement of their birth mother.

Against this backdrop, medical ethics and child-protection principles show why independent representation was required at the time the challenged decision was made. HLHS treatment is not a mechanical yes-or-no question. It requires informed judgment about whether, where, when, and how to pursue stabilization, surgery, interstage monitoring, and later staged procedures. Physicians affiliated with amici regularly encounter scenarios in which a child has a treatable condition but adult decisionmakers hesitate, object, or have interests that do not fully align with the child's medical welfare. In those circumstances, courts can and do appoint representatives or enter targeted orders to ensure that life-preserving treatment decisions are assessed from the child's perspective.[19] The Texas court's order directing care and appointing a guardian ad litem thus confirms the due-process principle amici invoke: when a judgment will allocate authority over a child's medically complex and life-preserving care, the child needs a constitutionally adequate representative before a decision is rendered.

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[18] S. W. Patrick et al., *Neonatal Opioid Withdrawal Syndrome*, 146 PEDIATRICS e2020029074 (Nov. 1, 2020), https://publications.aap.org/pediatrics/article/146/5/e2020029074/75310/Neonatal-Opioid-Withdrawal-Syndrome.

[19] For example, it is standard practice to seek a court-appointed guardian ad litem on behalf of a baby who requires a blood transfusion to save his life when the baby's parents are Jehovah's Witnesses. *See generally* F. Lagay, *When a Parent's Religious Belief Endangers Her Unborn Child*, 7(5) VIRTUAL MENTOR 331, 375–78 (2005), https://journalofethics.ama-assn.org/article/when-parents-religious-belief-endangers-her-unborn-child/2005-05.

Modern obstetrics also increasingly recognizes that the physician's duties are not exhausted by care for the pregnant mother alone. An obstetrician-gynecologist is called to care for two patients—the pregnant mother and her preborn child—and the physician's Hippocratic obligation requires beneficence and respect toward each patient. That ethical framework reflects contemporary medical practice. Technological advances such as magnetic resonance imaging and ultrasonography now permit physicians to diagnose and treat fetal conditions *in utero*, earlier and earlier.[20] Those advances have helped produce a "perinatal revolution" in which "fetal therapy and surgical interventions [make] it possible for [preborn children] with previously life-limiting or life-threatening diagnoses to not only survive to birth, but also to experience marked increases in quality of life and lifespan."[21] Practically speaking, the preborn child "has truly become a patient" apart from her pregnant mother.[22]

That does not diminish the physician's duties to the mother; it explains why the law should not treat the child's medical interests as legally invisible when a court order will control life-preserving care. Fetal treatment centers across the country now perform open fetal surgery, fetal cardiac interventions, fetoscopic procedures, and other treatments for conditions that may have once been life-limiting

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[20] C. Malloy et al., *The Perinatal Revolution*, 34 ISSUES L. & MED. 15, 16, 18 (2019), https://pubmed.ncbi.nlm.nih.gov/31179670/.

[21] *Id.*

[22] K. J. Moise, Jr., *The History of Fetal Therapy*, 31 AM. J. PERINATOL. 557, 564 (Feb. 25, 2014), https://d.docksci.com/queue/the-history-of-fetal-therapy_5afca5bcd64ab2bd4aea3164.html.

or fatal.[23] During these surgical interventions, the fetus may receive anesthesia or analgesia, as any surgical patient would.[24] And the medical paradigm has moved beyond a binary choice between continuing a pregnancy or ending it: as specialists in fetal diagnosis and therapy have explained, "[n]o longer do we accept the limited choices of prenatal diagnosis—by way of continuing the pregnancy, or not."[25] In this setting, a court order transferring authority over Baby G's care implicated not only competing adult claims to parentage, but also the medical interests of a second patient whose treatment may be accepted, delayed, or refused.

Existing child-protection principles further confirm that the proper answer to concerns about future medical decisions is targeted judicial review of the particular decision, not wholesale disregard of the child's interests at the parentage stage. The state retains "control over parental discretion in dealing with children when their physical or mental health is jeopardized." *Parham v. J. R.*, 442 U.S. 584, 603 (1979). And courts recognize the necessity of guardianship where parents have "made decisions that evidence substantial lack of concern for the child's interests." *Bowen v. Am. Hosp. Ass'n*, 476 U.S. 610, 627 n.13 (1986). At a minimum, that framework supports the modest relief of a stay preserving review.

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[23] *See* Malloy et al., *supra* note 20, at 20–23; Moise, Jr., *supra* note 21, at 561–64.

[24] C. V. Bellieni, *Analgesia for Fetal Pain During Prenatal Surgery: 10 Years of Progress*, 89 PEDIATR. RES. 1612 (2021); Malloy et al., *supra* note 20, at 19–20.

[25] M. Choolani & A. Biswas, *Fetal Diagnosis and Therapy*, 26 BEST PRAC. & RSCH. CLIN. OBSTET. & GYNAECOL. 515, 515–16 (2012), https://www.sciencedirect.com/science/article/abs/pii/S1521693412000946?via%3Dihub.

Because Baby G's prenatal diagnosis made clear, at the time of the California decision, that legal authority would control difficult medical judgments affecting an identifiable child, due process required a guardian ad litem or other representative for that child before the judgment allocated that authority. The Court should not allow that judgment to operate as a barrier to M.W.'s role in Baby G's life, parenting, and future medical care before the judgment's validity is reviewed.

II. A Stay Is Further Warranted Because the California Judgment's Legal Error and Continuing Exclusionary Harm Are Inseparable.

The stay grounds follow from many of the same harms that arise from the merits. *See Nken v. Holder*, 556 U.S. 418, 426–27 (2009). Because the California judgment was allegedly entered without jurisdiction and without any representative for Baby G at a time when the known medical facts made independent representation necessary, the judgment creates the very harm that emergency relief is designed to prevent. The later order directing medical care and appointing a guardian ad litem mitigates the immediate risk that Baby G would be denied treatment at birth. It does not mitigate the separate injury caused by using a procedurally defective California judgment to exclude M.W. from the child's continuing care and family life.

That is irreparable harm in the most concrete sense. A later appellate ruling cannot restore lost months of bonding, caregiving, medical advocacy, or participation in decisions during the interstage periods of HLHS treatment (many of which could mean the difference between life and death for Baby G). Nor can it retroactively undo the practical consolidation of parental authority that occurs when a

disputed judgment is treated as final while Baby G's early medical and family relationships are forming. The likelihood-of-success inquiry therefore overlaps with irreparable injury: the stronger the objections to the California judgment, the stronger the reason to prevent that judgment from continuing to exclude M.W. before review.

Recent stay decisions confirm that the irreparable-harm inquiry focuses on whether denial of interim relief will inflict injury that cannot later be undone. In *Trump v. CASA, Inc.*, this Court explained that a stay applicant must show likely irreparable harm absent a stay, and that threshold legal error may bear on that analysis even before final merits review. 606 U.S. 831, 859 (2025). Likewise, in *National Institutes of Health v. American Public Health Ass'n*, this Court treated irreparable harm as turning on whether the consequences of denying a stay would be irrecoverable. 145 S. Ct. 2658, 2659 (2025). Those principles matter here because the injury from excluding M.W. from Baby G's early life, ongoing care, and medical advocacy cannot be fully recouped after appeal, especially where the judgment's validity remains seriously disputed.

The equities and public interest point the same way. A stay would not resolve parentage, displace the guardian ad litem, unwind medical treatment, or foreclose any party's ultimate position. It would preserve this Court's ability to review the California judgment before that judgment becomes the practical reason M.W. is excluded from Baby G's infancy, follow-up care, and developing family relationships. The public has a strong interest in ensuring that judgments affecting vulnerable

children, medically complex care, and parental authority rest on adequate jurisdiction, required statutory safeguards, and procedures that do not unnecessarily bar caregivers from a medically vulnerable child's life.

CONCLUSION

The Court should grant the Emergency Application for Administrative Stay and Stay Pending Petition for Certiorari.

Respectfully submitted.

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