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Chapter 5: Reproduction, Birth, and Adoption

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Editors' Notes

For information on decision-making for incompetent patients, see Chapter 2C, "Decision-Making for Incompetent Patients." For information about life-sustaining treatment issues, see Chapter 6, "End of Life." For informed consent information, see Chapter 2, "Consent to HealthCare."

Chapter Outline

5.1 Chapter Summary

Chapter 5 analyzes issues concerning reproduction, birth, and adoption. This chapter will introduce the practitioner to federal and state laws that address the complicated ethical, moral, and religious issues that arise as a result of reproductive choices and technologies. Gaps in federal and state laws will also be addressed. Although statutory, regulatory and case law are the primary sources of information pertaining to this chapter's subject matter, canon law also may be relevant. For questions pertaining to canon law, the practitioner may wish to consult the *Ethical and Religious Directives for Catholic Health Care Facilities* promulgated by the National Conference of Catholic Bishops. Canonic directives relevant to this chapter include Directives #45 and #48, which generally prohibit abortion, and Directive #53, which generally prohibits sterilization.

In addition, many of the issues addressed in this chapter overlap issues addressed elsewhere in this Manual. Although this chapter contains some references to relevant passages in other chapters, readers may wish to refer to the following chapters for more in-depth discussions: Chapter 2, "Consent to Health Care."

5.2 Reproduction

5.2.1 Procreation and Contraception

The United States Constitution protects the right to procreate.[1] The Constitution also protects the right to contraception.[2] The Washington Reproductive Privacy Act protects the "fundamental right of privacy with respect to personal reproductive decisions," including the rights to choose or refuse birth control and the right to obtain an abortion.[3]

5.2.2 Assisted Reproduction

The pace with which medical advances occur in the field of assisted reproduction tends to surpass the development of laws addressing the issues arising out of these medical advances. Although Washington has a number of laws pertaining to assisted reproduction, it is important to recognize that situations may arise which are not covered by either Washington or federal law.

The Washington Uniform Parentage Act, which addresses assisted reproduction, defines the term as a method of causing pregnancy other than sexual intercourse and includes intrauterine insemination, donation of eggs, donation of embryos, in vitro fertilization and transfer of embryos, and intracytoplasmic sperm injection.[4]

The technologies generally are distinguishable by whether fertilization takes place inside or outside the woman's body. Intrauterine (also known as "artificial") or donor insemination involves implanting sperm into the woman's vagina, cervical canal, or uterus, where fertilization then takes place. Gamete intrafallopian transfer involves the insertion of both the ovum and sperm at the end of a woman's fallopian tube through a small abdominal incision with the goal of fertilization occurring inside the woman's body. By contrast, in vitro fertilization involves fertilizing the woman's ovum in a petri dish; the fertilized ovum or embryo is then implanted in the uterus by a process called "embryo transfer." Surrogate embryo transfer or gestational surrogacy is similar, except the woman who will carry the fetus receives the transfer of an embryo created using the sperm from another woman's ovum. Intracytoplasmic sperm injection is a process by which sperm are

[1] *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942).

[2] *Carey v. Population Serv. Int'l*, 431 U.S. 678, 685, (1977); *Eisenstadt v. Baird*, 405 U.S. 438, 453-454 (1972); *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965).

[3] RCW 9.02.100.

[4] RCW 26.26.011(4).

collected, examined for quality, and injected directly into the egg cell. Cytoplasmic donation involves removing the cytoplasm from a younger donor egg and injecting it into an older egg to increase the developmental success of the recipient egg.[5]

5.2.3 Fertility Clinic Success Rate and Certification Act of 1992

The Fertility Clinic Success Rate and Certification Act of 1992[6] requires: a) states to certify "embryo laboratories" according to a model developed by the Centers for Disease Control,[7] and b) each "assisted reproductive technology" program to report annually its pregnancy success rates for each embryo laboratory it used.[8] The Centers for Disease Control then publish this information.[9]

The Act defines "assisted reproductive technology" as:

> [A]ll treatments or procedures which include the handling of human oocytes or embryos, including in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer, and such other specific technologies as the Secretary [of the Department of Health and Human Services] may include.[10]

The Act defines an "embryo laboratory" as "a facility in which human oocytes are subject to assisted reproductive technology treatment or procedures based on manipulation of oocytes or embryos which are subject to implantation."[11]

5.2.4 Determination of Parentage Involving Children of Assisted Reproduction

The portion of the Washington Uniform Parentage Act, which pertains to children of assisted reproduction (specifically RCW 26.26.705 through 26.26.740) defines a donor as someone who is *not* the parent of a child conceived by assisted reproduction.[12] A donor is an individual who produces eggs or sperm used for assisted reproduction, but does not include: a) a husband who provides sperm or a wife who provides eggs for assisted reproduction by the wife, or b) a woman who gives birth to a child by means of assisted reproduction, except via a surrogate parenting arrangement (see below).[13] If a husband provides sperm for, or consents to, assisted reproduction by his wife, he is the father of the resulting child born to his wife.[14] A woman and her husband must sign a consent to assisted reproduction, except in situations involving the donation of eggs for assisted reproduction by another woman.[15] However, if a husband and wife openly treat a child born to the wife as their own, the husband's failure to sign a consent does not preclude a finding that the husband is the father of the child born.[16] The husband of a wife who gives birth to a baby by assisted reproduction may not challenge his paternity unless: a) he commences a paternity proceeding within two years after learning of the child's birth, or b) a court finds that he did not consent to the assisted reproduction, either before or after the child's birth. A

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[5] Ronald Munson, Intervention and Reflection, Basic Issues in Medical Ethics (Wadsworth/Thomson Learning) (6th ed. 2000).

[6] 42 U.S.C. § 263a, *et seq.*

[7] 42 U.S.C. § 263a-2.

[8] 42 U.S.C. § 263a-1.

[9] 42 U.S.C. § 263a-5.

[10] 42 U.S.C. § 263a-7(1).

[11] 42 U.S.C. § 263a-7(2).

[12] RCW 26.26.705.

[13] RCW 26.26.011(8).

[14] RCW 26.26.710(1).

[15] RCW 26.26.715(1).

[16] RCW 26.26.715(2).

paternity proceeding may be maintained *at any time*, however, if the court finds that: a) the husband neither provided the sperm for, or the consent to, assisted reproduction; b) the husband and the mother of the child have not cohabited since the probable time of assisted reproduction; and c) the husband never openly treated the child as his own.[17] The above limitations apply to a marriage declared invalid after assisted reproduction.

The Washington Uniform Parentage Act also addresses the effects of marital dissolution or the death of a spouse on the determination of parentage of a child conceived by assisted reproduction. If a marriage is dissolved prior to the placement of eggs, sperm, or embryos, the former spouse is not a parent of the resulting child unless he or she consented in writing that he or she would be a parent after a divorce. In addition, a former spouse's consent to assisted reproduction may be revoked at any time before the placement of eggs, sperm, or embryos.[18] In a situation in which a spouse dies before the placement of eggs, sperm, or embryos, the deceased spouse is not the parent of the resulting child unless the deceased spouse consented in writing to postmortem parentage.[19]

A female donor who provides an ovum to a licensed physician to assist another woman in becoming pregnant is not treated as the lawful natural mother of the resulting child, unless the two women agree in writing that the donor is to be a parent. Consequently, a woman who gives birth to a child conceived through alternative reproductive medical technology procedures under the supervision of a licensed physician is treated as the lawful natural mother, unless a written agreement with the donor states otherwise. Any agreements mentioned above must be signed by the ovum donor, the woman who gives birth to the child, and any other intended parent. The physician shall certify the parents' signatures, the date of the ovum harvest, identify any subsequent medical procedures, and identify the intended parents. The agreement must be filed with the registrar of vital statistics in a confidential, sealed file.[20] A birth certificate requested from the Department of Health for any child born as a result of an alternative reproductive medical technology procedure indicates the legal parentage of the child as intended by any agreement filed with the registrar of vital statistics.[21]

5.2.5 Surrogate Parenting

Washington law recognizes surrogate parentage contracts and contains detailed descriptions of the legal requirements for surrogate parenting arrangements, particularly in RCW 26.26.210 through RCW 26.26.260. RCW 26.26.210 defines a "surrogate parentage contract" as:

> [A] contract, agreement, or arrangement in which a female, not married to the contributor of the sperm, agrees to conceive a child through natural or artificial insemination or in which a female agrees to surrogate gestation and to voluntarily relinquish her parental rights to the child.[22]

Apparently, neither this statute nor Washington's Statute of Frauds[23] requires a surrogate parentage contract to be in writing.

A mother-child relationship is established by a valid surrogate parentage contract, under which the mother is an intended parent of the child.[24] Similarly, a father-child relationship is established by a valid surrogate parentage contract, under which the father is an intended parent of the child.[25] A surrogate mother, as opposed to a non-

[17] RCW 26.26.720.

[18] RCW 26.26.725.

[19] RCW 26.26.730.

[20] RCW 26.26.735.

[21] RCW 26.26.740.

[22] RCW 26.26.210(4).

[23] RCW 19.36.010.

[24] RCW 26.26.101(1)(d).

[25] RCW 26.26.101(2)(f).

surrogate mother, is a woman who is naturally or artificially inseminated with sperm from a man to whom she is not married, and who subsequently gestates a child conceived through the insemination pursuant to a surrogate parentage contract.[26] A person shall not enter into, arrange, procure, or assist in the formation of a surrogate parentage contract under which the surrogate mother is an unemancipated minor, is mentally retarded, or has a mental illness or disability.[27] Compensation on the part of any person, organization, or agency to induce arrange, procure, or otherwise assist in the formation of a written or unwritten surrogate parentage contract is prohibited.[28] Anything of monetary value may constitute compensation, except for the payment of expenses incurred as a result of the pregnancy, actual medical expenses of a surrogate mother, and the payment of reasonable attorneys' fees incurred in drafting the surrogate parentage contract.[29] A surrogate parentage contract formed for compensation is void and unenforceable in Washington, regardless of the state in which the contract was executed.[30] Intentional violations of any of the prohibitions outlined above constitute a gross misdemeanor.[31]

Under this statutory scheme, the Superior Court must resolve any custody dispute arising from a surrogate parentage contract by using the seven factors listed in the domestic relations custody statutes.[32] These factors range from the child's emotional needs to the parent's employment schedule.[33] The principal factor is the "relative strength, nature, and stability of the child's relation-ship with each parent."[34] Another of the seven factors is the "agreements of the parties, provided they were entered into knowingly and voluntarily."[35] The party having physical custody of the child may retain physical custody of the child until the Superior Court orders otherwise.[36]

5.2.6 Rights to Genetic Materials

Although the Washington Uniform Parentage Act does not address what happens in situations in which changed circumstances, such as death or divorce, interrupt the implantation of the ova, sperm, or embryos, the Washington Supreme Court has addressed the issue of the disposition of preembryos in an action to dissolve a marriage known as *In re The Marriage of Litowitz*.[37] During the marriage, the parties had employed an egg donor and a surrogate mother in order to have a child. Five donated eggs were fertilized by the husband's sperm, resulting in five preembryos. After implanting three of the preembryos in the surrogate mother, one child was produced. The remaining two preembryos were cryogenically preserved pursuant to the terms of a contract and their disposition became the subject of the dispute between the parties.

The Pierce County Superior Court awarded the preembryos to the husband. The Court of Appeals affirmed the award, holding that the husband had a constitutional right to privacy, which granted him the right not to procreate and entitled him to determine the preembryos' fate. The Washington Supreme Court reversed the decision of the Court of Appeals, however, holding that the dispute was governed by the preembryo cryopreservation contract, which provided that the remaining two preembryos were to have been thawed out

[26] RCW 26.26.210(3).

[27] RCW 26.26.220.

[28] RCW 26.26.230.

[29] RCW 26.26.210(1).

[30] RCW 26.26.240.

[31] RCW 26.26.250.

[32] RCW 26.26.260.

[33] RCW 26.09.187(3).

[34] RCW 26.09.187(3)(a)(i).

[35] RCW 26.09.187(3)(a)(ii).

[36] RCW 26.26.260.

[37] 146 Wn.2d 514, 53 P.3d 516, 48 P.3d 261 (2002).

and not allowed to undergo further development five years after the initial date of cryopreservation, a time period which had already elapsed.

The Washington Supreme Court relied considerably upon the Tennessee Supreme Court's decision regarding the fate of frozen embryos in *Davis v. Davis*.[38] This divorce case also dealt with the disposition of preembroyos produced by in vitro fertilization, but differed from *In re The Marriage of Litowitz* in that both parties in *Davis v. Davis* were progenitors. By the time the *Davis v. Davis* appeal reached the Tennessee Supreme Court, the wife wished to donate the frozen embryos and the husband wished to have them destroyed. The Court found that the wife and husband had competing constitutional rights to procreate or not to procreate.[39] The Court's decision that the husband's interest in not procreating outweighed the wife's interest in procreating was based on the couple's preferences contained in a prior agreement:

> [D]isputes involving the disposition of preembryos produced by *in vitro* fertilization should be resolved, first, by looking to the preferences of the progenitors. If their wishes cannot be ascertained, or if there is dispute, then their prior agreement concerning disposition should be carried out. If no prior agreement exists, then the relative interests of the parties in using or not using the preembryos must be weighed. Ordinarily, the party wishing to avoid procreation should prevail, assuming that the other party has a reasonable possibility of achieving parenthood by means other than use of the preembryos in question.[40]

The New York Court of Appeals case of *Kass v. Kass* similarly held that the parties' agreement to donate preembryos to an in vitro fertilization program for research purposes would control.[41] In addition, in *A.Z. v. B.Z.*, the Massachusetts Supreme Court held that a consent agreement that provided for the giving of preembryos to one of the donors for implantation upon their separation, was not enforceable because: a) it did not contain a duration provision; b) it did not represent the true intention of the parties with regard to disposition; and c) it was against public policy to compel a person to become a parent against that person's will.[42]

5.3 Emergency or Postcoital Contraception

Emergency or postcoital contraception ("EC") refers to any health care treatment approved by the U.S. Food and Drug Administration ("FDA") that prevents pregnancy.[43] The most common EC regimen, Plan B® involves the ingestion of a high dose of the oral contraceptive levonorgestrel within seventy-two hours of sexual contact.[44] Plan B® works in one of three ways depending on when it is taken following sexual contact.[45] It prevents release of an

[38] 842 S.W.2d 588 (Tenn. 1992), *cert denied*, *Stowe v. Davis*, 507 U.S. 911 (1993).

[39] 842 S.W.2d at 600.

[40] 842 S.W.2d at 604.

[41] 91 N.Y.2d 554, 562, 569, 696 N.E.2d 174 (1998).

[42] 431 Mass. 150, 157-62, 725 N.E.2d 1051 (2000).

[43] *See* RCW 70.41.020(3); WAC 246-320-010(14).

[44] FDA Approved Labeling for Plan B® (Application No. 21-045/S011), *available at* http://www.fda.gov/CDER/foi/nda/2006/021045s011_Plan_B_PRNTLBL.pdf (last visited Nov. 5, 2008).

[45] *Id.*

egg from the ovaries, fertilization of an egg; as well as implantation of fertilized ova in the uterus.[46] Plan B® is not an abortifacient because it does not interfere with a fertilized ova already attached to the uterus.[47]

Until recently, Plan B® was available only by prescription. On August 24, 2006, the FDA approved Plan B® as an over-the-counter medication for those aged 18 and older; it remains a prescription-only drug for minors.[48] In Washington, emergency room providers must notify victims of the option to receive EC.[49] They are also obligated to provide victims of sexual assault with factually accurate and unbiased information about EC and must provide EC upon request to such individuals as long as the treatment is not medically contraindicated.[50]

In 2007, the Washington State Department of Health's Board of Pharmacy issued regulations that prohibit pharmacies from engaging in "refuse and refer" practices.[51] The regulations require pharmacies to dispense medications regardless of individual pharmacists' refusal.[52] Pharmacists may ask another pharmacist on duty to provide the medicine, but the pharmacy may not refuse to fill the prescription and then simply refer the patient to another pharmacy due to moral or ethical objections.[53] Though the regulations do not specifically mention EC, Board of Pharmacy guidance suggests that access to time-sensitive and controversial drugs like Plan B® was a key factor in their adoption.[54]

The day before they were to become effective, these regulations were challenged in the United States District Court for the Western District of Washington.[55] The plaintiffs (comprised of pharmacists and a pharmacy) contended that enforcement of the regulations would violate federal anti-discrimination laws, their right to freely exercise their religious conscience, as well as the Equal Protection and the Due Process Clauses of the Fourteenth Amendment.[56] The court issued a preliminary injunction prohibiting enforcement of the regulations.[57] The defendants promptly

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[46] *Id*.

[47] *See* Food and Drug Administration: Plan B: Questions and Answers, *available at* http://www.fda.gov/cder/drug/infopage/planB/planBQandA20060824.htm (published Dec. 14, 2006, last visited Nov. 6, 2008).

[48] FDA Approval Letter for Plan B® (levonorgestrel) from Center for Drug Evaluation and Research, Food and Drug Administration to Duramed Research, Inc., a subsidiary of Barr Pharmaceuticals, Inc. (Aug. 24, 2006).

[49] RCW 70.41.350; *See also* WAC 246-320-370.

[50] *Id*.

[51] WAC 246-869-010.

[52] *Id*. ("Pharmacies have a duty to deliver lawfully prescribed drugs or devices to patients and to distribute drugs and devices approved by the U.S. Food and Drug Administration . . . in a timely manner consistent with reasonable expectations for filing the prescription . . . .").

[53] Rule Summary and Compliance Document for WAC 246-869-010 and WAC 246-863-095, State of Washington Department of Health, Board of Pharmacy, *available at* https://fortress.wa.gov/doh/hpqa1/hps4/Pharmacy/documents/ComplianceDocument_153228.pdf (last visited Nov. 6, 2008).

[54] *Id*.

[55] *Stormans, Inc. v. Selecky*, 524 F.Supp. 2d 1245 (W.D. Wash. 2007); *See also* Complaint, *Stormans, Inc. v. Selecky*, No. C07-5374-RBL (W.D. Wash. 2007) (filed on July 25, 2007).

[56] *Id*. at 1255.

[57] *Id*. at 1259-60, 1263, 1266 (holding that (1) the regulations were not neutral; (2) the regulations were not generally applicable; and (3) the plaintiff pharmacists' and pharmacies had established substantial likelihood of success warranting injunctive relief).

appealed to the Ninth Circuit seeking a stay of the injunction pending their appeal of its grant and were denied a stay.[58] The Ninth Circuit heard oral argument appealing the grant of the preliminary injunction on July 8, 2008 and has not issued a ruling.[59] A bench trial is scheduled in District Court for April 20, 2009.[60]

At the federal level, on December 19, 2008, the Department of Health and Human Services issued a final rule that would permit health care providers working for federally funded entities and the federally funded entities themselves to decline to take part in health care service and research activities to which they object for religious, moral, ethical, or other reasons.[61] The rule requires recipients of such funds to certify their compliance with laws protecting provider conscience rights and will become effective on January 20, 2009. Prior to the issuance of the final rule, however, Senators Hillary Rodham Clinton (D-NY) and Patty Murray (D-WA) introduced legislation to block its implementation.[62] In addition, while campaigning in the race for the U.S. Presidency, President Barack Obama criticized the proposed rule and stated that he was "committed to ensuring that the health and reproductive rights of women are protected."[63] Should this rule become effective, however, the "refuse and refer" practices, prohibited under the Washington regulation, would be shielded from sanction.

5.4 Maternal Health

The Washington State Legislature has imposed requirements on physicians treating pregnant women. First, all persons licensed or certified to provide prenatal care must provide information regarding the use and availability of prenatal tests to all pregnant women in their care within the time limits prescribed by state rules.[64] Health care providers also are required to provide information on certain prenatal tests to their pregnant patients.[65]

In addition, every physician attending a pregnant woman is required at the time of the first examination to collect a blood sample and have the sample submitted to an approved laboratory for a syphilis test.[66] If the woman presents herself for examination after the fifth month of gestation, the health care provider shall also advise and urge the patient to secure a medical examination and blood test before the fifth month of any subsequent pregnancies.[67]

Finally, every health care practitioner attending a pregnant woman shall insure that AIDS counseling of the patient is conducted.[68]

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[58] *Stormans, Inc. v. Selecky*, 526 F.3d 406 (9th Cir. 2008).

[59] *Stormans, Inc. v. Selecky*, No. 07-36039, 07-36040 (9th Cir. 2008).

[60] Deadlines/Hearings, *Stormans, Inc. v. Selecky*, No. C07-5374-RBL (W.D. Wash. 2007).

[61] Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law, 73 Fed. Reg. 78,072 (Dec. 19, 2008) (to be codified at 45 C.F.R. pt. 88).

[62] Protecting Patients and Health Care Act, S. 20, 110th Cong. (2008).

[63] David G. Savage, Health Providers' 'Conscience' Rule to Take Effect, L.A. TIMES, Dec. 19, 2008 at A18.

[64] RCW 70.54.220.

[65] WAC 246-680-001.

[66] RCW 70.24.090, 70.24.100.

[67] RCW 70.24.090.

[68] RCW 70.24.095.

5.5 Protection of the Fetus

A continuously evolving area of the law concerns the status to be accorded a fetus during the course of a woman's pregnancy. In the disparate areas of civil and criminal law, some courts have moved towards according the protection of "personhood" to a fetus.[69] This added protection runs into direct conflict with a woman's rights of self-determination, privacy, and bodily integrity that are protected under the common law and the federal and state constitutions; when the fetus is not its own person, it is considered a part of the mother and virtually any action taken to protect it against the mother's will interferes with the mother's autonomy and rights.[70] Underlying this conflict are intense emotions regarding abortion, the protection of children, and women's rights. The following subsections explore some of the developments in this controversial area. It must be noted that these legal developments place a health care provider who treats a pregnant woman into a difficult position. A health care provider who is treating a pregnant woman owes a duty of care towards the woman's fetus.[71] However, the health care provider also owes a duty of care towards the pregnant woman,[72] as well as a duty to maintain the confidentiality of the patient-physician relationship.[73] Thus, the health care provider is placed in a difficult position when the pregnant woman's actions appear to place the fetus at risk.[74]

5.5.1 Protection of Fetus in Tort Law

Attaching the qualities of personhood to a fetus are particularly relevant in the medical malpractice arena. For years, tort law principles have been used to achieve redress for harm done to a developing fetus by a health care provider's negligence. In Washington, parents have been allowed to recover damages for harm done to a fetus prenatally and even prior to conception.[75] Under an action for "wrongful birth", parents of a child with birth defects may recover damages for a health care provider's breach of a duty with is a proximate cause of the birth of the child.[76] Such damages include extraordinary medical, educational, and related expenses attributable to the child's birth in a defective condition and damages for their emotional injuries caused by the birth of a defective child.[77] Parents also have been allowed to recover under the wrongful death statute for the demise of a viable fetus.[78] Of even more importance to health care providers, children have been allowed to recover damages from health care providers for injuries suffered in the womb.[79] Under an action for "wrongful life", a

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[69] *See generally* Dawn E. Johnson, *The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy, and Equal Protection*, 95 Yale L.J. 599 (1986); Susan Goldberg, *Of Gametes and Guardians: The Impropriety of Appointing Guardians Ad Litem for Fetuses and Embryos*, 66 Wash. L. Rev. 503 (1991).

[70] *See generally Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 278 (1990) (a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment); *In re Colyer*, 99 Wn.2d 114, 120-21, 660 P.2d 738 (1983) (recognition of constitutionally protected right of privacy to refuse treatment that only prolongs the dying process; recognition of common-law right to be free from bodily invasion), *modified on other grounds*; *In re Hamlin*, 102 Wn.2d 810, 689 P.2d 1372 (1984).

[71] *Harbeson v. Parke-Davis, Inc.*, 98 Wn.2d 460, 480, 656 P.2d 483, 495 (1983).

[72] *Harbeson*, 98 Wn.2d at 472.

[73] RCW 5.60.060(4); RCW 70.02.020.

[74] *See generally* J. Nocon, *Physicians and Maternal-Fetal Conflicts: Duties, Rights and Responsibilities*, 5 J. of Law & Health 1 (1991) [*Hereinafter Maternal - Fetal Conflict*].

[75] *Harbeson*, 98 Wn.2d at 472.

[76] *Harbeson*, 98 Wn.2d at 465-467.

[77] *Id.*

[78] RCW 4.24.010; *Moen v. Hanson*, 85 Wn.2d 597, 601, 537 P.2d 266 (1975).

[79] *Seattle-First National Bank ex rel. Rankin*, 59 Wn.2d 288, 367 P.2d 835 (1962); *Harbeson*, 98 Wn.2d at 480.

child with a birth defect may recover special damages for a health care provider's breach of a duty, which is a proximate cause of the birth, to either inform the parents of the risk of birth defects, or to perform procedures with due care to prevent conception or birth.[80] Recoveries by children in such actions are typically larger than the recoveries by their parents.[81] At least one state has expanded these principles to allow a mother to be sued by her child for injuries allegedly suffered by the child in the womb because of the mother's negligent behavior.[82] Commentators have suggested that such a cause of action might be an appropriate tool to fight substance abuse by pregnant women.[83] Other states have refused to allow children to sue their mothers, however, on the grounds that such actions would "subject the woman's every act while pregnant to state scrutiny, thereby intruding upon her rights to privacy and bodily integrity and her right to control her own life."[84]

5.5.2 Abuse of Controlled Substances by a Pregnant Woman

Health care providers, attorneys, and legislators have been struggling with the issues raised by a pregnant woman's abuse of alcohol and/or illicit drugs. In some states, prosecutors have used criminal laws to incarcerate pregnant women.[85] One state court has interpreted the definition of "child" in child abuse laws to include a viable fetus.[86] Also, some state legislatures have expanded child abuse reporting laws to require health care providers to report suspected "abuse" of a fetus to child welfare agencies.[87]

The Washington State Legislature has taken a more moderate approach. In l993, the legislature established a pilot program of drug/alcohol treatment programs for pregnant women.[88] To date, Washington's child abuse reporting laws have not been amended or interpreted to apply to unborn children.[89] Child abuse reporting laws generally grant immunity from liability for reports of child abuse by mandatory reporters, such as health care providers.[90] Since Washington's reporting laws do not extend this immunity to reports regarding fetuses, a health care provider arguably is prohibited by confidentiality laws from reporting concerns about a pregnant woman's substance abuse.[91] As soon as the child is born, however, the health care provider is required to report to Children's Protective Services any abuse or neglect that the health care provider has reasonable cause to believe the child has suffered.[92]

A health care provider's inability to report a pregnant woman's substance abuse to authorities raises some concerns. As discussed above, a health care provider owes a duty of care toward the fetus of a pregnant woman

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[80] *Harbeson*, 98 Wn.2d at 478-482.

[81] Steven Paskal, *Liability for Prenatal Harm in the Workplace: The Need for Reform*, 17 U. Puget Sound L. Rev. 283, 304 (1994).

[82] *Grodin v. Grodin*, 396, 301 N.W.2d 869 (Mich. Ct. App. 1981).

[83] P. Van Grunsven, *Dilemmas of Providers Treating Pregnant Mothers Who Use Drugs: Patient Confidentiality Versus the Duty to Report Drug Use*, 28 J. Health & Hospital Law 243, 247 (1995) [*hereinafter Dilemmas*].

[84] *In re Baby Boy Doe*, 632 N.E.2d 326 (III. App. Ct. 1994), *describing Stallman v. Youngquist*, 531 N.E.2d 355, 360 (Ill. 1988).

[85] Kary Moss, *Substance Abuse During Pregnancy*, 13 Harv. Women's L.J. 278, 283; *Dilemmas*, *supra* note 46, at 244.

[86] *Whitner v. State*, 492 S.E.2d 777 (S.C. 1997).

[87] *See, e.g.*, Minn. Stat. Ann. § 626.5562; *see generally Dilemmas*, *supra* note 46, at 244.

[88] *See* RCW 70.83C.

[89] *See, e.g.*, RCW 26.44.020, 26.44.030.

[90] *See, e.g.*, RCW 26.44.060; *see generally Dilemmas*, *supra* note 46, at 246.

[91] RCW 70.02.020; *see generally Dilemmas*, *supra* note 46, at 246.

[92] RCW 26.44.030.

under his or her care.[93] When a health care provider is treating a pregnant woman whose substance abuse appears to place her fetus at risk, however, there is little the health care provider can do on behalf of the fetus because of confidentiality concerns.[94]

Practice Tip

A health care provider with concerns about a pregnant woman's behavior should: a) ensure that the woman has been fully informed of the risks of her behavior under the principles of informed consent,[95] and b) ensure that the woman's medical records reflect all warnings of risk and referrals to social services made by the provider.

5.5.3 Forced Medical Treatment of a Pregnant Woman

Many dilemmas arise when a pregnant woman refuses medical treatment that can save either her life or the life of the fetus. In Washington, the right to refuse medical treatment is constitutionally protected but is not absolute.[96] The state's interest in protecting the sanctity of the lives of its citizens may override an individual's refusal of medical treatment upon consideration of the following four interests: a) the preservation of life; b) the protection of interests of innocent third parties; c) the prevention of suicide; and d) the maintenance of the ethical integrity of the medical profession.[97] A pregnant woman's refusal of medical treatment implicates the first, second, and fourth of these interests.

Although there is minimal case law that addresses the issue of whether a health care provider's administration of care in spite of a pregnant patient's refusal of care constitutes a tort, in general Washington law does not address the dilemmas faced by health care providers when confronted by a pregnant patient who refuses care. Nationwide, these issues first arose with regard to the refusal of blood transfusions on the part of Jehovah's Witnesses and Christian Science patients. In the reported cases, the courts have overridden the mother's objections to a blood transfusion in order to preserve the life of the fetus and protect an innocent third party.[98]

In addition, courts have been asked to order a pregnant woman to undergo a caesarian section over her objections in order to save the life of the fetus. In the 1980s, some courts forced such surgeries upon pregnant women.[99] More recently, courts have disapproved of ordering such an intrusive procedure over a pregnant woman's desires.[100]

Members of the medical profession have taken a position upholding the pregnant woman's autonomy in medical decision-making.[101] The American Medical Association's Board of Trustees cautions that the physician's duty is not to dictate the pregnant woman's decision, but to ensure that she is provided with the appropriate information to make an informed decision.[102] If the woman rejects the doctor's recommendation,

[93] *Harbeson*, 98 Wn.2d at 480.

[94] *Maternal-Fetal Conflicts*, *supra* 39, at 34; *Dilemmas supra* note 46, at 248.

[95] *See* Chapter 2 of this Manual.

[96] *In re Colyer*, 99 Wn.2d at 122 (modified on other grounds); *In re Hamlin*, 102 Wn.2d at 810.

[97] *In re Colyer*, 99 Wn.2d at 122; *In re Grant*, 109 Wn.2d 545, 556, 747 P.2d 445 (1987).

[98] *Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson*, 201 A.2d 537 (N.J. Sup. Ct. 1964), *cert.. denied*, 377 U.S. 985 (1964); *In re Jamaica Hospital*, 491 N.Y.S.2d 898 (N.Y. Sup. Ct. 1985).

[99] *See, e.g., Jefferson v. Griffen Spalding County Hospital Authority*, 247 Ga. 86, 274 S.E.2d 457 (Ga. 1981); *In re Maydun*, 114 Daily Wash. L. Rptr. 2233 (D.C. Super. Ct., July 26, 1986).

[100] *In re Baby Boy Doe*, 632 N.E.2d 326 (III. App. Ct. 1994); *In re A.C.*, 573 A.2d 1235 (D.C. Cir. 1990).

[101] *Legal Interventions During Pregnancy: Court Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women*, 264 J.A.M.A. 2663, 2665, 2670 (1990).

[102] *Id.*

the appropriate response is not to attempt to force the recommended procedure upon her, but to urge her to seek consultation and counseling from a variety of sources.[103] According to the Board of Trustees, judicial intervention might be appropriate only in exceptional circumstances in which medical treatment poses an insignificant or no health risk to the woman, entails a minimal invasion of her bodily integrity, and clearly would prevent substantial and irreversible harm to her fetus.[104]

5.5.4 Parent-Fetus Conflict

A final issue involves the care and delivery of the children of brain-dead patients. In one California case, a husband requested a court order to sustain his wife's life long enough to perform a caesarian section to save the baby.[105] The wife's family disagreed.[106] The Santa Clara County Superior Court issued the requested court order on the grounds that no parent-fetus conflict existed.[107]

A conflict may arise if the mother has executed a Living Will under Washington's Natural Death Act.[108] Under this Act, an individual may execute a directive instructing health care providers not to sustain the individual's life under certain circumstances.[109] The Act includes a model health care directive, which states that the advance directive shall have no force or effect if the individual is pregnant.[110] Therefore, if a pregnant individual uses the model health care directive, the directive may have no force or effect, creating a parent-fetus conflict. The statute also states, however, that the directive "may include other specific directions."[111] As a result, it may be possible for an individual who is or anticipates becoming pregnant to include a clause in her health care directive that reconciles any potential parent-fetus conflicts.

In *DiNino v. State ex. rel.*, Gorton, a woman challenged the constitutionality of this statute.[112] The Washington Supreme Court refused to address the issue, on the grounds that the case presented no justiciable controversy, because the petitioner was neither pregnant nor on a life support system.[113] The court suggested, however, that a woman can delete the pregnancy clause from a Living Will.[114] Other states have statutes that more clearly prohibit the removal of life-support systems from pregnant women, the constitutionality of which has not gone unchallenged.[115]

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[103] *Id.*

[104] *Id.*

[105] *Id.*

[106] *See discussion* in *Maternal-Fetal Conflicts*, *supra* note 39, at 26, describing the unreported case of *Poole v. Santa Clara County Kaiser Hospital* (604 575, Sup. Ct., Santa Clara Co., California 1986).

[107] *Id.*

[108] RCW 70.122.

[109] RCW 70.122.030.

[110] RCW 70.122.030(1).

[111] *Id.*

[112] 102 Wn.2d 327, 684 P.2d 1297 (1984).

[113] 102 Wn.2d at 331, 684 P.2d at 1300.

[114] 102 Wn.2d at 331, 684 P.2d at 1300.

[115] *See* Elizabeth C. Benton, *The Constitutionality of Pregnancy Clauses in Living Will Statutes*, 43 Vand. L. Rev. 1821 (1990).

5.6 Abortion

5.6.1 The Right to Abortion

The right to obtain an abortion derives from the U.S. Constitution and Washington statute. Since the landmark case of *Roe v. Wade*,[116] the U.S. Constitution has been interpreted to protect the right to privacy, including a limited right to choose abortion. This right to abortion initially was limited by balancing the interests of the woman and the government in what has become known as the Court's "trimester analysis." In *Planned Parenthood v. Casey*,[117] however, the court abandoned the trimester analysis and the "strict scrutiny" standard of review.[118] Instead, the Court adopted an "undue burden" standard of review, and ruled that a state may not prohibit a woman from terminating her pregnancy "before viability" of the fetus.[119]

As early as 1909, the Washington criminal code outlawed abortion.[120] In 1991, however, the people of Washington approved an initiative enacting the Washington Reproductive Privacy Act.[121] Generally, the Act provides that the state may not deny or interfere with a woman's right to choose an abortion prior to viability of the fetus or to protect her life or health.[122] Viability is defined as the point in the pregnancy when, in the treating physician's judgment, there is a reasonable likelihood of the fetus's sustained survival outside the uterus without the application of extraordinary medical measures.[123] As stated above, the Act bases the assessment of viability on the judgment of physician in each particular case, thus making the physician the gatekeeper to abortions. Under the Act, an individual is entitled to rely on: a) a physician's "good faith judgment" of viability; b) a physician's good faith judgment of the risk to a woman's life or health; and c) a health care provider's good faith judgment of the duration of pregnancy.[124]

A physician is authorized to terminate a pregnancy and a "health care provider" is authorized to assist in terminating a pregnancy.[125] A "physician" is defined as a physician licensed under RCW 18.57 or 18.71.[126] A "health care provider" is defined as a physician or "a person acting under the general direction of a physician."[127] One should note that the performance of an unauthorized abortion constitutes a felony under the Act.[128] In addition, one should note that if an attempted abortion results in a live birth, the infant's right to medical treatment is "the same as the right of an infant born prematurely of equal gestational age."[129]

5.6.2 Third-Party Consent and Notification

Some states have enacted legislation requiring third parties, such as a parent, spouse, or court, to be given notice and/or an opportunity to consent before a woman may obtain an abortion. Washington law used to require the

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[116] 410 U.S. 113 (1973).

[117] 505 U.S. 833 (1992).

[118] 505 U.S. at 837.

[119] *Id.*

[120] Former RCW 9.02.010.

[121] RCW 9.02.100.

[122] RCW 9.02.110.

[123] RCW 9.02.170.

[124] RCW 9.02.130.

[125] RCW 9.02.110.

[126] RCW 9.02.170(4).

[127] RCW 9.02.170(5).

[128] RCW 9.02.120.

[129] RCW 18.71.240.

consent of a married woman's husband or a minor woman's legal guardian.[130] Although the U.S. Supreme Court struck down a state law requiring pre-abortion spousal notification as "unduly burdensome",[131] the issue of whether states may enact laws requiring specified third parties to receive notice prior to an abortion has remained a hot topic, both in the press and in the courts. On the one hand, the U.S. Supreme Court has struck down a state law that required parental notification with respect to every minor seeking an abortion.[132] On the other hand, the Court has upheld state laws that require parental notification, but allow minors to seek a judicial bypass of the notice requirement.[133] The Washington Reproductive Privacy Act requires neither third-party notification nor consent. For laws on consent for medical procedures and minors, see Chapter 2.

5.6.3 Public Funds and Facilities

Controversy has raged over the government's ability to limit or refuse to pay for abortions both on the federal and state levels. Currently, federal law prohibits the use of federal funds for the performance of abortions, unless necessary to preserve the mother's life.[134]

The Washington Reproductive Privacy Act requires that in any program funded in whole or in part by the state, whatever benefits, services, or information the state provides for maternity care also must be provided for abortion.[135]

Under the administration of President Reagan, a "Gag Rule" prohibited health care providers in federal facilities from advising patients about the option of abortion.[136] In 1993, the Department of Health and Human Services suspended the Gag Rule[137] in response to directions from President Clinton.[138] Then, in 2001 during his first few days in office, President Bush instituted a global gag rule, which denies U.S. foreign assistance to organizations that provide abortion services, counsel their patients regarding abortion options, refer their patients for abortion services, or educate their communities about or lobby their governments for safe abortions, even with their own non-U.S. funds.

5.6.4 Right to Refuse to Perform Abortions

The Washington Reproductive Privacy Act also protects a person's or private medical facility's right to refuse to participate in performing an abortion.[139] The Act defines a "private medical facility" as "any medical facility that is not owned or operated by the state."[140] In addition, the Act prohibits discrimination "in employment or professional privileges" against a person who participates or refuses to participate in the termination of a pregnancy.[141]

Under federal law, no individual "shall be required to perform or assist in the performance of any part of a health service program or research activity funded in whole or in part under a program administered by the

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[130] Former RCW 9.02.070.

[131] *Planned Parenthood v. Casey*, 505 U.S. 833 (1992).

[132] *Bellotti v. Baird*, 443 U.S. 622 (1979).

[133] *See, e.g., Lambert v. Wicklund*, 520 U.S. 292 (1997).

[134] 42 U.S.C. § 300a-6; *see also* Pub. L. 104-69, title II, sec. 207 (Dec. 22, 1995), 109 Stat. 770 (Hyde Amendment).

[135] RCW 9.02.160.

[136] *See* 42 C.F.R. § 59.

[137] 58 Fed. Reg. 7462-7463 (Feb. 5, 1993).

[138] *See* Memoranda of President, 58 Fed. Reg. 7455 (Jan. 22, 1993).

[139] RCW 9.02.150.

[140] RCW 9.02.170(7).

[141] RCW 9.02.150.

Secretary of Health and Human Services if his performance or assistance in the performance of such part of such program or activity would be contrary to his religious beliefs or moral convictions."[142]

5.6.5 Abortion Clinic Demonstrations

5.6.5.1 Washington Law

The Washington Interference with Health Care Facilities or Providers Act protects "lawful picketing or other publicity for the purpose of providing the public with information."[143] However, the Act prohibits willfully or recklessly interfering with access to or from a health care facility, or disrupting the normal functioning of such facility, by: a) physically obstructing or impeding free passage; b) making noise that unreasonably disturbs the peace; c) trespassing on the facility; d) repeatedly telephoning the facility; or e) threatening to injure the owners, agents, patients, employees, or property.[144] A "health care facility" is a facility that provides health care services directly to patients, including a hospital, clinic, health care provider's office, health maintenance organization, diagnostic or treatment center, neuropsychiatric or mental health facility, hospice, or nursing home.[145] A violation of the Act constitutes a gross misdemeanor and may result in civil and criminal penalties. Depending on the offense, minimum jail time ranges from 24 hours to 30 days and minimum fines range from $250 to $1,000.[146]

In addition, the Act provides a mechanism for an "aggrieved" person or health care facility to seek civil damages or injunctive relief.[147] Civil damages may include actual damages, costs, attorneys' fees and up to $500 per day of violation for an individual plaintiff or up to $5,000 per day for a plaintiff that is a health care facility.[148] Potential "aggrieved" plaintiffs include (a) a person physically present during the violation, whose access to the health care facility is or is about to be impeded, (b) a person physically present during the violation, whose care is or is about to be disrupted, (c) the health care facility, its employees or agents; and (d) the owner of the health care facility or the building or land on which the facility is located.[149]

In criminal and civil cases, the Act instructs courts to protect patients and health care providers who are parties and witnesses.[150] The definition of health care providers in the Act includes health care facility officers, directors, employee, and agents.[151]

5.6.5.2 Federal Law

The Freedom of Access to Clinic Entrances Act of 1994 prohibits the use of force, threat of force, or physical obstruction to intentionally injure, intimidate, interfere, or attempt to injure, intimidate, or interfere with any person seeking or providing reproductive health services or seeking or exercising religious

[142] 42 U.S.C. § 300a-7(d).

[143] RCW 9A.50.060.

[144] RCW 9A.50.020.

[145] RCW 9A.50.010(1).

[146] RCW 9A.50.030.

[147] RCW 9A.50.040.

[148] RCW 9A.50.040(1), .050.

[149] RCW 9A.50.010(3)(a)-(d).

[150] RCW 9A.50.070.

[151] RCW 9A.50.010(2).

freedom.[152] The Act also prohibits destroying the property of a facility that provides reproductive health services or a place of worship.[153] The Act imposes penalties for first, second, and later violent offenses of jail time ranging from one to three years, for nonviolent offenses of jail time from six months to eighteen months, and of fines from $10,000 to $25,000.[154] A person aggrieved under the Act may bring a cause of action for injunctive relief, compensatory damages, punitive damages, costs, attorneys' fees, and expert witness fees.[155]

In 2001, a federal court jury entered an award against several anti-abortion activist groups[156] under the Racketeering Influenced and Corrupt Organizations Act.[157] The jury found that the activists conspired to restrict access to abortion clinics through extortion and threats of violence.[158]

5.6.6 Non-surgical Abortion

In addition to employing surgical techniques, physicians use medications to induce abortions. Mifepristone, formerly known as RU-486, blocks progesterone receptors, which are crucial to the establishment and maintenance of pregnancy.[159] When used in conjunction with a prostaglandin in early pregnancy, mifepristone induces an abortion.[160] The drug has been used in France since 1988, and was approved by the FDA on September 28, 2000.[161] An alternate non-surgical abortion regimen involves the off-label use of methotrexate in conjunction with misoprostol, a drug approved for use in prevention of ulcers.[162] While not approved in the United States as an abortifacient, methotrexate is approved for other indications, so physicians can prescribe this medication legally for the off-label evidence-based induction of abortion.[163]

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[152] 18 U.S.C. § 248(a)(1)-(2).

[153] 18 U.S.C. § 248(a)(3).

[154] 18 U.S.C. § 248(b).

[155] 18 U.S.C. § 248(c).

[156] *National Organization for Women v. Scheidler* (N.D. Ill., No. 86 C 7888, March 28, 2001).

[157] 18 U.S.C. § 1961 *et seq.*

[158] *NOW v. Scheidler* (N.D. Ill., No. 86 C 7888, March 28, 2001).

[159] Ranjan Basu, Tina Gundlach & Margaret Tasker, *Mifepristone and Misoprostol for Medical Termination of Pregnancy: the Effectiveness of a Flexible Regimen*, 29 J. OF FAM. PLAN. AND REPROD. HEALTH CARE 139, 140 (2003).

[160] *Id*.

[161] FDA Approval Letter for Mifeprex® (mifepristone) from the Center for Drug Evaluation and Research, Food and Drug Administration to Population Council (Sept. 28, 2000).

[162] FDA Approved Labeling for Cytotec (misoprostol) at 6, *available at* http://www.fda.gov/cder/foi/label/2002/19268slr037.pdf (last visited Nov. 6, 2008).

[163] S. Marie Harvey, Christy A. Sherman, Sheryl Thorburn Bird & Jocelyn Warren, *Understanding Medical Abortion Policy, Politics, and Women's Health*, 8, 11, RESEARCH PROGRAM ON WOMEN'S HEALTH, CENTER FOR THE STUDY OF WOMEN IN SOCIETY, UNIVERSITY OF OREGON (2002) ("[methotrexate] is not approved by the FDA for early pregnancy termination, but because it is available by prescription, physicians may legally pre-scribe it for this use. Evidence supports its safety and effectiveness for this purpose.").

5.7 Birth

5.7.1 Emergency Medical Treatment and Active Labor Act

The Emergency Medical Treatment and Active Labor Act ("EMTALA"),[164] is a provision of the Comprehensive Omnibus Budget Reconciliation Act ("COBRA") that is also known as the "Anti-Dumping Act." EMTALA prohibits a hospital that receives Medicare funds from discharging or transferring an individual with an "emergency medical condition" whose condition has not been "stabilized." Most courts have concluded that EMTALA applies to all patients, regardless of whether they are receiving Medicaid or Medicare benefits.[165] The purpose of the statute is to prevent disparate treatment between patients, not to insure that a certain standard of care is delivered.

Under EMTALA, an "emergency medical condition" includes a pregnant woman in "active labor", which means that: a) there is inadequate time to affect a safe transfer to another hospital before delivery, or b) transfer may pose a threat to the health or safety of the woman or the unborn child.[166] The Code of Federal Regulations further elaborates that active labor means "the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta."[167] For purposes of EMTALA, labor is not considered to have "stabilized" until the woman has delivered the child and the placenta.[168] Accordingly, a woman who is in labor cannot be discharged or transferred unless: a) the mother (or a responsible person acting on her behalf) requests a transfer or discharge in writing; or b) a physician has certified in writing that the benefits of a transfer outweigh the risks and the receiving facility has agreed to accept the transfer of the individual.[169] Generally, courts will look to the statutory language rather than medical standards to determine whether a woman is in "active labor."[170]

In the past, physicians were wary of discharging women in false labor due to EMTALA standards. Now, regulations specify that a woman can be discharged from the hospital if "a physician certifies that, after a reasonable time of observation, the woman is in false labor."[171]

Even though the federal statute is drafted to focus on patients who present to a hospital's emergency department, some courts have held that EMTALA prohibits the discharge of patients admitted to the hospital with emergency medical conditions, who never were physically present in the emergency department.[172] Federal regulations now specify that any patient who is on "hospital property", is in an ambulance owned by the hospital, wherever it is located, or is in a nonhospital-owned ambulance that is on hospital grounds will be deemed to have come to the emergency department.[173] A hospital in "diversionary status", which means to be without the staff or facilities to accept additional emergency patients, may direct a nonhospital-owned

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[164] 42 U.S.C. § 1395dd (1992).

[165] *See, e.g., Brooker v. Desert Hospital Corp.*, 947 F.2d 412, 415 (9th Cir. 1991).

[166] 42 U.S.C. § 1395dd(e)(1)(B).

[167] 42 C.F.R. § 489.24(b).

[168] 42 C.F.R. § 489.24(b).

[169] 42 U.S.C. § 1395dd(c). Health care providers should note that courts will scrutinize a physician's deliberative process in signing a certification. *Burditt v. U.S. Department of Health and Human Services*, 934 F.2d 1362, 1368 (5th Cir. 1991).

[170] *Burditt*, 934 F.2d at 1369.

[171] *Id.*

[172] *See, e.g., Thornton v. Southwest Detroit Hospital*, 895 F.2d 1131 (6th Cir. 1990).

[173] 42 C.F.R. § 489.24(b).

ambulance not to come to the hospital. [174] However, if the ambulance staff disregards the instructions and comes onto hospital property, then EMTALA protections are triggered.[175]

The stakes involved in violating the statute are quite high: a) both the hospital and the physician can be subjected to civil monetary penalties of up to $50,000 each,[176] and b) a physician who repeatedly offends may be excluded from the Medicare/Medicaid program.[177] In addition, the statute creates a private cause of action against the hospital.[178]

5.7.2 Insurance Coverage of Maternity Stay and Newborn Child

Under federal law, private insurers must provide insurance coverage for maternity stays of at least 48 hours for vaginal deliveries and 96 hours for caesarian sections.[179] In 1996, Congress amended both the Employee Retirement Income Security Act[180] and the Public Health Service Act[181] to require such coverage.

Under Washington law, insurers also must extend insurance coverage at a level no less than the mother's to a newly born child for at least three weeks after birth.[182]

5.7.3 Medical Testing of Newborns

A variety of medical tests are available at the time of a child's birth to gauge the health of the child. Washington law requires that all newborns be screened for certain disorders, subject to the exceptions described below. In addition to mandatory screening, newborns may be given other screening tests, some of which raise sensitive legal issues.

The declared policy of the State of Washington is to make every effort to detect as early as feasible and to prevent where possible preventable heritable disorders leading to developmental disabilities or physical defects.[183] Accordingly, state law requires that hospitals providing obstetrical delivery services or neonatal care must obtain a blood specimen from each newborn infant prior to discharge from the hospital or, if not yet discharged, no later than five days of age, to screen the infant for phenylketornuria and other heritable or metabolic disorders leading to mental retardation or certain physical defects.[184] The parents or guardian are entitled to refuse such tests on religious grounds.[185]

Another policy of the State of Washington is to protect the confidentiality of individuals who are infected with the Human Immunodeficiency Virus (HIV).[186] Accordingly, a health care provider must obtain specific written

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[174] *Id*.

[175] *Id.*

[176] 42 U.S.C. § 1395dd(d).

[177] *Id.*

[178] 42 U.S.C. § 1395dd(d)(2)(A).

[179] Newborns' and Mothers' Health Protection Act of 1996, P.L. 104-204 (Sept. 26, 1996).

[180] *See* ERISA Part 7, subtitle B, title I.

[181] *See* Title XXVII of the Public Health Service Act, subpart 1.

[182] RCW 48.43.115(2)(f).

[183] RCW 70.83.010.

[184] RCW 70.83.020; WAC 246-650-020.

[185] RCW 70.83.020; WAC 246-650-020(1)(a)(iv), (e).

[186] *See generally* RCW Chapter 70.24; *see also* Chapter 1 of this Manual.

consent, generally from the parents or appointed guardian, prior to testing a newborn for HIV.[187] If a health care provider has reason to believe that the newborn is at risk of infection, but is unable to obtain consent for testing, the provider may ask a state or local public health officer to obtain a court order authorizing testing and/or treatment.[188]

Testing for the presence of alcohol or illicit drugs in the newborn's blood (known as performing a "tox screen") may also pose legal difficulties. The presence of alcohol or drugs in a newborn's blood indicates the use of such substances by the mother during pregnancy. Health care and child care providers have a duty to report child abuse or neglect, and typically health care providers interpret this duty as a requirement to report a positive tox screen to Child Protective Services.[189]

A determination of the type of consent that must be obtained prior to performing a tox screen on an infant's blood poses legal issues.[190] Since a positive tox screen carries potentially serious legal consequences, some hospitals require that specific informed consent be obtained from a newborn's parent or legal guardian before conducting the tox screen. Other hospitals consider the tox screen a diagnostic test, which can be performed by a health care provider pursuant to a general consent for the infant's care provided by the parent or guardian.[191]

5.7.4 Withholding Medical Treatment from Newborns

A discussion of the issues raised by parents' refusal to authorize treatment of handicapped or prematurely born infants can be found in Chapter 2C, "Decision-Making for Incompetent Patients."

5.8 Adoption of a Newborn

A full discussion of adoption law belongs in a family law treatise, such as the Washington State Bar Association's *Washington Family Law Deskbook*. However, since some of the many aspects of adoption occur in the health care setting, this section will address issues that may arise regarding the adoption of a newborn child.

5.8.1 Who Can Adopt?

Washington law places few limitations on who may be an adoptive parent. Any person who is legally competent and at least 18 years of age may be an adoptive parent.[192] Washington law contains no requirements regarding to the marital status, sexual preference, or age (other than the requirement to be at least 18 years of age) of the adoptive parent(s).

Some states, such as Oregon, expressly prohibit health care providers from becoming involved in child placement.[193] Even though Washington does not have such a law, some hospitals have policies prohibiting staff from adopting children born in the facility. Such policies protect women who have recently given birth from any undue influence exerted by a health care professional seeking to adopt a newborn.

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[187] RCW 70.24.330; RCW 7.70.065 (listing the individuals who can provide informed consent for an incompetent patient).

[188] RCW 70.24.024.

[189] *See* RCW 26.44.030(1) (health care providers required to report suspected child abuse and/or neglect).

[190] For a general discussion of who can provide consent on a minor's behalf, see Chapter 2B of this Manual, "*Special Consent Rules*."

[191] For an in-depth discussion of general consent rules, see Chapter 2A of this Manual.

[192] RCW 26.33.140(2).

[193] ORS 418.300.

5.8.2 Minor Offering a Child for Adoption

If either birth parent (or alleged father) of a child offered for adoption is under 18 years of age, the court must appoint a guardian ad litem for that parent.[194] The guardian ad litem will conduct an investigation and file a report with the court discussing whether any written consent or petition for relinquishment signed by the minor was signed voluntarily, with an understanding of the consequences of the action, and whether the adoption of the minor's child is in the minor's best interest.[195]

5.8.3 Adoption Procedures

Every adoption in Washington requires a multi-step investigation into the best interests of the child adoptee. If prospective adoptive parents intend to bring a newborn child adoptee directly to their home from the place of its birth, it is essential that those prospective parents lay the legal groundwork well before the child's birth.

First, the prospective adoptive parents must obtain a "preplacement report" (formerly called a "home study") that attests to their fitness as parents.[196] Preparation of such a report generally requires at least a month. Second, the written consent of the birth mother (and the birth father, if available) to the proposed adoption must be obtained. As stated above, if either birth parent is a minor, a guardian ad litem must be appointed by the court to represent that parent.[197]

The court cannot act on the birth parent's consent to adoption until 48 hours after the child's birth or 48 hours after the consent is signed, whichever occurs later.[198] This 48-hour waiting period provides the birth parents an opportunity to revoke their consent. In fact, the birth parents may revoke their consent any time prior to the court's approval of the consent.[199] Awkward issues regarding who is responsible for protecting the child's best interests may arise from the time the birth mother enters the hospital in labor until the expiration of the waiting period. Note that per the discussion below, the waiting period is ten days for an American Indian child.[200]

Ideally, before the child is born, the birth mother (and birth father, if available) and prospective adoptive parents will develop a birth plan to address sensitive issues such as who will first hold the newborn child and what will happen if the child requires serious medical attention. Such a birth plan should be reviewed by the health care providers who will be involved in the child's birth and care before the birth mother goes into labor.

During the 48-hour waiting period, however, and until the court has issued an order granting custody of the child to the prospective adoptive parents, only a birth parent has the right to consent to medical care for the child. In the absence of a birth plan with the prospective adoptive parents, or if disagreement arises between a birth parent and prospective adoptive parents, the wishes of the birth parent should be honored. *See* Chapter 2 of this Manual for a further discussion of consent issues.

After the 48-hour waiting period has elapsed, a hearing may be held to: a) approve the natural parent's consent to adoption; b) enter a temporary order transferring custody of the child to the adoptive parents or to the appropriate department or agency; and c) appoint the prospective adoptive parents (or agency) as legal guardians.[201]

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[194] RCW 26.33.070.

[195] RCW 26.33.070(1).

[196] RCW 26.33.190; WAC 388-73-216.

[197] *See* RCW 26.33.070.

[198] RCW 26.33.160(4)(d).

[199] RCW 26.33.160(2).

[200] *See* 25 U.S.C. § 1913(a).

[201] RCW 26.33.090.

Additional issues may arise if the birth mother is discharged from the hospital before the court has issued an order transferring custody of the child. One alternative is to discharge the child to the birth mother; she can transfer the child to the adoptive parents at a later point. Another option is to keep the child in the hospital with the birth parent's authorization (at the cost of the agency or adoptive parents), until a court order transferring custody is obtained.

Health care providers are not entitled to defer to the directions of a newborn child's prospective adoptive parents until they have obtained legal custody of the child pursuant to a court order. A prudent health care provider will insist on seeing a certified copy of the court order transferring custody before deferring to the prospective adoptive parents.

Once the prospective adoptive parents have legal custody of the child, several more steps are required to finalize the adoption. The parental rights of both natural parents must be formally terminated.[202] A post-placement report regarding the propriety and advisability of the adoption must be prepared.[203] If an agency is involved, it must consent to the adoption.[204] Finally, the petitioners must appear before the court to finalize the adoption.[205]

5.8.4 Indian Child Welfare Act

The Indian Child Welfare Act[206] and Washington statutory provisions impose greater procedural requirements on the adoption of a child who qualifies as an "American Indian."[207] If a child adoptee is suspected to have any Native American heritage whatsoever, it is essential to determine whether the child falls within the definition of an American Indian by being "eligible for membership in an Indian tribe and . . . the biological child of a member of an Indian tribe."[208] As stated above, the additional procedural protections applicable to the adoption of an American Indian child include a requirement that a relinquishing parent may not sign a consent to the child's adoption until at least ten days have elapsed since the child's birth.[209] Notice of the initial adoption hearing must be served on the child's tribe pursuant to RCW 26.33.310 also. In addition, the court may enter a temporary custody order only if the federal requirement pursuant to 25 U.S.C. §1913(a) regarding voluntary foster care placement have been satisfied.[210]

5.8.5 Open Adoption

Washington law provides a procedure for the birth parents and adoptive parents to enter an enforceable agreement allowing contact between the child and the birth parents after adoption.[211] Such agreements are enforceable only if specific statutory procedures are followed. The parties are free to work out acceptable arrangements among themselves; the agreement is enforceable only if the court finds that the proposed communication or contact would be in the child adoptee's best interests.[212]

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[202] RCW 26.33.080 – 130.

[203] RCW 26.33.200.

[204] RCW 26.33.160.

[205] RCW 26.33.240.

[206] 25 U.S.C. §1901, *et seq.*

[207] *See* 25 U.S.C. § 1903(3) - (4); RCW 26.33.080(3).

[208] 25 U.S.C. § 1903(4).

[209] 25 U.S.C. § 1913(a); RCW 26.33.080(3).

[210] RCW 26.33.090(1).

[211] RCW 26.33.295.

[212] RCW 26.33.295(2).

5.8.6 Compensation for Birth Mother

Washington's criminal code makes it "unlawful for any person to sell or purchase a minor child."[213] Thus, a birth parent's consent to adoption may in no way be conditioned upon receiving compensation. The statute does allow the prospective adoptive parents to pay "consideration" of certain hospital bills, medical bills, and attorneys' fees.[214]

5.8.7 Interstate Adoptions

RCW 26.34 sets forth the Interstate Compact on the Placement of Children, which governs interstate placements preliminary to adoptions. The Act establishes elaborate procedures for approval of placements in other states. In Washington, the Interstate Compact is administered by the Department of Social and Health Service's Division of Children and Family Services.

5.8.8 Confidentiality

Washington's adoption statute[215] contains provisions to protect the confidentiality of information about the parties to an adoption proceeding.[216] The statute also contains provisions, allowing parties to seek additional information about an adoption, such as non-identifying information about the parties and the location of the court in which the adoption occurred.[217] In addition, once the adoptee has reached the age of 21, either the adoptee or the birth parent may petition the court to appoint a confidential intermediary to locate the other parties to an adoption and obtain their consent to further communications.[218] An adoptee under the age of 21 may also petition the court in the manner described above, provided that the adoptee has obtained the permission of the adoptive parent.[219]

5.9 De Facto Parentage

The Washington Supreme Court has held that the common law recognizes de facto parents and grants them standing to petition a court for determination of the rights and responsibilities that accompany legal parentage in the state.[220] A de facto parent is an individual who is a parent in fact, in all respects functioning as a child's actual parent, even though not formally or legally recognized as such.[221] De Facto parentage is not affected by one's sex. Therefore, same sex partners have the opportunity to present evidence to the court sufficient to establish their status as de facto parents, and if successful, to obtain the rights and responsibilities associated with parentage.

5.10 Sterilization

At this time, Washington does not have a comprehensive statutory scheme regarding sterilizations; this section will discuss the disparate legal guidelines that exist. For further discussion of special consent rules relating to sterilization, see Chapter 2B of this Manual.

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[213] RCW 9A.64.030.

[214] RCW 9A.64.030(2)(f).

[215] RCW 26.33.

[216] RCW 26.33.340.

[217] RCW 26.33.340, .345.

[218] RCW 25.33.343.

[219] *Id.*

[220] *In the Matter of L.B. Sue Ellen v. Page Britain*, 155 Wn.2d 679, 683; 122 P.3d 161 (2005).

[221] *Id.*

5.10.1 Voluntary Sterilization of Competent Adults

In the past, in an effort to encourage high birth rates, some states attempted to prohibit married couples from obtaining voluntary sterilization as against a public policy.[222] No such case law exists in Washington.

An adult's right to undergo voluntary sterilization probably is protected as a constitutional right under the holding of *Griswold v. Connecticut*.[223] Federal regulations condition Medicaid payment on the use of a special informed consent form, and funding is available only if patients are mentally competent, are 21 years of age or older, and comply with a 30-day waiting period.[224]

5.10.2 Voluntary Sterilization of Minors

No Washington statutory or case law addresses the specific question of whether a minor may consent to a surgical sterilization procedure, although Oregon allows minors as young as fifteen to consent to sterilization.[225] The Washington Supreme Court has declared, however, that a minor's constitutional right of privacy to decide reproductive matters is coextensive with that of an adult's.[226] Under this analysis, a Washington court could find that a minor's rights of reproductive control include the right to consent to sterilization. A troublesome issue with respect to a minor's consenting to sterilization, however, is that a minor, with the exception of an emancipated minor is not capable of providing informed consent for health care.[227] For discussion of consent issues, see Chapter 2 of this Manual.

Federal funds are not available for the sterilization of individuals under 21 years of age.[228]

5.10.3 Involuntary Sterilization of Mentally Incapacitated Individuals

Involuntary sterilization of the mentally ill, mentally retarded, convicted criminals, and victims of certain debilitating diseases became popular in this country in the early twentieth century.[229] The theory of "eugenic sterilization" was that certain traits and diseases were hereditary, and could be eliminated to the benefit of all society simply by preventing procreation. More than 20 states, including Washington, enacted statutes authorizing eugenic sterilizations.[230]

In 1927, the United States Supreme Court upheld the constitutionality of a eugenic sterilization law regarding mentally incompetent individuals.[231] Nevertheless, many of the statutes that had been enacted in the early twentieth century authorizing eugenic sterilizations have been repealed or struck down as having inadequate procedural safeguards. Today, some states have laws that allow involuntary sterilization when authorized by a court order.[232] The Washington legislature has not established such a procedure, but in *In re Hayes* the Washington Supreme Court authorized the Superior Courts of Washington to order the sterilization of mentally incapacitated individuals in certain exceptional circumstances.[233] Under *Hayes*, the consent of a parent or

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[222] *See, e.g., Jessin v. County of Shasta*, 274 Cal. App. 2d 737, 79 Cal. Rptr. 359 (1969); *Shaheen v. Knight*, 11 Pa. D. & C. 2d 41 (Pa. 1957).

[223] 381 U.S. 479 (1965); *see also Jessin v. County of Shasta*, 79 Cal. Rptr. at 369.

[224] 42 C.F.R. §§ 441.253, .257, and .258.

[225] ORS 436.205(2).

[226] *State v. Komme*, 84 Wn.2d 901, 904, 530 P.2d 260 (1975).

[227] RCW 7.70.065; RCW 13.64.060.

[228] 42 C.F.R. §§ 441.253, 441.257 and 441.258.

[229] *See In re Hayes*, 93 Wn.2d 228, 234, 608 P.2d 635 (1990).

[230] *Hayes*, 93 Wn.2d at 235.

[231] *Buck v. Bell*, 274 U.S. 200 (1927).

[232] *Hayes*, 93 Wn.2d at 233.

[233] *See, e.g.*, 93 Wn.2d at 237-240.

guardian alone is an inadequate basis for sterilization.[234] A court, however, can order an individual to be sterilized when:

- The incompetent is represented by a guardian ad litem.
- The court has received independent advice based upon a comprehensive medical, psychological, and social evaluation of the individual.
- To the greatest extent possible, the court has elicited and taken into account the view of the incompetent individual.
- The proponent of sterilization demonstrates by clear, cogent, and convincing evidence that the sterilization will be in the best interests of the incompetent individual.[235]

The *Hayes* decision also sets forth additional factors that must be proven by clear, cogent and convincing evidence.[236] A more recent decision also requires the appointment of an attorney for the mentally incapacitated individual whenever such an appointment is "necessary for a thorough, adversary exploration of the issues."[237]

The *Hayes* decision has been described as establishing a standard of proof that is too high to be met.[238] To date, however, the legislature has allowed the decision to stand.

Federal funds are not available for the sterilization of mentally incompetent individuals.[239]

5.10.4 Involuntary Sterilization of Criminals

Washington's criminal code still contains a 1909 law authorizing the involuntary sterilization of any person adjudged to be a habitual criminal, or convicted of rape or carnal abuse of a female under the age of ten years.[240] In the only reported decision challenging this statute, the Washington Supreme Court upheld its constitutionality under the state constitution.[241]

The constitutionality of this statute under today's standards may be questionable. The Washington Supreme Court already has rejected the declaration of *State v. Feilen* that "modern scientific investigation shows that idiocy, insanity, imbecility, and criminality are congenital and hereditary."[242] Moreover, the United States Supreme Court struck down as unconstitutional a similar statute authorizing the involuntary sterilization of habitual criminals in *Skinner v. Oklahoma*.[243] The weight of authority today opposes the application of such statutes to criminals,[244] and federal funds are not available for the sterilization of institutionalized individuals.[245]

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[234] *Id*.

[235] *Id*.

[236] 93 Wn.2d at 236.

[237] *In the Matter of the Guardianship of K.M.*, 62 Wn. App. 811, 818, 816 P.2d 71,75 (1991).

[238] Stephen M. Lamberson, *Jurisdiction: Sterilization of Mental Incompetents*, 16 Gonz. L. Rev. 465, 478 (1981); *see also* Craig L. Mclvor, *Equitable Jurisdiction to Order Sterilization*, 57 Wash. L. Rev. 37 (1982).

[239] 42 C.F.R. § 441.254.

[240] RCW 9.92.100.

[241] *State v. Feilen*, 70 Wash. 65, 71-72, 126 P. 75,78 (1912).

[242] *State v. Feilen*, 70 Wash. at 68, 126 P. at 76; *Hayes*, 93 Wn.2d at 235.

[243] 316 U.S. 535 (1941).

[244] *See generally*, Annot., *Validity of Statutes Authorizing Asexualization or Sterilization of Criminals or Mental Defectives*, 53 A.L.R.3d 960 (1973).

[245] 42 C.F.R. § 441.254.