July 28th, 1975

CONSENT OF MINORS TO HEALTH CARE

The purpose of this memorandum is to seek opinion on consent to medical treatment of minors. The reason is that the Provincial Government in late 1974 formally asked us to make recommendations on this subject. Shortly before that, the College of Physicians and Surgeons of Alberta had asked us to support legislation on this same subject. About the same time, various individuals called our attention to the problem of administering contraceptives to minor girls, a problem which has been underlined by the recent action against the City of Edmonton and the Edmonton Public School Board. Even earlier, on 31 May 1973 a Family Planning Conference in Alberta asked us to "investigate the legal pressures limiting the prescribing of contraceptives for girls under the age of 18 without parental consent."

This memorandum will (1) describe the present law (2) describe recent trends elsewhere and (3) outline possible alternatives and seek comment thereon.

The Present Law

The age of majority in Alberta was reduced from 21 to 18 in 1971, and as a consequence the problem has been reduced. The oldest minor is now 17, and we are concerned with boys and girls of that age and below.

What is the present law as to consent to medical treatment of minors? There is in Alberta no general statute on the subject. In other words our law is the common law, consisting of judgments of the Court. The difficulty is that there are few judgments on this subject in England or Canada. However, there is a good discussion in a leading

English text by Lord Nathan on Medical Negligence, and two Ontario cases: Booth v. Toronto General Hospital (1910) 17 O.W.R. 118 and Johnston v. Wellesley Hospital (1970) 17 D.L.R. (3d) 139.

These authorities show that there is no rigid common law rule in England or Canada that a person must always have reached the age of majority before he can give his own consent. Even in the United States, where the rule seemed at one time to be rigid, some courts have recognized exceptions in the case of the "emancipated minor" and sometime the "mature minor" whether emancipated or not. In recent years some states have enacted statutes that specifically allow an emancipated minor to give his own consent, and at least one state (Mississippi) has enacted that a minor, whether emancipated or not, may give his own consent if he is "of sufficient intelligence to understand and appreciate the consequences of the proposed treatment."

We think that under the common law as it applies in Alberta, a mature minor may give his own consent, whether emancipated or not. The question then is: how can the physician be sure the minor is mature? Does maturity depend on age--sixteen or fifteen or some other age, or does it depend on the individual? The answer to these questions is uncertain. This being the case, the physician may be unwilling to treat the minor unless he has the consent of parent or guardian.

The risk of treating a minor without a valid consent is that the treatment may be wrongful in the sense that it exposes the physician to an action for damages. Most treatment involves a touching of the patient, and if there is not a valid consent to the touching, it is a trespass to

the person, or more specifically a battery (which for the present purposes is the same as an assault). One can argue that the prescribing of a drug is not a battery by anyone, let alone the prescribing physician, though even if it is not there is an argument that it is still wrongful without proper consent. We need not here go into this technical question. The point is that the law should be clarified so the physician will know when the minor's consent is valid.

We shall now mention the matter of medical treatment of minors in an emergency. The common law permits a physician to treat any patient, whether a minor or not in emergencies when the patient through lack of consciousness or mental incapacity cannot give his consent. The term "emergency" is not precise. However it can be described as a situation where the patient's life or health is in immediate danger. We think the court would accept the physician's judgment where he has acted in good faith.

Before ending this short account of existing law we point out a problem sometimes raised in connection with the giving of contraceptives to a minor who is a juvenile for the purposes of the Juvenile Delinquents Act. Is this contributing to the delinquency of the minor? We think not.

Recent Legislation Elsewhere

In the past six or seven years there has been a widespread movement toward reduction in the age of majority from twenty-one. In most cases, as in Alberta, the reduction is to the age of eighteen whereas in some places, e.g. British Columbia, the reduction is to nineteen. This legislation has been accompanied by a movement toward putting in the form of a statute the law that is to govern consent

to medical treatment of minors. Thus, England's Family Law Reform Act, 1969, in reducing the age of majority to eighteen, provides that persons sixteen years and over can give their own consent. Section 8 reads:

> (1) The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian.
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> (2) In this section "surgical, medical or dental treatment" includes any procedure undertaken for the purposes of diagnosis, and this section applies to any procedure (including, in particular, the administration of an anaesthetic) which is ancillary to any treatment as it applies to that treatment.
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> (3) Nothing in this section shall be construed as making ineffective any consent which would have been effective if this section had not been enacted.

A major question that arises from the wording of the English Act is whether it covers contraceptives. There is a strong argument that it does not. Prescribing the pill, for instance, is not the prevention of illness. On the other hand if one thinks of measures to protect health, and gives a wide definition of health, then the giving of contraceptives is health care. In England, the National Health Service (Family Planning) Act, 1967, authorized local health authorities to provide advice, conduct medical examinations, and supply substances and appliances in connection with contraception. The Medical Defence Union in a pamphlet

(Consent to Treatment, 1974) discussed the problem of giving contraceptives to girls under sixteen. The assumption seems to be that there is no problem where the girl is sixteen or over. In the case of girls under sixteen, there was fear that the doctor might be regarded as aiding and abetting the offence of having unlawful sexual intercourse. In answer to this the report says: "The Union's legal advisors state that it is for the doctor to decide whether to provide contraceptive advice and treatment and if he does so for a girl under the age of sixteen he is not acting unlawfully provided he acts in good faith in protecting the girl against the potentially harmful effects of intercourse."

Before leaving England's Act, we point out that the scope of Subsection (3) is not clear. In introducing the Bill the Attorney General stated that it covers consent by patients under sixteen years of age where they are mature enough to give their own consent. Others have suggested that it contemplates consent by a parent for a patient aged sixteen or seventeen who has refused consent, or whose consent the physician has not sought. It has even been suggested that Subsection (3) covers emergencies. We doubt this, for the Subsection speaks of consent, not of absence of consent. In any case we doubt the wisdom of this provision because its scope is so uncertain.

In 1972 Quebec passed the Public Health Protection Act. Sections 36 and 37 provide:

> 36. An establishment or a physician may provide the care and treatment required by the state of health of a minor fourteen years of age or older with his consent without being required to obtain the consent of the person having paternal authority; the establishment or the physician must however inform the person having paternal authority in the case where the minor is sheltered for more than twelve hours, or of extended treatment.
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> Where a minor is under fourteen years of age, the consent of the person having paternal authority must be obtained; however, if that consent cannot be obtained or where refusal by the person having paternal authority is not justified in the child's best interest, a judge of the Superior Court may authorize the care or treatment.
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> 37. An establishment or a physician shall see that care or treatment is provided to every person in danger of death; if the person is a minor, the consent of the person having paternal authority shall not be required.

We note that the age of consent is fourteen, but the parent or guardian must be notified where the minor is in a hospital for more than twelve hours or where the treatment is extended.

In 1973 the Saskatchewan government introduced a Bill. We understand it was like the English Act. It was defeated by a vote of 22 to 20.

In the same year British Columbia put a new section in the Infants Act. As introduced the Bill was close to England's, but during the debate it was amended by adding a subsection that said the minor's consent is

valid only if "a reasonable effort" has first been made to obtain parental consent, or if a written opinion is obtained from another practitioner that the proposed treatment "is in the best interest of the continued health and well-being of the infant." Another subsection empowers the physician, but does not require him, to inform the parent where the minor has been treated without the parent's consent. We are inclined to agree with a critic who thinks the amendment is unsatisfactory.

Ontario has not enacted any legislation, but the government passed regulations under the Public Hospitals Act permitting surgical operations and other treatment in hospitals on the consent of a person sixteen years of age or who is married. We understand that New Brunswick, Quebec and Saskatchewan have similar regulations. They offer only a partial solution to the problem. We do not plan to recommend regulations under any existing act, but rather new legislation.

For the past two years the Conference of Commissioners on Uniform Laws has had on its agenda a Model Medical Consent of Minors Act. The draft produced in 1974 bears some resemblance to England's section 8. However it has a provision permitting a minor under 16 to give his consent where the physician, supported by the opinion of another physician, is of the opinion that (a) the minor is capable of understanding the nature and consequence of the treatment and (b) the treatment is in the best interests of the minor and his continuing health and well-being. The draft also has a provision authorizing treatment of a minor under 16 without the consent of the minor or his parent or guardian where the physician is of the opinion that "the medical treatment is necessary in an emergency to meet

imminent risk to life or health." The Conference will consider the draft Model Act further at its annual meeting near the end of August, 1975.

In the United States the statutes vary a great deal. The usual age for consent in general is twenty-one or eighteen. However many of the statutes permit minors to give consent, for example, when married, or when emancipated, or where the treatment is for venereal disease or for drug abuse or for pregnancy or in connection with birth control information and devices. They do not have a single specified minimum age for all treatment as England has.

In the past five years or so there has been increasing support in the literature for legislation permitting minors to give their own consent, especially in connection with contraceptives. Noteworthy articles are the following.

(1) Pilpel, Minors' Right to Medical Care (1971-72), 36 Albany Law Review 462.

This article describes recent legislation in the United States that broadens the minor's right to give his own consent, and suggests a Model Act.

(2) Pilpel and Wechsler, Birth Control, Teenagers and the Law: A New Look (1971), 3 Family Planning Perspectives 37.

"It is self-evident that withholding contraceptives from sexually active persons is certain to produce unwanted babies, dangerous illegal abortions, high rates of illegitimacy and blighted young lives." Public and private programs can do little to control premarital sex but they can

control unwanted pregnancies resulting from premarital sex.

This article has a chart analyzing all state laws on medical treatment of minors, and it describes the support of the AMA, ACOG, AAPed., and AAFP for permitting physicians to prescribe contraceptives to sexually active minors.

(3) Cavanaugh, Minors and Contraceptives: The Physician's Right to Assist Unmarried Minors in California (1972), 23 Hastings Law Journal 1486.

Legislation is needed in California respecting the giving of contraceptives to minors. (Governor Reagan vetoed three bills.) Recent Supreme Court cases (Griswold and Baird) show increasing disenchantment with the notion that state regulation of contraceptives is an appropriate means of influencing the morality of individuals.

(4) Bodine, Minors and Contraceptives: A Constitutional Issue (1973), 3 Ecology Law Q. 843.

One who has reached puberty has the fundamental right of access to contraceptives. A legal requirement of parental consent does not deter premarital sexual activity.

(5) Note, Parental Consent Requirements and Privacy Rights of Minors: The Contraception Controversy (1975), 88 Harvard Law Rev. 1001.

This note considers the basic principle of Wade and Bolton (the abortion cases), namely that patients have a right of privacy that enables them to obtain medical treatments to terminate pregnancy (at least until the foetus is viable) without state intervention. Then the note asks

whether this principle extends to minors who want to obtain medical care. The minors' interest must be weighed against the parents' interest in maintaining parental authority. The note concludes that the traditional family structure would not be threatened by permitting minors to give their own consent.

We shall now quote some of the recent state legislation in the United States on medical care and on contraceptives to show the emerging pattern.

The first two statutes are those of Alabama and South Carolina. They do not mention contraceptives but commentators have regarded both statutes as being comprehensive; that is to say, they include contraceptive measures.

Alabama (1971)

> 104 (15). Any minor who is fourteen years of age or older, or has graduated from high school, or is married, or having been married is divorced, or is pregnant, may give effective consent to any legally authorized medical, dental, health or mental health services for himself or herself and the consent of no other person shall be necessary.
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> 104 (16). Any minor who is married, or having been married is divorced, or has borne a child may give effective consent to any legally authorized medical, dental, health or mental health services for himself, his child or for herself or her child.

> 104 (17). Any minor may give effective consent for any legally authorized medical, health or mental health services to determine the presence of or to treat pregnancy, venereal disease, drug dependency, alcohol toxicity or any reportable disease and the consent of no other person shall be deemed necessary.
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> 104 (18). When consent not required; minors generally--Any legally authorized medical, dental, health or mental health services may be rendered to minors of any age without the consent of a parent or legal guardian when, in the physician's judgment, an attempt to secure consent would result in delay of treatment which would increase the risk to the minor's life, health or mental health.

We have omitted Subsections (19)-(22) as not of immediate interest. It will be noted that the general provision (Subsection 15) has several alternative categories of minors who can give their own consent, and that one of these is minors fourteen years old. Subsection (16) has no minimum age, and besides it includes medical care for baby children of the minor. Subsection (17) is typical of several modern state laws in that <u>any</u> minor can give his own consent in connection with pregnancy, drugs, etc. Subsection (18) is an emergency provision. Nowhere is contraception specifically mentioned.

<u>South Carolina (1972)</u>

> 565. Any minor who has reached the age of sixteen years may consent to any health services from a person authorized by law to render the particular health service for himself and the consent of no other person shall be necessary unless such involves an operation which shall be performed only if such is essential to the health or life of such child in the

> opinion of the performing physician and a consultant physician if one is available.
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> 566. Health services of any kind may be rendered to minors of any age without the consent of a parent or legal guardian when, in the judgment of a person authorized by law to render a particular health service, such services are deemed necessary unless such involves an operation which shall be performed only if such is essential to the health or life of such child in the opinion of the performing physician and a consultant physician if one is available.

Section 565 is comprehensive and uses sixteen years as the age of consent, except for operations. Then Section 566 applies to minors of any age. It covers any health service that is deemed necessary. No specific disease is mentioned, but the section is wide enough to cover almost everything. The Attorney General gave an opinion under Section 565 that "minors, sixteen years and older, are authorized by existing law to procure birth control pills without the consent of their parents or other persons."

The next two states are Maryland and Virginia. We group them together because in both states the consent provisions specifically cover contraception and no minimum age is fixed in connection with treatment for it.

Maryland (1971)

> S.135. (a) A minor shall have the same capacity to consent to medical treatment as an adult if one or more of the following apply:

(1) The minor has attained the age of eighteen (18) years.
(2) The minor is married or the parent of a child.
(3) The minor seeks treatment or advice concerning veneral disease, pregnancy or <u>contraception not amounting to sterilization</u>.
(4) In the judgment of a physician treating a minor, the obtaining of consent of any other person would result in such delay of treatment as would adversely affect the life or health of the minor.
(5) The minor seeks treatment or advice concerning any form of drug abuse as defined in S.2 (d) of Article 43B of the Annotated Code.

S.135A. (a) A minor who has attained the age of 16 years and who has or professes to have a mental or emotional disorder may consent to diagnosis and consultation of the disorder by a physician or clinic. Consent given under this section shall have in all respects the same effect as if the minor had reached majority.

It will be noted that under Section 135 (a) (3) there is no minimum age in connection with venereal disease, pregnancy and contraception. We have omitted sub-paragraphs (b) and (c) of Section 135: (b) protects from any liability the physician who has acted on the minor's consent and (c) permits the physician to inform the guardian, and he may do so even over the minor's objection.

§135A. (a) A minor who has attained the age of 16 years and who has or professes to have a mental or emotional disorder may consent to diagnosis and consultation of the disorder by a physician or clinic. Consent given under this section shall have in all respects the same effect as if the minor had reached majority.

Virginia (as amended to 1974)

> S.32-137 (7) Except as otherwise provided in §18.1-62.1 (e) [having to do with abortions] any person under the age of eighteen years may consent to medical or health services required in case of birth control, pregnancy or family planning, or needed in the care, treatment or rehabilitation of drug addicts, or other persons who because of the use of controlled drugs are in need of medical care, treatment or rehabilitation; provided, that the provisions of this subsection shall not apply in the case of vasectomy, salpingectomy, or other surgical sterilization procedures as provided for in §32-423 of the Code of Virginia.

We have omitted the rest of section 137, which permits various public officers and others to give consent for minors, and the provision for blood donations, and has an emergency provision.

The last three states are Colorado, Illinois and Tennessee. We shall set out those provisions dealing with Family Planning or Birth Control, and not the general consent provisions.

Colorado (1971)

> 91-1-38. Except as otherwise provided in section 40-2-50, C.R.S. 1963, [having to do with abortions] birth control procedures, supplies, and information may be furnished by physicians licensed under this article to any minor who is pregnant, or a parent, or married, or who has the consent of his or her parent or legal guardian, or who has been referred for such services by another physician, a clergyman, a family planning clinic, a school or instititution of higher learning, or any agency or instrumentailty of this state or any subdivision thereof, or who requests and is in need of birth control procedures, supplies, or information.

Illinois (1969)

> S.18.7. Birth control services and information may be rendered by doctors licensed in Illinois to practice medicine in all of its branches to any minor:
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> 1. who is married; or
> 2. who is a parent; or
> 3. who is pregnant; or
> 4. who has the consent of his parent or legal guardian; or
> 5. as to whom the failure to provide such services would create a serious health hazard; or
> 6. who is referred for such services by a physician, clergyman or a planned parenthood agency.

Tennessee (1971)

> 53-4607.
> Contraceptive supplies and information may be furnished by physicians to any minor who is pregnant, or a parent, or married, or who has the consent of his or her parent or legal guadian, or who has been referred for such service by another physician, a clergyman, a family planning clinic, a school or institution of higher learning, or any agency or instrumentality of this state or any subdivision thereof, or who requests and is in need of birth control procedures, supplies, or information.

The section just quoted is one of eleven that constitute the Family Planning Act of 1971. The other provisions are not of immediate interest. We might mention that the sterilization provision fixes a minimum age of eighteen years, and provides that informed consent is necessary to the operation.

To conclude our discussion of recent legislation in the United States, we point out that the American Academy of Pediatrics in 1973 proposed a Model Act. It has much in common with recent state legislation. Minors who can consent are those who have married or had a child, or graduated from high school, or who are emancipated or separated from their parents and self-supporting. Then there is a provision like some of those set out above, permitting any minor to give his or her consent respecting pregnancy, communicable diseases and drug abuse. There is no specific mention of contraception apart from the fact that the definition of "health services" includes "receiving contraceptive advice and devices."

This Model Act, like some of the other recent statutes, shows concern over the relation between parent and child in the matter of treatment, especially in the areas of pregnancy, drugs and contraception. The parents' rights must be accommodated in some way to the minors' rights to treatment and to the physician's obligation of confidentiality. The Prefatory Note to the Model Act puts it this way.

> In a democratic nation such as ours, individuals' rights are paramount. In order for everyone, including minors, to have the right of obtaining health services, the balance of this right against others becomes of the utmost importance. This Model Act accepts the concept that getting health services is a basic right. Also, it accepts that parents have their basic right of protecting and promoting the health and welfare of their minors. Therefore, this Act is a compromise and a balance of these two basic rights in the conditions specified. The goal of this Act is to insure that all minors can have quality health services by granting

> the minors selfconsent in conditions and instances that will prevent them from seeking services if parental consent is required and by encouraging health professionals to deliver quality services to minors without incurring legal liability. Reasonable safeguards and limitations are stipulated in this Act to protect the minors' safety and the right of the parent. This Act also emphasizes the promotion of family harmony and minor's maturity.

It will be seen that the Model Act recognizes the parents' right to know of the treatment only to the extent of permitting the physician to give information to the parent or guardian and only where the minor consents or where his consent can be presumed. In the case of physical or emotional problems, the physician may notify the parent unless the life of the minor or the treatment of him would be jeopardized by such action; and in the case of emergencies the parent must be notified.

Possible Alternatives in New Legislation

1. Should there be a statute at all? Although we put the question the answer seems obvious to us.

2. A number of questions arise in connection with the scope of the act.

(a) Should the act extend to contraception? Whatever the answer, we would like reasons, based, if possible, on facts in Alberta.

(b) If the act is to extend to contraceptives, should it say so specifically, or should the legislation speak merely of health services of health care, and define health on the lines of the WHO definition: "A state of

complete physical, mental and social well-being and not merely the absence of disease or infirmity."?

(c) Should the act extend to sterilization? Some of the literature states that the produre is in theory reversible, but we understand that for practical purposes it is irreversible. The decision is so serious and the alternatives so much less drastic that there is a strong case against permitting any minor to consent to sterilization. Should it be included or not?

(d) Should the act extend to abortions? We are familiar with the existence of therapeutic abortion committess under section 251 of the code. It would help to know whether these committees and the physician who has been asked to perform the abortion, act on the infant's consent or whether they require the parent's consent. In other words: is a double consent required in practice? As to the advisability of double consents in general, we consider this in 4 (b) below.

3. The next questions have to do with defining those minors who can give their own consent. The English and the Canadian Acts speak in terms of age, though it will be remembered that England's section 8 (3) by implication may permit some minors under sixteen to give their own consent. In the United States the legislation sometimes prescribes a given age, but more frequently the minor can give his own consent when he has a certain status, e.g. has been married, or had a child or been emancipated, etc., and as we have seen, some of the recent statutes in connection with certain conditions such as veneral disease, drug abuse and

pregnancy any minor can give his own consent.

The following questions are designed to bring out the different alternatives.

(a) Should there be a minimum age?
(b) What should it be?
(c) Should there be an exception whereby a minor under the prescribed age may give his own consent if he has sufficient intelligence to do so?
(d) Should there be an exception whereby a minor below the minimum age can give his own consent in connection with drug or alcohol abuse, abortions and contraceptives?
(e) Are there any other health care problems for which any minor should be able to give his own consent?
(f) Do we have to mention venereal disease? This is frequently done in the United States, but in view of our Venereal Diseases Act we doubt that this is either necessary or appropriate.

4. The next questions have to do with the parents' role where the minor is permitted to give his own consent. There has been some uncertainty as to whether the parent can "veto" the minor's decision either by refusing consent where the minor has given it, or by giving consent where the minor has refused it. We doubt that the parents' consent should ever be required when the minor himself has capacity to consent. There may however be factors we have overlooked.

(a) Should the parent be able to give a valid consent when the minor refuses?
(b) Should the minor's consent ever require parental consent as well?

5. The next questions, like the last, are related to the role of the parent. Assuming the decision is made not to require parental consent as well as the minor's consent, should the physician be obliged to notify the parent; and if not should he have the right to do so if he wishes?

6. A question that is perhaps not so thorny as those posed above is this: should the Act set out those professions or institutions whose members are protected by the consent? England simply speaks of "surgical, medical or dental treatment." Quebec's Act covers hospitals (establishments) as well as physicians. The Model United States Act, mentioned earlier, applies to a "health professional" who is defined as a "state licensed physician, psychologist, dentist, osteopathic physician, nurse, and other licensed health practitioner." We do not have a firm opinion on the following questions.

(a) Should any specific professions be named?
(b) If so, what should they be?
(c) Should hospitals be named?

7. The next matter is that of emergencies. We have pointed out that the common law already permits treatment in emergencies without consent. If an act dealing with consent of minors to medical treatment is passed, then our tentative view is that the legislation should deal with emergencies. Many of the American acts do this either in terms of immediate danger to life, or in some cases, immediate danger to life or health. The Draft Canadian Uniform Act,

mentioned earlier, covers emergencies where there is "imminent risk to life." Our tentative view is to include an emergency provision permitting treatment without any consent where the physician is of opinion that there is immediate risk to life or health if the treatment is not given.

(a) Should there be an emergency provision?
(b) What should be its scope?

8. This question has to do with the relation between the proposed legislation and the Child Welfare Act. Sections 15-17 of that Act provide for the apprehension of a child when he is not receiving proper medical treatment, and the person apprehending him may authorize the treatment. This provision is sometimes invoked when the parents forbid treatment of their child on religious grounds, e.g. the transfusion of blood. A child for the purpose of the Child Welfare Act is an unmarried boy or girl under eighteen years of age.

A somewhat different scheme is proposed in the draft Canadian Uniform Act (mentioned above, and not yet in final form). It puts the age of consent at 16, and then has a special provision dealing with minors under 16 where the consent of parent or guardian is refused or not obtainable. In that situation any person may apply to the court for an order dispensing with the consent and the court may grant the order if satisfied that the withholding of the consent would endanger the minor's life or health.

The questions are these:

(a) Should there be provision for treatment of minors below the age of consent where the parent or guardian refuses consent or cannot be reached?

(b) If so, are the provisions in the Child Welfare Act satisfactory? or would the proposal in the draft Uniform Act be better? or some other scheme?

9. We mention now several miscellaneous points. Some have to do with matters that are included in some of the American acts and some of them have to do with criticisms of the English or Canadian acts. Our present view is that none of these matters needs to be dealt with in the legislation. However we set them out to call attention to them in case others may think they should be dealt with.

(1) A definition of consent in terms of informed consent.
(2) Liability for the physician's account
(3) Withdrawal of consent (several American acts forbid withdrawal of consent).
(4) Gifts of human tissue including the giving of blood for transfusion. (This is covered by the Human Tissue Gift Act and in our opinion does not belong in the act we are now considering.)

10. Finally, there may be points that occur to the reader and that have not been raised in this memorandum. If there are such points we would be glad to have them called to our attention.

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