

**IN THE COURT OF APPEALS OF IOWA**

No. 1-007 / 10-1996  
Filed September 21, 2011

**IN THE INTEREST OF M.R.R.,  
Minor Child,**

**J.M.D., Mother,  
Appellant.**

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Appeal from the Iowa District Court for Bremer County, Peter B. Newell,  
District Associate Judge.

A mother appeals from an order finding her daughter to be a child in need  
of assistance. **REVERSED.**

Thomas P. Frerichs of Frerichs Law Office, P.C., Waterloo, for appellant  
mother.

Christy R. Liss, Waterloo, for father.

Thomas J. Miller, Attorney General, Bruce Kempkes, Assistant Attorney  
General, and Kasey E. Wadding, County Attorney, for appellee State.

Terry Parsons of Olsen & Parsons Law Firm, Cedar Falls, for minor child.

Considered by Sackett, C.J., and Potterfield and Doyle, JJ.

**SACKETT, C.J.**

In this appeal by the mother of a nine-year-old girl who suffers from an atypical epileptic seizure disorder, we are faced with the difficult question of whether the juvenile court was correct in finding the State was entitled to intervene and in directing medical care for the child.<sup>1</sup> Failing to find clear and convincing evidence to support the juvenile court's finding the State proved the child was a child in need of assistance as defined by Iowa Code section 232.6(e) (2009), we reverse.

**Scope of Review.** We review child-in-need-of-assistance proceedings de novo. *In re K.N.*, 625 N.W.2d 731, 733 (Iowa 2001). Although we are not bound by them, we give weight to the district court's factual findings, especially when considering credibility of witnesses. *In re D.D.*, 653 N.W.2d 359, 361 (Iowa 2002). To support a finding the child is in need of assistance, the State must establish the need by clear and convincing evidence, which is "evidence that leaves 'no serious or substantial doubt about the correctness of the conclusion drawn from it.'" *Id.* at 361 (quoting *Raim v. Stancel*, 339 N.W.2d 621, 624 (Iowa Ct. App. 1983)).

**Background and Proceedings.** The child was born in January of 2002. The marriage of her parents was dissolved in 2005. The dissolution court approved the parties' stipulation that agreed they receive joint legal custody, the mother receive physical care, and the father receive specified reasonable visitation.

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<sup>1</sup> The father, who stipulated to a finding that the child was in need of assistance, has not appealed.

The child, at age four, began having seizures where there was a sudden onset of her rolling her eyes up in her head. The seizures were brief in duration, lasting about one second. The child was immediately back to normal or slightly confused for a short period of time. She has developmental delays and behavior difficulties. The parents sought medical advice, and in August 2006, the child was diagnosed with atypical epileptic seizure disorder. The child has been seen by her family doctor, as well as medical specialists in the areas of her problems at the University of Iowa Hospitals and Clinics, John Hopkins Medicine, Mayo Clinic, and a medical facility in Indiana. The child was put on special diets, which the mother successfully implemented,<sup>2</sup> and medications, which both parties administered.<sup>3</sup> The child did not react well to the medication.<sup>4</sup>

The event that led to the Iowa Department of Human Services to intervene in the child's medical treatment was a call in October of 2010 to the department

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<sup>2</sup> In the summer of 2000 the child went to John Hopkins Medicine and participated in the modified Atkins diet study. She was having about twenty seizures a day where she would stop, stare, roll her eyes, and be confused for several seconds with an EEG showing rapid, probably spike wave discharge. At the time she went to John Hopkins, the child was not on any anticonvulsant, and she was put on the modified Atkins diet. Seizures improved and she went down to about two or four seizures a day, which the doctors approximated to be about a fifty percent improvement. In her second month on the study, the seizures remained under good control of approximately three or four a day. The doctors found, in September of 2009, there was no clear reason to stop the diet. The doctor did discuss with the mother that his next advice would probably be to add a dose of medication to see if they could get the child's seizures under better control. The doctor noted the decision to do so was ultimately up to the mother and he was of the impression that she was not particularly inclined to do so at that time.

<sup>3</sup> The father acknowledged that because of the custody arrangement, the mother was more involved in the child's treatment than was he.

<sup>4</sup> In April of 2008, a doctor at the University of Iowa Hospitals and Clinics said, "Because [the child's] seizures are very brief and not very frequent, and because [the child] has had substantial side effects from Topamax therapy in the past, I recommend that [the child] be treated with no anticonvulsant at this time. If the seizures become more frequent or more severe, then strong consideration could be given to reinstating anticonvulsant therapy."

from Mayo Clinic where the child was being treated. Mayo Clinic reported there was a conflict between the parents as to how the child's treatment should proceed. As a result of the call, the State, in December of that year, filed a child-in-need-of-assistance petition, contending the child was in need of assistance under Iowa Code Section 232.2(6)(e).<sup>5</sup>

The petition came on for hearing on January 12, 2010. The parents agreed to continue the adjudication hearing and to the entry of a temporary order by the juvenile court requiring both parties "to comply with the recommendations of the pediatric neurologist at Mayo Clinic, including any dietary and medication protocols for the child." The order also provided that either party could seek a second opinion, but that any contrary recommendations would not relieve the parents of complying with the recommendations of Mayo Clinic.

On February 8, 2010, the child went to Mayo Clinic for monitoring, which showed she had about two seizures per hour. The Mayo Clinic agreed with the mother putting the child on a ketogenic<sup>6</sup> diet at a ratio of 2.5 fats to 1 protein and carbohydrate. The Minnesota Epilepsy Group also concurred with the initiation of the ketogenic diet, but noted that if the seizures were not completely controlled within a month, then medication should be initiated.

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<sup>5</sup> .This section provides:

6. "child in need of assistance" means an unmarried child:

. . . .

e. Who is in need of medical treatment to cure, alleviate, or prevent serious physical injury or illness and whose parent, guardian or custodian is unwilling or unable to provide such treatment.

<sup>6</sup> The ketogenic diet is a very strict high-fat, low-carbohydrate diet. It is a more intensive version of the Atkins diet. By limiting carbohydrates, the ketogenic diet forces the body to use fat for energy. This results in the body having an abnormally high level of ketones (known as a state of ketosis), which reduces the frequency of seizures.

The child returned to the Mayo Clinic for a follow-up appointment on March 9, 2010. The Mayo Clinic reported:

[The child] is currently on the ketogenic diet. The ketogenic diet is an excellent treatment for both symptomatic and primary generalized epilepsy. However, it is typically done as adjunctive therapy. The goal of the ketogenic diet is for a fifty percent reduction in seizures. Therefore, I suspect that [the child] will not likely be able to be seizure free with the ketogenic diet as monotherapy. I am hopeful that the diet will significantly decrease the seizure frequency, but I suspect it will not allow her seizures to resolve. [The child] will return to the Pediatric Epilepsy Monitoring Unit for continuous video EEG monitoring April 28-29 for seizure quantification. If [the child] continues to have frequent seizures, then I would recommend that she also be treated with an antiseizure medication in addition to the ketogenic diet.

The mother cancelled an appointment scheduled at the Mayo Clinic for late April. The appointment was rescheduled and she cancelled it again. The State, in turn, filed a motion to compel the mother to take the child to the Mayo Clinic. The motion was granted and the mother was ordered to take the child to the Mayo Clinic on May 17. The court further stated a failure to do so could result in a contempt finding.

At the May appointment, the Mayo Clinic reported a two-thirds reduction in the number of the child's seizures and agreed to give the diet an additional two months to see if any further progress could be made. However, the Mayo Clinic continued to say if complete seizure control was not obtained by the next appointment, medication would be ordered.

On June 29, 2010, Dr. Breitzkreuz,<sup>7</sup> on the parents' behalf, contacted Chareila N. Joshi, M.D. at the University of Iowa Hospitals and Clinics,

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<sup>7</sup> He apparently is the child's family doctor.

requesting the doctor see the child prior to a scheduled appointment at the Mayo Clinic. An appointment at the University of Iowa was made for July 15, 2010, and both parents appeared with the child. Dr. Joshi had received certain medical reports and records addressing the child's diagnose and treatment. Dr. Joshi was advised the parents were seeking another opinion regarding the child's treatment. Apparently, a separate report of the visit was requested by the father for himself, and he requested a second one for the department worker.

Dr. Joshi summarized the visit in a written report. The doctor noted that the father said he was very happy with the child's care at the Mayo Clinic but he was there to support the mother, as the parents share custody. The child at the time was on the ketogenic diet, and the mother indicated, after speaking with other families that had used the diet, she felt more could be done with it for her child. The doctor also noted that:

Mom's goal also seems to be to get [the child] better since according to a seizure chart that was brought and carefully kept by the family, at her worst [the child] was having upwards of 110 seizures a day, but since initiation of the diet and since maintenance of the diet there has been significant improvement such that there are days that the family sees no seizures.

The doctor also noted: "Both parents agree that seizures have definitely better controlled with the diet. Mom feels that [the child's] comprehension has improved."

The doctor was aware of the father's concern the child was not being treated.<sup>8</sup> The doctor also was aware of the mother's wishes to continue to try diets. The doctor opined:

[I]t would be very soon realized whether a 3.5 or 4.1 ratio will help keep [the child] seizure free longer especially given the fact that between February and May of 2010 [the child's] EEG as well as seizure count seems to have improved on the diet. I would possibly give [the child] a trial of the 3.5:1 therapy for 2-4 weeks. If [the child] has no side effects in the form of lethargy, vomiting, nausea, constipation, and if [the child] does not have hypertriglyceridemia or hypocholesterolemia on the same, I would be willing to push the diet to 4 as to 1, once again making sure that she does not have any side effects for a couple week period to see if [the child's] seizures go down to 0. Should that happen I think it would satisfy mother's curiosity since she feels that the diet is not tweaked enough to give [the child] the best potential.

The doctor also reported he told the parents:

[A]ccording to articles written by Tassinari and Bureau, a combination of high dose of valproic acid and ethosuximide seems to be the best therapy for myoclonic absence. There is no reason to believe the above therapy cannot be used in conjunction with the diet. I would feel that probably given that the diet has done so well for [the child], we might be able to get away with a smaller dose of anticonvulsant medications for her, and according to a recent randomized trial by Tracy Glauser, et al, it seems that ethosuximide seems to give the best results in the treatment of absence epilepsy within approximately 16 weeks with the least possible side effects of inattention/clouding of attention.

The doctor further stated:

Currently, since dad points to me that by court order they are only allowed to have a second opinion without making any changes, I will leave it to the family to decide whether they would want to change the diet over a brief duration of time.

The doctor then noted that:

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<sup>8</sup> It appears this refers to the child not being on medication.

I am the 6th or 7th doctor that [the child] has seen. . . . All doctors have felt that [the child's] epileptic encephalopathy needs treatment. I do not feel seeking multiple more medical opinions is in [the child's] best interest.

On August 10, 2010, the child returned to the Mayo Clinic for additional monitoring. The Clinic reported:

Overnight, [the child] did not have any absence seizures. She does continue to have innumerable myoclonic seizures. Her myoclonic seizures occur up to four times within a half hour. In addition, during sleep she has increased activation of epileptiform discharges that occur in bursts up to ten seconds in duration.

The Mayo Clinic determined a low dose of clonazepam should be initiated at bedtime to help decrease the epileptiform discharges during sleep. The mother apparently then told the Mayo Clinic that the University of Iowa had recommended maximizing the ketogenic diet. She did not give them the report from Dr. Joshi. Whether the father and the department provided Mayo Clinic a copy of the report is not clear. The Mayo Clinic stated it was willing to increase the diet ratio slowly to a ratio of 3.25:1, but it needed to be done in conjunction with the medication. The mother then told the Mayo Clinic she would discuss its recommendations with the child's father. Later that afternoon, she told the Mayo Clinic social worker she did not intend to give the child medication until it was decided in court. The social worker contacted the department, which in turn contacted the mother's attorney. The mother's attorney told the department the mother was willing to risk a finding of contempt rather than give her child medication. The father filled the prescription, and both parents have since been providing the child with the medication.



The petition came on for additional hearings on August 17 and October 20, 2010. At the hearings, the department caseworker and the father both testified that without court involvement, the mother would not be giving the child medication. The mother testified she was not against giving medication, but only wanted to see the ketogenic diet brought to “its full potential before adding any medication.” Both parents acknowledged difficulties in communicating with each other. The father admitted he deferred getting treatment for the child, stating, “I don’t feel that I have the ability to because of the placement.” He also admitted he had stopped exercising visitation or talking to the mother because “the conflict between [the mother] and I is just too overwhelming for me.”

The guardian ad litem recommended finding the child in need of assistance, opining the child has a “serious medical condition,” proper medical treatment would not have occurred without the department’s involvement, and the parents are “unable to get on the same page with regard to this child, who requires a lot of help from her parents.”

On October 29, 2010, the juvenile court entered an adjudication order finding:

The overall consensus of medical opinion has been that this Child needs to take medication. The Child’s mother has been resistive to this Child taking medication. The Child’s father has been receptive to the Child taking medication.

Physicians have expressed concern that this Child has not been taken to follow-up appointments as needed. Physicians have expressed concern that the mother’s continual search for a medical opinion that coincides with her own is detrimental to the Child; that the Child is in need of immediate treatment and that the Child’s seizures need to be controlled.

The Child’s mother has shopped this child around to different medical providers in an attempt to obtain a medical opinion which is

consistent with her own non-medically-based opinion that this Child can be treated by diet alone.

. . . .  
 [The mother] has a pattern of only hearing what she wishes to hear with regard to recommendations made for this Child to undergo medical treatment and with regard to court orders regarding this Child's medical treatment.

Accordingly, juvenile the court found the child to meet the definition of a child in need of assistance under Iowa Code section 232.2(6)(e). On November 19, 2010, the juvenile court entered a dispositional order keeping primary physical placement of the child with her mother, subject to the existing visitation schedule, under the protective supervision of the department. The order further required the parents to comply with the recommendations of the Mayo Clinic, including any dietary and medication protocols for the child.

**Child in Need of Assistance.** To prove its case, the State needs to prove by clear and convincing evidence that the child is in need of medical treatment to cure, alleviate, or prevent serious physical injury or illness, and the mother is unwilling to provide such treatment. The focus of the State's case is that the mother was apparently unwilling to agree to the child receiving medication<sup>9</sup> to alleviate what the State contends is a serious physical illness.<sup>10</sup>

The mother contends there is no medical evidence that the child was ever subject to a risk of a serious injury because she failed to provide the child with adequate care. In making this argument she recognizes a social worker with a B.A. degree testified to such things as "unless the seizures were reduced to zero

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<sup>9</sup> However, by the time of the adjudicatory hearing the mother was providing medication.

<sup>10</sup> The issue concerns the mother's alleged reluctance. The mother testified she is not opposed to medication, however, she testified she wanted to complete the diet first before putting the child on medication.

[the child's] academic and behavior problems would increase and that the seizures caused brain damage," and "our fear at this point is critical care is denied if she does not follow the medical protocol." The mother contends these opinions should not be considered because they are contrary to the medical evidence. We agree that the social worker advanced medical opinions that are not supported by medical opinions advanced in medical reports. Therefore we give any medical opinions advanced by the social worker little or no weight.<sup>11</sup>

The evidence from medical experts came in by way of medical reports from doctors at respected medical facilities, all of which include certain medical opinions. Therefore, the usual testimony required to admit a medical opinion, including a recitation of the qualification of the doctor as well as his or her statement that his or her opinion is based on reasonable medical certainty, is not present. Nor have the parties had the opportunity to cross-examine the doctors. We consider these factors in interpreting the reports and determining the weight the opinions therein should be given.

The record clearly supports a finding the mother is dedicated to the child, provides for her needs, has sought opinions on her care from outstanding medical experts in the field of the child's problems, and has religiously implemented and monitored diets prescribed by experts, which have at times substantially reduced the child's seizures. What the record also clearly supports, is that the mother has not at all times been in favor of supplementing the child's

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<sup>11</sup> We do, however, consider her testimony on other issues and give it the required weight.

diet with medication and has been extremely reluctant to do so. There also is evidence that the child had suffered reactions to medication in the past.

Assuming that the seizures will be stopped if the child takes medication,<sup>12</sup> the question is what are the medical concerns if the medication is not administered. Finding no such opinion in any doctors report to support the social worker's and father's claim that the child may suffer brain damage from seizures, we disregard this evidence. The testimony of Mayo Clinic's Elaine C. Wirrell, M.D., who opined "I am very concerned that with ongoing frequent seizures, her learning will continue to suffer." Yet the University of Iowa's Daniel Bonthius, M.D., Ph.D., opined, "However, I emphasized to [the child's] mother that the behavioral and academic problems are not caused by the seizures, per se."<sup>13</sup> John Hopkins, in September of 2009, while discussing adding medication to the Atkins diet with the mother, indicated it was up to her what she wished to do. Dr. Joshi of the University of Iowa, who saw the child in July of 2010, and opined that

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<sup>12</sup> While there seems to be an assumption this will happen, we are asked to so assume without the benefit of anything more than a reference to a drug name or type. There is no specific information as to the success of the drug, and, more troubling, is the lack of any evidence of the side effects of the drugs. Elaine C. Wirrell of the Mayo Clinic says that she and another doctor believe the child requires anti-epileptic medication. She opines, "It is imperative to initiate antiepileptic medication as soon as possible, and I have serious concerns about waiting several months." Yet there is no information in the report as to the particular medicine or medicines to be prescribed, what it is anticipated it will do to the seizures, or what the side effects of the medication are.

<sup>13</sup> In an April 24, 2008 report the doctor stated:

I discussed with the child's mother that the child may have academic troubles in school. She appears to have some behavioral and academic problems already in kindergarten. I explained that these academic behavior problems often accompany seizure disorders. However, I emphasized to the child's mother that the behavioral and academic problems are not caused by the seizures, per se.

a modified diet might be tried, while discussing with the parents certain drug therapy, indicated no concern in not having medication immediately prescribed.<sup>14</sup>

*Black's Law Dictionary* 1398 (8th Ed. 2004), defines "serious" as to an injury or illness, accident, etc., "dangerous; potentially resulting in death or other severe consequences." We recognize the desires of the doctor and the father to assure that the child performs at her academic best, and until her seizures are totally controlled, she may not do so. We recognize there is competent medical evidence that seizures can have an undefined impact on the child's academic progress, and immediate medication is necessary.<sup>15</sup> We also recognize there is other evidence that does not support this opinion. We also believe, even if we accept the fact that the seizures could be stopped with medication, there is not clear and convincing evidence to support the juvenile court's findings that the child was in need of medication to alleviate death or other serious consequences.

While as a state we are committed to seeing our children have adequate care, we should recognize that in most cases the child's parents are the best decision makers. The history of jurisprudence of this state on issues of child welfare shows, for the most part, the state and the courts do not involve themselves with medical decisions made by engaged and concerned parents.

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<sup>14</sup> We also do not agree with the State's argument that Dr. Joshi's opinion was that there should be medication in addition to the diet that was implemented. It is clear there was conversation about a light dose with the diet, but there are no indications it was to be a part of the diet that was suggested for several weeks.

<sup>15</sup> A November 17, 2010 Mayo Clinic report opined:

I suspect her recent seizure increase was related to a significant change in her schedule as well as multiple stressors, . . . . I am hopeful that once [the child's] routine is reestablished, her seizure control will improve. I also emphasized with her parents the importance of [the child] maintaining a good routine and that the routine should be stable when she goes from one household to the next.

Making a decision to give one's child medication and/or treatment may find the parents faced with weighing the differing opinions of medical experts.<sup>16</sup>

The mother knows her child better than anyone else knows this child. The mother was concerned about the side effects of medications the child takes. She wanted the diet explored fully before putting the child on more medication. There is no evidence as to the prognoses with medication and there is no evidence of side effects, if any, from the use of the medicine.

It is undeniable that the mother has continually sought treatments for the child. She also has successfully implemented diets that have decreased the child's seizures. She was giving the child medication at the time of the hearing. A child is in need of assistance under section 232.2(6)(e) when she is in need of treatment to cure a mental illness or emotional damage and her parent is unwilling or unable to provide such treatment. Upon our de novo review of the record, we find the evidence to support this ground of adjudication lacking. Both parents are willing and able to provide their daughter with treatment for her seizures. The mother has been active in assuring the child receives the directed diet and progress was made with the diet. She also testified that her reason for withholding the medicine is that she wanted to see the potential of the diet. Accordingly, we find clear and convincing evidence does not support the district

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<sup>16</sup> For example: Should the child be treated by a medical doctor or a doctor of chiropractic medicine for a bad back. Should a child receive vaccination for certain illnesses? Should a hyperactive child take medicine to control the child's behavior? The parent can probably find an expert opinion on each side of these issues. In contrast is the child who is bleeding and will die without a transfusion, the child who may die of a disease for which there is a treatment, or a child who may live with serious brain damage if antibiotics are not given for a fever.

court's adjudication of the child under section 232.2(6)(e) and reverse on this issue.

This said, we recognize that the father saw fit to agree to a finding the child was in need of assistance. Yet by his own admission, he has not been as involved in the care of his daughter as one would hope he would be. If issues as to the type of treatment this child should have continue to exist between the parents who have joint custody, those issues should be addressed in the district court in the context of the dissolution decree. See *Harder v. Anderson, Arnold, Dickey, Jensen, Guillickson & Sanger, L.L.P.*, 764 N.W.2d 534, 538 (Iowa 2009).

**REVERSED.**