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PAYING FOR CHILDREN'S MEDICAL CARE: INTERACTION BETWEEN FAMILY LAW AND COST CONTAINMENT

*Walter J. Wadlington**

Health care cost containment has much support as a general proposition. However, it may have significant deleterious effects on the medical care afforded our children. This Article analyzes family law issues relating to the medical care of children in light of current health care cost restraints. Professor Wadlington discusses judicial and statutory parental duties to provide for children's health care, as well as termination thereof, children's own financial responsibility for health care, and the impact of the tort system on children's health care costs. He concludes with some observations concerning family law as it might interact with medical cost restraints and suggests avenues which need to be explored.

INTRODUCTION

IN ADDITION TO the difficulties that new cost-containment measures will present for health care institutions and practices generally, our system for delivering medical care to children may face special problems that we are only beginning to recognize. Choices about resource allocation may be limited by political and legal restraints largely beyond the control of planners trying to focus on the most effective distribution of health care dollars. Much of our limited system of state financial contribution to children's medical care is tied to a public assistance program which also faces cost-reduction pressures. In the current political climate, increased emphasis is being placed on enforcing private child support obligations in order to reduce governmental costs, while at the same time there is increased conflict over the respective roles of parents and state in deciding what constitutes appropriate or required medical care for children.

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This Article is the result of an exploration of possible ways in which family law and legal rules regarding children and their rights may interact with cost-containment measures directed toward children's health care. Among the pertinent issues are how such interaction might limit workable alternatives by producing unwanted results, such as family destabilization, and possible ways which the interaction might help promote better health care for children. Some findings do little more than confirm the bleakness of the current picture; others seem to suggest a need to alter our approach if we are to provide adequate health care for children in accordance with widely-held societal values in a time of diminishing resources.

I. SOME DISTINCTIVE PROBLEMS AND NEEDS: AN INITIAL ASSESSMENT

Although assertions that children have a basic "right" to adequate health care are not uncommon, such statements at this time are best categorized as exercises in political rhetoric.¹ It is ironic that despite long and vocal public affirmation of overriding interest in the protection and nurture of children, the United States is virtually the only industrialized nation with no family allowance programs.² Some consider it anomalous that Medicare, our first major venture into a broad national health care system, focused not on young children but on the elderly. In recent years, the latter group has increased in size while the former has decreased.³ Because the elderly are especially likely to require highly cost-intensive services, attempts to institute a broad social insurance scheme for children may thus be all the more difficult.⁴

Although many children today receive medical assistance through government programs such as Medicaid or Supplemental

1. This statement is not meant to indicate that a right to basic health care for children should not be our goal.

2. Family allowances may be described as regular cash payments to families with children. See SOCIAL SECURITY ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, RESEARCH REPORT NO. 59, SOCIAL SECURITY PROGRAMS THROUGHOUT THE WORLD 1983 xxv (1984).

3. The number of persons 65 years and over in the United States increased from 22,696,000 in 1976 to 26,824,000 in 1982. The number of persons below age 18 decreased from 67,165,000 to 62,765,000 during the same period. The percentage of persons over age 65 increased from 10.5 to 11.6 percent of the population, while persons 17 or younger decreased from 31.2 to 27.1 percent. STATISTICAL ABSTRACT OF THE UNITED STATES 34 (10th ed. 1984). Population projections suggest continuation of this trend to the year 2000. *Id.* at 32.

4. Another obstacle, of course, is our traditional approach to financing social insurance schemes by basing eligibility on participation in the work force.

Security Income (SSI), those programs focus on population groups with the greatest financial need—persons eligible for public assistance under a program such as Aid to Families with Dependent Children (AFDC) or close enough to that eligibility line to be deemed “medically needy.” Further, these public assistance programs are already under attack from many quarters, and the services they provide vary from one state to another. Other categorical assistance programs and various private philanthropic efforts may aid some children who have specific medical needs, but such a fragmented system can hardly be regarded as the embodiment of a “right” to medical care.⁵

Budgetary constraints are not new to those involved in trying to expand children’s health care.⁶ Financial cuts hamper existing programs and preclude the development of new ones, moving us farther from the goal of assuring health care to children on the basis of medical need regardless of family economic status. Nevertheless, barring major changes in political priorities, it seems unrealistic to expect significant expansion of government funding in the near future. In fact, some existing Medicaid coverage may be in jeopardy. Under most predictable scenarios, private insurance and family contributions are likely to be of increasing importance. Each of these sources, however, has built-in limitations on its effectiveness in a time of cost cutting, since many families with young children stand low on the economic ladder.

At a time when private employers seek to pare their health care insurance contributions (a significant part of employee fringe benefit packages), their interests might best be served by maintaining health coverage for their employees while decreasing coverage of other family members, including children. Even without such an extreme approach, other measures such as increasing employee deductibles may have a harsh impact on children’s medical care. Although cost sharing by insurance could be structured so as to minimize or avoid such a result,⁷ it must be recognized that children will not be sitting at contract negotiating tables or in under-

5. See generally Cluff, *Chronic Disability of Infants and Children*, 38 J. CHRONIC DISEASE 113 (1985); Strauss, *The Arms Race and Children in Fiscal Year 1985*, 75 PEDIATRICS 1149 (1985).

6. For an excellent review of these cost problems, see Blendon, *Paying for Medical Care for Children: A Continuing Financial Dilemma*, 29 ADVANCES IN PEDIATRICS 229 (1982).

7. For greater discussion of this issue, see Austin, *Child Health-Care Financing and Competition*, 311 NEW ENG. J. MED. 1117 (1984); Davidson, Connelly, Blim, Strain & Taylor, *Consumer Cost-Sharing as a Means to Reduce Health Care Costs*, 65 PEDIATRICS 168 (1980).

writers' offices when those decisions are made. This concern highlights a problem central to many issues involving children: too often there is no effective mechanism for raising the concerns and protecting the interests of children in policy determinations that will have great impact on them.⁸

In considering where cuts might be made in children's health care costs, it is important to recognize that with a few major exceptions, such as neonatal intensive care, pediatrics has not involved, until recently, either the commitment to routine use of expensive technology or the potential for excessive hospitalization that has characterized the practice of many other specialties. Although highly regarded in their communities, pediatricians often command smaller fees than those accorded most other major specialists. These factors suggest that there may be fewer areas where funding cuts might be made without immediate, noticeable effects on patient care.

The economic well-being of many families is vulnerable to even modest increases in medical costs. With the prospect of new specialty procedures and greater use of expensive technology, many families who traditionally have paid for their children's basic medical care without governmental help are uneasy about potential financial exposure. Significant reductions in insurance coverage could further exacerbate such worries.

II. WEIGHING POTENTIAL IMPACT ON FAMILIES: THE SIGNIFICANCE OF FAMILY LAW

Recent legal consideration of children's medical care has focused chiefly on problems of state intervention protecting defective neonates or seriously ill children whose parents refuse to permit or provide traditional medical treatment because of personal or religious views.⁹ Courts in those cases usually have not explained what, if any, consideration was given to who should pay for such

8. This problem can extend to judicial decisions as well. Among the most noteworthy of such examples is *Stanley v. Illinois*, 405 U.S. 645 (1972), a case involving a state's denial of a fitness hearing to the father of his illegitimate children upon the mother's death. Although seemingly unintended, the language of the court's decision created havoc in the process of adoptive placement and its impact still is felt after more than a decade. See also *Lehr v. Robertson*, 463 U.S. 248 (1983) (a custody case in which the court seemed more interested in whether procedural requirements were followed than assuring subjective determination of the best interests of the child).

9. See, e.g., *Matter of Hofbauer*, 47 N.Y.2d 648, 393 N.E.2d 1009, 419 N.Y.S.2d 936 (1979); *Custody of a Minor*, 375 Mass. 733, 379 N.E.2d 1053 (1978); *Custody of a Minor* (No. 3), 378 Mass. 732, 393 N.E.2d 836 (1979).

treatment or care. One might speculate that many were "test" cases that involved difficult constitutional issues that needed resolution before cost-allocation problems could be faced.¹⁰ In this judicial vacuum, courts might have assumed that someone was prepared to foot the bill, thereby ignoring the cost issue. Perhaps no one gave serious thought to the relationship between health care policy or resource allocation and legal rules involving family governance and children's rights. Whatever the reason, a combination of legal and practical developments such as increased emphasis on enforcing private support obligations supported by stringent enforcement measures, a broader definition of medical neglect, and intensified financial pressures from the state make it almost inevitable that financial factors will increasingly crop up in legal disputes regarding medical care for children. Already there have been some cases involving children in state custody with no parents available. In such instances courts have not been reluctant to find a state duty of support under doctrines such as *parens patriae* or *in loco parentis*.¹¹

In the past there have been significant instances when obvious legal implications of new developments in medical practice have been ignored.¹² There may now be sufficient recognition of the need to consider legal issues as well as ethical, scientific, and economic factors if we are to succeed in introducing health care reforms that will function effectively without unduly threatening existing institutions. Legal changes may obviate many such concerns, but there is a need to anticipate the problems and take the necessary steps in a timely fashion before crises arise.

A. *Defining Parental Duties to Provide Health Care*

One might assume that most questions regarding the legal duty

10. Among such pioneering cases dealing with the confrontation between parents and the state (or the medical establishment) were *State v. Perricone*, 37 N.J. 463, 181 A.2d 751 (1962) (blood transfusion); *People ex rel. Wallace v. Labrenz*, 411 Ill. 618, 104 N.E.2d 769 (1952); *Custody of a Minor*, 375 Mass. 733, 379 N.E.2d 1053 (1978), 378 Mass. 732, 393 N.E.2d 836 (1979) (the Chad Green cases); and *Matter of Hofbauer*, 47 N.Y.2d 648, 393 N.E.2d 1009, 419 N.Y.S.2d 936 (1979).

11. See, e.g., *In re Tanner*, 549 P.2d 703 (Utah 1976) (ordering a state's division of family services to pay for orthodontia needed by a child whose mother was dead and whose father had disappeared). See also *In re Karwath*, 199 N.W.2d 147 (Iowa 1972) (court ordered removal of tonsils at state expense over father's religious objections).

12. One of the most obvious instances of this has been in cases involving artificial conception. See Wadlington, *Artificial Conception: The Challenge for Family Law*, 69 VA. L. REV. 465 (1983). For a broader commentary on the relationship between law and the health care system, see Springer, *Law and Medicine—Reflections on a Metaphysical Misalliance*, in *POLITICS AND LAW IN HEALTH CARE POLICY* 201 (J. McKinlay ed. 1973).

of parents to pay for their children's medical care and the means for enforcing such an obligation would have been answered long ago. This, however, is not the case. Worse yet, new questions now are being raised in a time of changing views about the rights of children and the role of the state regarding health care decisions for them. This situation may be analogized to the uncertain scope of an older child's capacity to consent to medical care, an area of much confusion today.¹³ More than providing an analogy, the manner in which we resolve some important issues regarding children's capacity to give, and parental authority to withhold, consent may affect the determination of who must pay for children's medical care.

Much of our law governing support duties of children has developed through cases involving parents who were separated or divorced. One explanation for this is that restrictions on intrafamily legal actions prevented children from suing their parents, and thus it was in the context of a custodial parent's action against an absent (perhaps divorced) parent that the issue most often reached the courts. Exceptions to this tendency are those cases involving parents who refused consent to necessary medical procedures (particularly in the face of life-threatening circumstances), or where parental failure to provide a minimal level of support jeopardized a child's welfare to the extent that removal from the home and perhaps even criminal prosecution were considered to be the appropriate response. Changes in this process may now occur as a result of modern moves toward abolishing procedural rules that have prevented legal actions by minors against their parents.¹⁴

1. *Equitable and Statutory Responses to Inadequate Common Law Remedies*

A melange of statutory, equitable and common law approaches have been used to seek reimbursement from parents of children to

13. For further discussion see A. HOLDER, *LEGAL ISSUES IN PEDIATRICS AND ADOLESCENT MEDICINE* (2d ed. 1985); Bennett, *Allocation of Child Medical Care Decision Making Authority: A Suggested Interest Analysis*, 62 VA. L. REV. 285 (1976); JUVENILE JUSTICE STANDARDS PROJECT, *STANDARDS RELATING TO RIGHTS OF MINORS, PART IV: MEDICAL CARE* (1980); Goldstein, *Medical Care for the Child at Risk: On State Supervention of Parental Autonomy*, 86 YALE L.J. 645 (1977); Shaw, *Dilemmas of "Informed Consent" in Children*, 289 NEW ENG. J. MED. 885 (1973); Wadlington, *Minors and Health Care: The Age of Medical Consent*, 11 OSGOODE HALL L.J. 115 (1973).

14. Even when there has been relaxation of the rule against initiating such an action, courts may for some time be unwilling to permit children to actually sue their parents for support, on the theory that other provisions, such as the abuse and neglect laws, have been designed to deal with support problems. Cf. *Burnette v. Wahl*, 284 Or. 705, 588 P.2d 1105 (1978) (children's damage actions for failure to perform parental duties not allowed).

whom medical care has been extended. At common law a parent was considered to have a natural but not necessarily legal duty to support a child.¹⁵ This meant that the duty could not be enforced through legal action. As recently as 1953, the Supreme Court of New Jersey confronted this problem in a physician's action against the parent of a child whom he had treated for a broken foot.¹⁶ The child had been taken to a doctor by the father of one of her friends, and in the ensuing months the parents had seen their child on crutches and knew that she had received medical treatment. They refused to pay for such treatment, however, because they had not contracted with the physician for the care. Taking notice of the common law view that a parent's obligation was only moral rather than legal in such an instance, the court elected to follow the approach developed through equity under which a parent could be held liable for necessities supplied to a child in an emergency or when there was an inference that the parents had accepted them. The decision, now regarded as a landmark, illustrates the surprising recentness of the establishment of a clear, nonstatutory parental duty to provide needed medical care for a child.¹⁷

State statutes specifically requiring parents to support their minor children are now widespread.¹⁸ Generally, they do not abrogate existing common law support duties, but they do provide a means for permitting exercise of extraordinary judicial enforcement measures such as the contempt power. Due to constitutional concerns about sex discrimination, many legislatures have amended their statutes to restate the duty created as being owed by both parents.¹⁹

Equitable (or judicially established) support duties and statutory provisions on nonsupport may be gauged by different standards

15. This is reflected in the statements of Blackstone, an eighteenth century commentator who in recent years has been cited or quoted on the general subject of parent and child relationships occasionally in either strange or misguided fashion. See 1 W. BLACKSTONE, COMMENTARIES ON THE LAWS OF ENGLAND 434 (1965).

16. *Greenspan v. Slate*, 12 N.J. 426, 97 A.2d 390 (1953).

17. Ironically, in 1983 the *Greenspan* holding was used by a court of another state to support its decision that the owner of five Great Dane dogs seized by a humane society was required to pay for support of the animals while they were in protective custody. See *Biggerstaff v. Vanderburgh Humane Soc.*, 453 N.E.2d 363 (Ind. App. 1983).

It is interesting to note that the New York Society for Prevention of Cruelty to Children (the first SPCC) was founded in 1875 after the Society for the Prevention of Cruelty to Animals (SPCA) had assisted in the rescue of a maltreated child a year earlier. The SPCA was founded in 1866. See 6 DICTIONARY AM. HIST. 331 (1976).

18. See, e.g., VA. CODE § 20-61 (1983). See also H. KRAUSE, CHILD SUPPORT IN AMERICA (1981).

19. See, e.g., VA. CODE § 20-61 (1983).

with respect to the level of maintenance which will be required. The statutory duty often assumes a basic minimum level of support. Under the nonstatutory duty, there may be greater latitude for subjective appraisal and determination based on a particular parent's ability to maintain a support level higher than that required under the nonsupport statute.²⁰

2. *Laws on Child Abuse and Neglect*

Another group of statutes must be considered in addressing issues of parental responsibility to provide medical assistance. Generally described as abuse and neglect statutes, these laws impose upon parents the duty to provide certain basic needs to their children on pain of criminal prosecution, temporary removal of children from the home, or even peremptory severance of parental rights.

Although there may be a popular view of abuse and neglect statutes as involving extreme cases of failure to provide minimal sustenance or of intentional acts causing physical injury, a typical statutory definition of a "dependent or neglected child" includes a child whose parent or guardian "fails or refuses to provide proper or necessary subsistence, education, medical care, or any other care necessary for his health, guidance, or well-being."²¹ This concept, described as "medical neglect," has gained increasing recognition.

Minors are regarded as legally incompetent for many purposes, including the authorization of medical care for themselves.²² Thus, a physician who performs an invasive procedure on a child in non-emergency situations without parental consent is theoretically vulnerable to a tort action for battery.²³ Children once were considered virtually to be the property of their parents,²⁴ and thus state intervention in order to override a parental decision concern-

20. In such jurisdictions, one might expect to find the nonsupport statutes used particularly in cases involving the neediest portion of the population—those more likely to be eligible for public assistance and Medicaid.

21. COLO. REV. STAT. § 19-1-103(20)(d) (1983).

22. See W. WADLINGTON, C. WHITEBREAD & S. DAVIS, *CASES AND MATERIALS ON CHILDREN IN THE LEGAL SYSTEM* (1983); Wadlington, *Consent to Medical Care for Minors: The Legal Framework*, in *CHILDREN'S COMPETENCE TO CONSENT* 57 (G. Melton, G. Koocher & M. Saks eds. 1983) [hereinafter cited as *Competence to Consent*]; Batey, *Rights of Adolescents*, 23 WM. & MARY L. REV. 363 (1982).

23. Battery can be defined as the unauthorized and unprivileged invasion of another person's protected bodily interest. See RESTATEMENT (SECOND) OF TORTS §§ 13-20 (1965).

24. For discussion of the implications of what sometimes has been labeled the "child as chattel" theory, see H. CLARK, *THE LAW OF DOMESTIC RELATIONS IN THE UNITED STATES* 631 (1968).

ing a child's medical care might have been viewed as just short of heresy at the turn of this century.²⁵ Given the state of medicine at the time, this may have been of little practical importance,²⁶ though clearly it is of legitimate concern today. Modern law has reacted through developing a concept of medical neglect largely through cases involving parental refusal to authorize specific medical procedures considered necessary or desirable for their children.

Changes in the rules affording virtually absolute parental authority came slowly at first, with courts willing to protect children against life-threatening conditions while retaining respect for parental decisionmaking autonomy in most other instances.²⁷ Eventually some courts began to display a willingness to overrule parental decisions when the threat to quality of life was deemed sufficiently grave even though there was no prognosis of imminent death.²⁸ Older

25. The 1912 case of *Tony Tuttendario*, 21 P. Dist. 561 (Q.S. Phil.) a seven-year-old boy with rickets, provides an example of this. When the child's doctors recommended surgery and his mother refused to consent, an agent of the SPCC attempted to obtain a judicial commitment that would allow the substitute custodian to authorize the procedure. In rejecting such a challenge to parental authority, the court explained, "We have not yet adopted as public policy the Spartan rule that children belong, not to their parents, but to the state. As the law stands, the parents forfeit their natural right of guardianship only in cases where they have shown their unfitness by reason of moral depravity." *Id.* at 563.

26. The court in *Tuttendario* noted that in 1911 there remained in medicine "a residuum of the unknown . . . which scientists, by a necessary law for the development of science, disregard, but which parents, in their natural love for their children, regard with apprehension and terror." *Id.*

27. Compare *People ex rel. Wallace v. Labrenz*, 411 Ill. 618, 104 N.E.2d 769 (1952) (judicially authorizing blood transfusion for a child in the face of religiously based parental objection) with *Matter of Seiferth*, 309 N.Y. 80, 127 N.E.2d 820 (1955) (no intervention to overrule parental decision refusing to consent to surgery for correcting cleft palate) and *In re Hudson*, 13 Wash.2d 673, 126 P.2d 765 (1942) (no intervention with parental decision not to permit amputation of oversized arm posing strains on body systems).

28. Probably the best known illustration of this is *In re Sampson*, 65 Misc. 2d 658, 317 N.Y.S.2d 641 (Fam. Ct. Ulster Cty. 1970), *aff'd*, 29 N.Y.2d 900, 278 N.E.2d 918, 328 N.Y.S.2d 686 (1972). Over a mother's religious objection, the courts appointed a guardian with authority to consent to essentially corrective surgery for a child whose face was grossly deformed due to neurofibromatosis. Because the objectionable growth was clinically benign and the proposed surgical intervention was substantial, one might analyze the case as one in which the operation was essentially cosmetic in purpose but also was potentially life threatening in nature. The trial court explained one basis for appointing the guardian:

I am persuaded that if this court is to meet its responsibilities to this boy it can neither shift the responsibility onto his shoulders nor can it permit his mother's religious beliefs to stand in the way of attaining through corrective surgery whatever chance he may have for a normal, happy existence, which . . . is difficult of attainment under the most propitious circumstances, but will unquestionably be impossible if the disfigurement is not corrected.

65 Misc. 2d at 674, 317 N.Y.S.2d at 657. Not all courts have agreed with the New York court's rationale in *Sampson*. For an opposing view, see *In re Green*, 448 Pa. 338, 292 A.2d 387 (1972), *aff'd*, 452 Pa. 373, 307 A.2d 279 (1973).

minors may now consent to some procedures as a result of either special statutory authorization or what is described as the "mature minor" rule.²⁹ But for very young children and in cases involving elective procedures (even for older adolescents), the concept of medical neglect is of considerable importance as a means of assuring that parents obtain needed medical care for their children.

a. *Federal Involvement in Setting Standards for Care of Defective Neonates Under the Concept of Medical Neglect.* A detailed review of the actions and assertions of the Department of Health and Human Services (HHS) in the saga of the babies Doe would extend beyond the scope of this Article. It is important, however, to understand that after two sets of administrative regulations faltered in the face of formidable legal obstacles,³⁰ a third approach was taken by Congress in the enactment of the Child Abuse Amendments of 1984.³¹ These amendments require that states wishing to qualify for federal assistance in developing and enforcing child abuse and neglect prevention and treatment programs must establish certain procedures or programs "for the purpose of responding to the reporting of medical neglect (including instances of withholding of medically indicated treatment from disabled infants with life threatening conditions . . .)."³² The amendments include detailed elaboration on the types of programs required and redefine "child abuse and neglect" so as to place special emphasis on the meaning of "withholding of medically indicated treatment."³³ This approach was further amplified in the third set of Baby Doe Regulations published in April 1985 under the direction of the congressional amendment.³⁴

The various state laws addressing the measures that must be

29. For further discussion of development of the mature minor rule, see Wadlington, *Minors and Health Care: The Age of Medical Consent*, 11 OSGOODE HALL L.J. 115, 117-20 (1973). Special statutes authorizing children to consent to their own medical care in limited instances are discussed at *infra* notes 55-62 and accompanying text.

30. See *American Academy of Pediatrics v. Heckler*, 561 F. Supp. 395 (D.D.C. 1983); *United States v. University Hosp. of State Univ. of New York*, 729 F.2d 144 (2d Cir. 1984). In *Bowen v. American Hosp. Ass'n*, 54 U.S.L.W. 4579 (U.S. June 10, 1986), the Supreme Court held that the HHS regulations were not authorized by § 504 of the 1973 Rehabilitation Act.

31. 42 U.S.C. §§ 5101-5105 (1982 & Supp. II 1984). For detailed commentary, see Lund, *Infanticide, Physicians, and the Law: The "Baby Doe" Amendments to the Child Abuse Prevention and Treatment Act*, 11 AM. J. LAW & MED. 1 (1985); Vitiello, *The Baby Jane Doe Litigation and Section 504: An Exercise in Raw Executive Power*, 17 CONN. L. REV. 95 (1984).

32. 42 U.S.C. § 5103(b)(2)(k) (Supp. II 1984).

33. *Id.*

34. 50 Fed. Reg. 14,878 (1985) (to be codified at 45 C.F.R. Part 1340).

taken in dealing with defective neonates vary substantially.³⁵ Louisiana's statute³⁶ is both the most explicit and inclusive. In addition to provisions prohibiting denial of nutrients or treatment, the statute provides a way in which parents may surrender their child to the state Department of Human Resources or another licensed adoption agency if they refuse to consent to treatment, without necessarily terminating their financial responsibility for medical expenses.³⁷

Instances of federal involvement in expanding the concept of medical neglect have been largely in the context of withholding treatment or life support systems from defective neonates, an issue over which there is considerable polarization of personal and medical views. From the standpoint of this Article, however, it is important to note two factors through which federal involvement can have impact beyond the poignant problems of defective neonates. One is the more than symbolic reinforcement of the concept of medical neglect as a basis for state intervention.³⁸ The other is that despite the elaborate administrative regulations and legislation, there has been little willingness to face such issues as who will pay for what constitutes the most expensive child care and treatment. Recently, Congress has directed the Department of Health and Human Services to study ways to fund care and treatment of such infants independently of Medicaid.³⁹

b. *Child Abuse Reporting Statutes.* An important component of the scheme for protecting children against abuse and neglect is the modern system of mandatory reporting laws. Statutory proposals of this type were enacted on an unusually rapid and widespread

35. Some such laws were adopted prior to the federal regulation in response to the celebrated Indiana "baby Doe" case that occurred in 1982. For the specific Indiana response, see IND. CODE § 31-6-4-3(7)(f) (Supp. 1985), which declares that "a child in need of services . . . includes a handicapped child who is deprived of nutrition that is necessary to sustain life, or who is deprived of medical or surgical intervention that is necessary to ameliorate a life threatening medical condition, if the nutrition . . . is generally provided to similarly situated . . . nonhandicapped children."

36. LA. REV. STAT. § 40:1299.36.1 (West Supp. 1985).

37. See *id.* at § 1299.36.2.A. Physicians also are required to report parental refusal to consent to treatment and are protected from liability if they provide medical care when delay would be life threatening. *Id.* at § 40:1299.36.2.B. For further discussion of the question of who must pay after such a relinquishment, see *infra* notes 63-98 and accompanying text.

38. With the third Baby Doe regulation relying heavily on state enforcement measures, this is especially important.

39. See 42 U.S.C. § 5103 (1982 & Supp. II 1984). For further discussion of these issues see Rhoden, *Treatment Dilemmas for Imperiled Newborns: Why Quality of Life Counts*, 58 S. CAL. L. REV. 1283 (1985).

scale by legislatures beginning some twenty years ago.⁴⁰ They require physicians and other health care providers⁴¹ to inform a governmental agency about cases of suspected child abuse that come to their professional attention. By this time, many of the original statutes have gone through several stages of revision and expansion. Although the drafters of the original versions may not have fully anticipated or intended it, health care professionals have used these statutes to report cases of medical neglect.

3. *New Teeth For an Old Enforcement Process*

Attempts to enforce private child and family support obligations in order to lessen economic burdens on state public assistance programs are by no means new. In 1950, a time when family law was characterized by lack of uniformity and it could realistically have been described as a major bastion of states' rights, a uniform law known as the Reciprocal Enforcement of Support Act (URESA) was published.⁴² Soon afterward it was widely adopted by state legislatures for the avowed purpose of simplifying enforcement of private support obligations across state lines. Even after subsequent revisions,⁴³ many critics considered the act to be an ineffective collection mechanism because it relied largely on its *in terrorem* effect.⁴⁴ This concern began dissipating after the adoption of the Child Support and Establishment of Paternity amendments to the Social Security Act in 1974⁴⁵ and 1975.⁴⁶ These amendments provided minimum standards with which state programs must comply in order to remain eligible for federal cost sharing. They also provided for inauguration of programs such as a parent locator service utilizing social security numbers, waiver of sovereign immunity by

40. For a contemporary discussion of their development, see Paulsen, Parker & Adelman, *Child Abuse Laws: Some Legislative History*, 34 GEO. WASH. L. REV. 482 (1966). See also W. WADLINGTON, C. WHITEBREAD & S. DAVIS, *supra* note 22, at 759.

41. Some people outside the health care system, such as teachers, social workers, and probation officers, may also be required to report. Other persons who are not required to report may be given an incentive to do so through providing immunity from liability for reporting. See, e.g., VA. CODE §§ 63.1-248.3, 63.1-248.4 (1983).

42. 9 U.L.A. 747 (1979).

43. Subsequent versions were promulgated in 1952 and 1958, and in 1968 a revised version (known as RURESA) was completed. See 9 U.L.A. 643 (1979).

44. Major reasons for this were the problem of locating peripatetic or intentionally elusive obligors and the lack of incentives for officials in a responding state to process petitions promptly.

45. Child Support & Enforcement Amendments of 1984, 42 U.S.C. §§ 651-660 (Supp. II 1984).

46. Amendments Relating to Social Security Act, Pub. L. No. 94-88, 89 Stat. 433 (1975).

the United States with regard to child support payments due from federal employees, and certification by the Secretary of Health and Human Services to the federal courts of certain support enforcement actions without respect to the amount in controversy.⁴⁷

Even more effective measures now are being introduced in response to the Child Support Enforcement Amendments of 1984 (CSEA).⁴⁸ Again, states are required to enact certain provisions in order to maintain continued federal participation in the funding of public assistance programs. The mandated provisions for aiding in the collection of overdue support obligations include simplified and speedy withholding from wages, deductions from tax refunds, methods requiring an absent parent to give security, and procedures for establishing liens against real or personal property.⁴⁹ Some states provide that support payments made by the parent of a child on public assistance will be paid directly to the public agency responsible for child support enforcement, with only the amount in excess of the public grant being remitted to the obligee.⁵⁰

The new provisions, combined with the earlier ones (including RURESA), establish what unquestionably will be a far more organized means for enforcing private support obligations, including those for medical assistance. The reason for them is economic—to shift state expenditures for child or family support to private obligors. Although cutting costs of medical assistance may not have been perceived as a primary goal, it was recognized as one of the areas in which state expenditures could be reduced.

B. *Children's Financial Responsibility for Their Own Medical Care*

Determining whether children will be obligated to pay for their own medical care raises a series of new and old legal issues. The old ones stem from traditional common law limitations on minors' contractual capacity, discussed earlier in the context of children's long-standing incapacity to consent to medical treatment. The new ones

47. For greater discussion of these federal provisions see H. KRAUSE, *CHILD SUPPORT IN AMERICA* 281 (1981).

48. 42 U.S.C. § 666 (Supp. 1985).

49. *See id.* States are expected to honor requests for withholding that come from other jurisdictions. A Model Interstate Withholding Act has been developed by the ABA National Legal Resource Center for Child Advocacy and Protection in cooperation with the National Conference of State Legislatures. *See* U.S. DEP'T OF HEALTH & HUMAN SERVICES, OFFICE OF CHILD SUPPORT ENFORCEMENT, MODEL INTERSTATE INCOME WITHHOLDING ACT WITH COMMENTS (1984).

50. *See, e.g.,* MINN. STAT. ANN. § 518.551 (West Supp. 1986).

reflect the trend toward granting increased personal autonomy to minors in response to what is sometimes labeled (or mislabeled) the "children's rights" movement.

At common law, minors were largely incompetent to execute binding contracts of any sort, and this rule remains widespread. In its strictest version, a minor can disaffirm a contract for the purchase of an item not classifiable as a necessity without incurring any liability for use, depreciation, damage or other diminution in property value following the purchase.⁵¹ A recent Wisconsin Supreme Court case⁵² indicates how the rule can affect an obligation to pay for medical services. An unmarried minor was hospitalized for the birth of a child. Medicaid paid only that part of the bill directly related to care of the infant, so the hospital sought reimbursement for the remainder of the bill from the minor patient and the infant's father, who had married the mother after she left the hospital. A claim against the mother's father was dismissed on the procedural basis of failure to obtain service of process. The appeals court affirmed dismissal of the claim against the minor patient on the ground that even though hospital care could be regarded as a necessity in this instance, there was no showing that she had expressly or impliedly agreed to make payment after she attained her majority. The court indicated that the duty to pay could have been imposed on the patient's father⁵³ if he had been properly before the court. The court eventually rationalized a way to hold the patient's new husband liable based on his paternity, even though it was a premarital obligation of the mother.

As the preceding case indicates, rules allowing minors to disaffirm their contracts still retain considerable vitality. They are now under attack, however, as part of the trend toward earlier recognition of minors' capacity to act for themselves either generally or specifically with regard to such matters as medical treatment. The latter area is where the most significant developments have occurred, and it is of special moment for this analysis. As noted earlier, parental consent historically has been required for medical

51. *Halbman v. Lemke*, 99 Wis. 2d 241, 298 N.W.2d 562 (1980), is the case widely cited to epitomize this dilemma in today's world.

52. *Madison Gen. Hosp. v. Haack*, 124 Wis. 2d 398, 369 N.W.2d 663 (1985).

53. In addition to providing new enforcement mechanisms, some states have extended the statutory support duty among family members. Under an Act adopted in Wisconsin during 1985 (1985 Wisconsin Act 56), the minor mother's parents might be required to support the minor's children during their minority. See WIS. STAT. § 49.19(4)(a) (West Supp. 1986).

treatment of children except in emergencies.⁵⁴ In response to problems that might flow from parental consent requirements in situations where the minors might be reluctant to consult or confide in their parents, state legislatures recently have adopted statutes permitting minors to consent to medical treatment for themselves in certain enumerated cases.⁵⁵ Conditions or circumstances usually specified are alcohol and substance abuse, crisis mental health counseling, family planning, pregnancy,⁵⁶ and certain contagious diseases. As a matter of policy, these laws reflect the substantial degree of change (some might say breakdown) that has taken place in the modern family. The selection of particular medical conditions for which minors can independently consent to treatment obviously was rooted in expediency. It reflects the fear that a child might not obtain timely medical care in those cases, thereby exacerbating drug related problems, threatening the spread of contagious disease, increasing unwanted pregnancies, or postponing prenatal care.

Two sets of problems have been created by the new minor consent statutes. One group stems from the failure to define the permissible and required scope of communication between physicians and the parents of their minor patients who consent in accordance with the statutes.⁵⁷ The other concerns liability for medical treatment. The IJA/ABA *Standards Relating to Rights of Minors*, an important contemporary statement of goals and a blueprint for legislative reform, affirms the basic duty of parents to be liable to persons providing medical treatment to their children "if the parent consents to such services, or if the services are provided under

54. For more complete discussion of the issues, see *Competence to Consent*, *supra* note 22, at 57.

55. See *id.* at 61. For an example of such a minor consent statute, see VA. CODE § 54-325.2 (Supp. 1985).

56. A minor's consent to abortion, however, typically is dealt with in a separate statutory provision. Litigation over the extent to which a state can legislate to require or promote parental involvement in a pregnant minor's decision with respect to abortion has appeared frequently on the U.S. Supreme Court's docket in recent years. See, e.g., *Planned Parenthood Ass'n of Kansas City, Mo., Inc. v. Ashcroft*, 462 U.S. 476 (1983) (declaring constitutional a state statute requiring minors seeking an abortion to obtain parental consent or a Juvenile Court declaration that they are mature enough to decide independently); *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983) (declaring unconstitutional a state statute requiring either parental or judicial consent for all minors under 15 seeking an abortion); *H.L. v. Matheson*, 450 U.S. 398 (1981) (upholding a state statute requiring physicians to notify parents of an unemancipated and immature minor upon whom an abortion is to be performed).

57. This is also relevant to the issue of professional malpractice liability. See *infra* notes 107-09 and accompanying text.

emergency circumstances. . . .”⁵⁸ However the standards express the view that a minor who consents to medical treatment under a special enabling statute should also be financially liable for such services and should not disaffirm any such obligation because of minority.⁵⁹ In what many consider a well-meaning but impractical attempt to balance the minor patient’s right to privacy and the problem of securing payment, the standards propose that insurance coverage should be payable under any policy in which the minor is a beneficiary even though the child rather than the parent has consented to the treatment.⁶⁰ However, no private or public health insurer should inform the parent or policyholder that such a claim has been filed unless the treating physician has previously notified the parent. Anyone who has dealt with billing procedures of either Blue Cross or most private health insurers is bound to express skepticism about the workability of the last part of the proposal, but it reflects the trend toward according greater recognition of personal rights of minors.

Some newer statutes specify not only that a minor cannot disaffirm a contract for medical care that was received, but also that the parent, guardian, or spouse of such a minor has no liability to pay for such care in the absence of a specific agreement to do so.⁶¹ A possible concern prompted by such statutes is that some parents might refuse to consent (or choose to have their minor children consent) in order to avoid financial responsibility. This in turn poses the question whether such conduct might be construed as constituting abuse or neglect, or whether the statute provides a tacit exception under the circumstances.⁶²

C. *Family Law Techniques for Ending or Replacing Parental Rights and Duties*

Increased concern about defining rights and duties that flow between children and parents without regard to the gender or marital status of the latter has been part of what some describe as the “constitutionalization” of family law in recent years. This has been accompanied by questions about what procedural requirements are

58. IJA/ABA Juvenile Justice Standards Project, *Standards Relating to Rights of Minors* 59 (1980).

59. *Id.* at 61.

60. *Id.*

61. *See, e.g.*, MONT. CODE ANN. § 41-1-404 (1985).

62. The question might not be perceived as a problem with regard to elective procedures.

necessary if a state wishes to terminate parental rights.⁶³ These developments have also affected existing procedures for adoption, through which a new "legal" parent may be substituted for a biological parent. Once used in ancient societies to accomplish some of the same goals for which the modern will was developed,⁶⁴ adoption could in the future become important as a means for shifting responsibility for children's medical needs, either voluntarily or involuntarily.

1. *Adoption*

Through the mechanism of adoption, an existing parent-child relationship is terminated and a new parent is substituted to assume all legal rights and duties of parenthood. Though not an indigenous American legal institution,⁶⁵ adoption has been reshaped by our legal system over the past century as a special means for providing homes and families for minor children who have no living parents or whose parents are unwilling or incapable of caring for them. There is no effective, widespread system of long-term child-care institutions in this country today. Orphanages began to disappear or change focus many years ago⁶⁶ and were replaced by a system of foster care and adoptive placement institutions operated by public agencies and state-licensed private organizations. By mid-century, most adoption laws had been refined to provide for judicial involvement and screening of the potential adopters and their homes by some responsible agency (at least in the case of non-relative adoptions) before a final decree. Some states placed narrow limits on "private placements" for adoption involving previously unrelated parties, thus increasing the importance of the agency placement process.

For many years demand for adoptable children has exceeded

63. See, e.g., *Santosky v. Kramer*, 455 U.S. 745 (1982) ("Before a state may sever completely and irrevocably the rights of parents in their natural child, due process requires that the state support its allegations by at least clear and convincing evidence."); *Lassiter v. Department of Social Services*, 452 U.S. 18 (1981) ("The Constitution does not require the appointment of counsel for indigent parents in every parental status determination proceeding. The decision whether due process calls for the appointment of counsel is to be answered in the first instance by the trial court, subject to appellate review.").

64. See Huard, *The Law of Adoption: Ancient and Modern*, 9 VAND. L. REV. 743 (1956).

65. For further discussion of the development of American adoption law, see Presser, *The Historical Background of the American Law of Adoption*, 11 J. FAM. L. 443 (1971); Wadlington, *Minimum Age Difference as a Requisite for Adoption*, 1966 DUKE L.J. 392.

66. For a discussion of some of the legal problems thus presented, see *In re Milne's Succession*, 230 La. 729, 89 So. 2d 281 (1956).

supply, often by a substantial margin.⁶⁷ During an earlier time this probably was affected by the prevailing emphasis on placements of healthy children immediately after birth. During that period specific criteria, some of which would be at best of questionable legal validity today, were used by some agencies to establish adopter eligibility. Such requirements as a low age ceiling, no prior divorces, or conformity with certain social or religious standards severely limited the pool of persons who might adopt through agency placements.

In recent years a combination of social, legal, and economic changes⁶⁸ has led to further decline in the number of normal, healthy infants available for adoption, while the demand for adoptable children has increased. This imbalance has had varying impact, ranging from the demise of some placement agencies to shifts in the major function of others. It also has led to the expansion of efforts to include children with "special needs" in the adoption pool. That label generally extends to several well-defined groups of children who once were considered difficult to place and, as a result, largely remained outside the adoption process. Older children, members of a larger sibling group needing placement together, children of minority racial or ethnic origins, and children with mental or physical handicaps or special medical demands are typically regarded as having special needs.

Although they may not constitute the largest number of "hard to place" children, this Article addresses only the problems of handicapped and medically needy children. Locating prospective adoptive parents who are able to cope with the problems of children with handicaps or severe medical needs presents one problem. Providing services and funding poses another.

a. *Subsidized Adoption: A New and Innovative Approach.* Subsidized adoption, a special procedure for facilitating adoption of children with special needs, has achieved wide legislative enactment since New York passed the first enabling statute less than two de-

67. Exact figures relating to adoption are difficult to determine today because of a lack of centralized statistical reporting. For a view of the general dimensions, see Plumez, *Adoption: Where Have All the Babies Gone?*, N.Y. Times, Apr. 13, 1980, § 6 (Magazine), at 34, col. 1.

68. These include legal access to abortion and contraceptive information and devices; changes in social and legal positions on legitimacy; greater economic access to child care assistance for single mothers who previously might have relinquished their children for adoption; the desire of many unwed fathers for custody of their children; and the development of better mechanisms for proving paternity and fixing and enforcing paternal support duties.

caes ago.⁶⁹ It opened to mixed reviews, probably because of both insufficient understanding of what it was designed to do and skepticism about governmental willingness to provide adequate funding.⁷⁰ One commentator noted the irony of this reception, pointing out that “[i]n a society in which two of the most cherished values are children and money, it is surprising that a proposal holding promise of both has met with much resistance.”⁷¹ The reference to saving money as well as children compares long term foster care with legal adoption by parents who want the child. Money can be saved because the cost of subsidized adoption for the state is less than that of foster care,⁷² and it is generally perceived that adoption is psychologically superior to serial foster homes.

Subsidized adoption received an enormous boost with Congressional passage of the Adoption Assistance and Child Welfare Act of 1980.⁷³ Prior to 1980, federal funds were available for assisting foster care but not for adoption. This provided a disincentive for state placement of “special needs” children for adoption under subsidy. The 1980 law extended the scope of federal financial assistance to subsidized adoption. Each state must now provide such adoption assistance in order to qualify for participation in the federal AFDC program.⁷⁴ Children eligible for the federal subsidy contribution must have “special needs” and qualify for AFDC or SSI benefits.⁷⁵ The amount of governmental assistance can vary according to the adoptive parents’ circumstances and the child’s special needs, although federal assistance cannot exceed what the child would have received from that source if the child had been placed in foster care.⁷⁶

69. For the present version of the New York law, see N.Y. SOC. SERV. LAW §§ 450-58 (McKinney 1983 & Cum. Supp. 1986). All states now have some provision for adoption assistance. For a general discussion of the various approaches, see Hardy, *Adoption of Children with Special Needs, A National Perspective*, 39 AM. PSYCHOLOGIST 901 (1984).

70. For example, the original California statute included a three-year limitation period on payments. See 1968 Cal. Stat. c. 1322—2498. This limitation was increased to five years in 1975 and finally removed in 1982 with respect to payments starting after that date. See CAL. WELF. & INST. CODE § 16120(b) (1975 West Supp. 1986).

71. Watson, *Subsidized Adoption: A Crucial Investment*, 51 CHILD WELFARE 220-24 (1972).

72. One cost advantage of subsidized adoption is that it obviates the need for ongoing state monitoring and supervision of foster placements.

73. 42 U.S.C. §§ 620-28 and §§ 670-76 (1982). For a detailed review of this Act and its subsequent administration, see Bussiere, *Federal Adoption Assistance for Children with Special Needs*, 19 CLEARINGHOUSE REV. 587 (1985).

74. 42 U.S.C. § 602(a)(20) (1982).

75. *Id.* at § 673(a)(1).

76. *Id.* at § 673(a)(2).

Children eligible for federally assisted subsidized adoption programs also are eligible for Medicaid because they are deemed to be dependent children and AFDC recipients. Problems have arisen, however, in some interstate placements or in situations in which a family has moved to another state after completing a subsidized adoption. Although the state in which the subsidy adoption agreement⁷⁷ was made can simply send the basic payments to the client's out-of-state address, third party providers in one state may be reluctant to accept another state's Medicaid card for reasons ranging from a concern about extra paperwork and payment delays to the possibility that some services may not be covered under the other state's program. A key feature of the federal Act is its intended reliance on interstate compacts to remedy such problems in our mobile society. Suggested language for an Interstate Compact on Adoption and Medical Assistance, developed by the American Public Welfare Association under an HHS grant and published in 1983, addresses the problem by providing for issuance of identification for medical assistance in the state where the child resides. It also suggests a formula under which the state of adoption would pay for services it normally would cover if such costs are not included under the program of the state of the child's residence. Enabling legislation that would allow appropriate agencies to enter into such compacts has been adopted by only a small number of states thus far, although HHS has issued instructions on the level of required compliance with medical assistance reimbursement across state lines even if a state has not entered into such a compact.⁷⁸

In summary, recent developments in the area of subsidized adoption have focused on the goal of providing stable families for children with handicaps or special medical needs, as opposed to relegating them to long-term foster care that could involve a series of homes where emotional and developmental requirements may not be met. Although statistical information is sparse, there is some indication that children with special medical handicaps or needs are becoming an increasingly larger portion of those served by this program. However, as cost-containment pressures increase, needed expansion may be in a precarious condition because of the dependency on Medicaid eligibility and further problems of interstate enforcement and inconsistency of services.

77. The written subsidy or adoption assistance agreement is a key part of the individualized approach to subsidized adoption. For discussion of matters that should be addressed in negotiating such an agreement, see Bussiere, *supra* note 73, at 587, 590-91.

78. For a critique and overview of the model Compact, see *id.* at 594.

There is a legitimate concern that subsidized adoption has been viewed too much as a cost-containment mechanism, although many obviously have supported it as an alternative to further expansion of what is regarded as a deeply troubled foster care system. To function properly in cases where the special needs are medical, the promise of cost reduction may not be fully justifiable if the program is to accomplish its "child saving" goal effectively.

The question sometimes is raised as to whether children may enter the adoption process rather than remain in foster care when the children are under foster care in the first place largely because of financial inadequacies of parents who might function satisfactorily if the subsidized adoption funding were instead given to them. This question may deserve serious policy consideration, but it should not be assumed that channelling funding to the natural parents would resolve all the cases in which subsidized adoption of children with special medical needs is being attempted. For example, the requirement that a child must be eligible for AFDC can serve to limit the use of subsidized adoption of a child relinquished by a financially capable parent in order to avoid future responsibility for medical costs of a child with a permanent or long-term handicap.

b. *Voluntary Adoptive Placement as a Means of Obtaining Medical Insurance Coverage.* Without reliable data one can only speculate about what is occurring or might occur as medical costs increase and parents feel incapable of coping with the needs of their children. In that vein one should consider that a possible avenue available to such parents is to voluntarily relinquish their children for adoption by someone with adequate medical insurance. If the adopter is a close relative, perhaps even a member of the same extended household, the adoption easily could be considered as taking place entirely for the purpose of securing insurance benefits. Modern laws typically provide for facilitating private placements between certain close relatives through such means as eliminating the number of judicial proceedings involved or deemphasizing certain review procedures.

Although there is insufficient data documenting the extent of this practice, a West Virginia Supreme Court opinion,⁷⁹ well known in family law for its explication of the "primary caretaker" doctrine as the criterion for determining child custody, substantiates the existence and acknowledgment of the practice. The mother of an infant with a chronic respiratory infection requiring hospitalization

79. *Garska v. McCoy*, 278 S.E.2d 357 (W. Va. 1981).

and "considerable medical attention" consented to the adoption of her child by the mother's grandparents in order to qualify the child for coverage under the grandfather's hospitalization and medical insurance.⁸⁰ Before the child's birth the mother had separated from the father, to whom she was not married, and returned to live with her grandparents. Although the child's father had not been supporting the child, he opposed the adoption and sought custody when the grandparents petitioned for adoption. A key issue before the court was whether the mother's consent to the adoption constituted abandonment, thereby making her an unfit parent. The court found that there had been no abandonment under the circumstances, but rather that the mother had "mobilized all of the resources at her command, namely the solicitous regard of her grandparents, in the interest of this child and that she went to extraordinary lengths to provide for him adequate medical attention and financial support."⁸¹ The court also noted that "it is well recognized that mothers in penurious circumstances often resort to adoption in order to make the child eligible for social security or union welfare benefits, all of which significantly enhance the child's opportunities in life."⁸²

Even though one can only speculate about the extent to which adoption is used to enroll a child for medical coverage, the ease with which this can be accomplished and the pressures that may dictate its use must be recognized. This is not among the traditional purposes for which adoption was developed, but one should not ignore that qualifying a child for medical coverage is a new need that is in some ways comparable to factors considered by unwed mothers several decades ago when deciding whether to relinquish children for adoption in order to afford them better opportunities in life.

c. *Voluntary Relinquishment for Adoption to End Parental Duties, Including Financial Liability.* There are well-known, recurring instances in which parents may seek to end all financial obligations for a child through consenting to private adoption by a specific person or through relinquishment to an adoptive placement agency.⁸³ The former is illustrated by the noncustodial parent who, though

80. The grandfather, with whom the granddaughter and her child were residing, was a retired coal miner with liberal medical benefits. *Id.* at 359.

81. *Id.* at 364.

82. *Id.*

83. Relinquishment might also be made to a private individual in some states. However, this is less likely to carry the same degree of finality that often is accorded the agency placement.

required to pay for child support, has little or no meaningful relationship with the child and therefore consents to adoption by a stepparent.⁸⁴ The latter is exemplified by the mother who does not wish to bear the extra economic and social burdens that can fall on a single parent and thus relinquishes her child to an agency.⁸⁵ In the past, both cases have usually been viewed in the context of the parent relinquishing a normal, healthy child. A scenario of growing concern today involves a parental desire to relinquish a child with irremediable defects or medical problems likely to be remediable only at the cost of draining all of the parents' assets. This is by no means farfetched. It echoes the theme of a celebrated forty-year-old case in which a father had killed his child in what would generally be described as an act of euthanasia.⁸⁶ The issue before the court was whether the father, who in an earlier proceeding had been convicted of manslaughter and placed on probation, was of "good moral character" for purposes of becoming a U.S. citizen through naturalization. The court's remarks indicated its assumption that the father's motive was the nurture of his other four children "which was being compromised by the burden imposed upon him in the care of the fifth."⁸⁷ Had the alternative been relinquishment of the child to the state or adoption, one wonders whether the outcome would have been different.

In assessing the likelihood that this could become a serious problem, one should understand that parents may owe a legal duty of support to their incapacitated children if the incapacity continues past majority.⁸⁸ Although many states have statutory provisions

84. Although there is an increasing tendency to impose child support duties on a stepparent who is married to and living with the custodial legal parent, usually these duties are secondary to the duties of the noncustodial natural parent and will end on dissolution of the marriage between the stepparent and the custodial parent unless the stepparent has adopted the child or continues to enjoy a special *in loco parentis* relationship. See, e.g., MO. REV. STAT. § 453.400 (Supp. 1986); *Washington Statewide Organization of Stepparents v. Smith*, 85 Wash. 2d 564, 536 P.2d 1202 (1975).

85. Another variation of this can be the case of a child born to a married woman when her husband is not the parent. While once there would have been a strong, often unchallengeable, presumption of the husband's paternity, this scenario is increasing in complexity today through both the erosion or disappearance of older rules barring husband and wife from testifying if it would affect their child's legitimacy, and the increased recognition of the standing of the biological father to assert paternity.

86. *Repouille v. United States*, 165 F.2d 152 (2d Cir. 1947).

87. *Id.* at 152.

88. See H. CLARK, *LAW OF DOMESTIC RELATIONS* 505 (1968); *Elkins v. Elkins*, 553 S.W.2d 34 (Ark. 1977) (upholding a judicial decree that obligated the father to continue child support payments as long as the dyslexic child was attending college); *Commonwealth v. Shepard*, 212 Va. 843, 188 S.E.2d 99 (1972) (holding the estate of an incompetent mother

that formally provide for voluntary relinquishment of parental rights, such laws were probably enacted in order to provide a means for avoiding costly and time consuming court proceedings in instances where less than adequate parents would at least acquiesce in the termination of their rights. That these provisions might, in the absence of further legislative direction, be construed as establishing a "right" to relinquish a child because of his special medical needs seems questionable—particularly in a time of state concern about shouldering medical costs.

A more likely course would be for the state to remove the child from the home while seeking continued support from the parents. As noted earlier, Louisiana has enacted a provision stating that parents of a child who refuse to consent to care and treatment of a child under their particular "Baby Doe" style enactment "shall at all times be free to execute a voluntary act of surrender" to a state or other adoptive placement agency.⁸⁹ However, the statute also provides:

All medical expenses incurred by the Department of Health and Human Resources on behalf of the child shall be reimbursed by the parent or parents of the child, provided they have not been declared financially needy. No medical insurer of the parent or parents of a child who would have otherwise been liable for such medical expenses may deny liability to their insured solely because of the parent or parents desire to withhold medical or surgical treatment for their child.⁹⁰

The statute further provides that the agency to which the child is relinquished shall immediately provide treatment and "make every effort" to find an adoptive home.⁹¹ It makes no reference to the potential long-term medical obligation of the relinquishing parents. However, the "financially needy" limitation to required reimbursement could conceivably be construed to deal with the problem of a child ineligible for federal subsidized adoption assistance by virtue of not being qualified for AFDC.⁹²

It should be noted that Congress has authorized the Secretary of Health and Human Services to make grants to states to help with the establishment, operation, or implementation of "programs to help

liable for maintaining her son who lived in a mental hospital); VA. CODE ANN. § 20-61 (1983).

89. LA. REV. STAT. ANN. § 40:1299.35.2 (West 1984). See *supra* notes 36-37 and accompanying text.

90. LA. REV. STAT. ANN. § 40:1299.35.2 (West 1984).

91. *Id.*

92. See *supra* notes 73-76 and accompanying text.

in obtaining or coordinating necessary services, including social and health services and financial assistance for families with disabled infants with life-threatening conditions, *and those services necessary to facilitate adoptive placement of such infants who have been relinquished for adoption.*"⁹³

2. *Involuntary Termination of Parental Rights for Failure to Meet a Child's Health Care Needs*

Adoption serves to shift parental rights, but it requires either the consent of existing parents or formal termination of their legal rights as parents. Termination of parental rights can be based on incapacity or unwillingness to care for a child's medical needs, though ordinarily such peremptory action is taken only in extreme cases.⁹⁴ Such cases are distinguishable from situations in which the state intervenes to overrule a specific parental decision about medical care. The latter, though known as medical neglect, is viewed by some courts as involving little, if any, moral culpability on the part of the nonconsenting parent.⁹⁵

One might ask why parental rights should be terminated for failure or unwillingness to provide medical care. One answer might be to free a child for adoptive placement with parents who will extend such care.⁹⁶ But many such children will be difficult to place for

93. 42 U.S.C. § 5103 (Supp. 1985) (emphasis added). See also *id.* at § 5111.

94. *In re M.L.G.*, 317 S.E.2d 881 (Ga. App. 1984) illustrates the type of case in which parental rights have been terminated because of physical or mental inability to meet a child's special medical needs. The particular child had been born without a sacrum, resulting in paralysis of her bladder that required maintenance of an ileostomy bag after a cutaneous vesicotomy. The parents were separated and the child had been placed in foster care by court order. The father, an alcoholic, had a history of beating the wife and on one occasion had knocked the child from a couch, causing her stoma to bleed. He was unemployed, lived alone in a trailer, was delinquent in child support payments, and had indicated to a case worker that he felt it inappropriate for him to have to change his nine-year-old daughter's ileostomy bag. The mother also had a record of excessive drinking and failure to maintain a sanitary living environment or even to bathe the child during the period when she was with her for weekend visits. On one occasion she applied a plastic sandwich bag to the ileostomy rather than the appropriate medical bag.

95. For example, in *In re Sampson*, 65 Misc. 2d 658, 317 N.Y.S.2d 641 (Fam. Ct. Ulster Cty. 1970), *aff'd*, 29 N.Y.2d 900, 278 N.E.2d 918, 328 N.Y.S.2d 686 (1972), the court overruled a mother's refusal to consent to corrective surgery for her son, but nevertheless stated that the adjudication "in no way imports a finding that the mother failed in her duty to her child in any other respect." 65 Misc. at 676, 317 N.Y.S.2d at 658.

96. Though it may be only peripheral to the current inquiry because of its key focus on costs, note should be taken of the increasing willingness of some courts to consider the concept of "psychological parenthood" as a factor in determining child custody independent of a blood relationship of parent and child. The cases regarding the guardianship of Phillip B. provide a possibly relevant example. A fourteen-year-old boy with Down's Syndrome was institutionalized by his parents soon after birth. Subsequently a legal controversy developed

adoption because of their medical needs. Some children might qualify for subsidized adoption that could include Medicaid coverage. If they do not, the state simply may be relieving the natural parents of further financial responsibility through the termination procedure. Those interested in child protection would say that termination should be predicated on parental incapacity or misconduct, whether or not an adoptive placement is likely to take place.⁹⁷ However, reluctance to take such steps is likely if they will result in greater cost to the state before it is certain that an adoptive placement will materialize.⁹⁸

III. POTENTIAL IMPACT OF THE TORT SYSTEM ON CHILDREN'S HEALTH CARE COSTS

The impact of professional liability under tort law could be increasingly significant, though projections are difficult to quantify. Costs of medical services might be expected to escalate due to the costs of defensive medical practice and increases in liability exposure and insurance premiums. The question to consider here is whether children's health care is more vulnerable to cost increases than other areas of medical practice. Once again, there are special legal and practical concerns that should be considered.

Until recently, practitioners in the children's health care field (other than those with narrowly defined specialties) usually were not cast into the more expensive professional liability insurance categories occupied by such specialists as surgeons, anesthesiologists, and orthopedists. This is still the case for family and general pediatric practice, though not for neonatology and obstetrics.⁹⁹ The increase in the number and severity of claims associated with birth-

over whether a guardian should be appointed to authorize a cardiac catheterization. The court held that the state had not met its burden of establishing clear and convincing reason. *In re Phillip B.*, 92 Cal. App. 3d 796, 803, 156 Cal. Rptr. 48, 52 (1979). Subsequently, two volunteer workers at the institution where the child resided were successful in petitioning to become his guardian on the basis of having become his psychological parents. The court explained that "[i]t is the emotional abandonment of Phillip, not his institutionalization, which inevitably has created the unusual circumstances which led to the award of limited custody to respondents." *Guardianship of Phillip B.*, 139 Cal. App. 3d 407, 424, 188 Cal. Rptr. 781, 792 (1983) (emphasis in original).

97. For a different point of view, see Garrison, *Why Terminate Parental Rights?*, 35 STAN. L. REV. 423 (1983).

98. The cost may be increased in some cases by a difficult and time consuming legal procedure.

99. It must be recognized that some family practitioners deliver babies, which can increase their professional liability insurance costs. Of all the groups mentioned, the greatest liability risk is generally considered to be associated with practices related to the birth process.

related procedures has become of special concern, and attention is being focused on the degree to which this increase is affecting delivery of services.¹⁰⁰ Some health care professionals are limiting their obstetrical practice. Nurse midwives are in a particularly precarious position because of difficulty in obtaining liability insurance coverage at a cost that would allow them to continue practice. Because many nurse practitioners and midwives have historically served lower income mothers, the impact will fall most heavily on those most unable to afford to see a physician.

Among the possible explanations given for the liability crisis in obstetrics are inadequate practices and risk management, increased specialization, and new technology coupled with a time lag in adequate training for its use. If these are significantly contributing factors to the liability crisis in obstetrics, one might postulate that similar developments could occur in pediatric practice. Increasing demands for expertise in areas such as genetic screening and counseling provide illustrations, though whether such practices will settle into the domain of pediatrics rather than another specialty is uncertain.

One special factor in tort law involving children's actions is the extended time period during which such actions can be commenced. In many states a statute of limitations will not begin to toll until a child reaches majority, generally age eighteen.¹⁰¹ Some states have reduced this time period, but not all such modifications have survived constitutional attacks based on their limited applicability to medical malpractice cases.¹⁰² It is difficult to assess the effect on physicians' costs of this extended period for bringing actions. However, uncertainty is one factor that often is identified as the cause of inflated liability insurance rates. An obvious concern is that the passage of time may make defense of a case more difficult

100. Attention is being focused on the possible reasons for the increase in claims, ranging from the vagaries of the tort system to inadequate medical risk management. With regard to the latter, see Julian, *Investigation of Obstetric Malpractice Closed Claims: Profile of Event*, 2 AM. J. PERINATOLOGY 320 (1985).

101. For an illustration of such a provision for extension, see VA. CODE § 8.01-229 (1984).

102. See, e.g., *Sax v. Votteler*, 648 S.W.2d 661 (Tex. 1983); *Schwan v. Riverside Methodist Hospital*, 6 Ohio St.3d 300, 452 N.E.2d 1337 (1983). Some states have upheld the validity of legislation shortening statutes of limitations even when applied to children. See, e.g., *Rohrbaugh v. Wagner*, 274 Ind. 661, 413 N.E.2d 891 (1980); *Reese v. Rankin Fite Memorial Hosp.*, 403 Ala. 158, 403 So.2d 158 (1981). It should be recognized that changing a statute of limitations may not affect outstanding claims under the construction announced by some courts. See, e.g., *Goodman v. St. Louis Children's Hosp.*, 687 S.W.2d 889 (Mo. 1985) (en banc).

because of the staleness of evidence. On the other hand, for the same reason it is more difficult for plaintiffs to meet their burden of proof. Perhaps an even more important concern is that in a period of dynamically changing medical practice, it may be difficult to reconstruct the prevailing standard of care that existed a decade or two earlier but is now rejected because of increased technology, new drugs, or greater experience.

There also is concern about development of new causes of action that raise the specter of unusually high damage awards. Prime examples are the actions described (or misdescribed) as wrongful pregnancy and wrongful life. The former refers to an action by the parent of a defective child based on physician negligence before the child's birth, while the latter is an action by the child himself. Considerable criticism of both actions has arisen because of what might best be described as their ethical and philosophical underpinnings, namely that they are based on failure to afford a parent the opportunity to choose abortion over childbirth. The conceptual problem is especially troubling in the case of an action by a child, who in essence seeks damages for having been born. Despite these theoretical difficulties, wrongful pregnancy or birth actions have been recognized by courts in numerous states.¹⁰³ Wrongful life actions are recognized by courts in four jurisdictions.¹⁰⁴ States that have recognized such actions—especially the suit for wrongful life—have tended to sharply restrict the scope of recoverable damages, including extraordinary medical care but excluding pain and suffering or impairment of childhood.¹⁰⁵ Although highly conjectural, critics have suggested that limiting recovery primarily to medical expenses in effect warps the tort system by providing a mechanism for assuring payment for expensive medical care that otherwise might be either a devastating burden to parents or a charge to the state, if not both. It is significant that the legislature of one state where a cause of action for wrongful life was judicially recognized has adopted a statute providing that “[n]o cause of action arises against a parent of a child based upon the claim that the child should not have been

103. See, e.g., *Schroeder v. Perkel*, 87 N.J. 53, 432 A.2d 834 (1981).

104. See *Procanik v. Cillo*, 97 N.J. 339, 478 A.2d 755 (1984); *Harbeson v. Parke-Davis, Inc.*, 98 Wash. 2d 460, 656 P.2d 483 (1983); *Turpin v. Sortini*, 31 Cal. 3d 220, 182 Cal. Rptr. 337, 643 P.2d 954 (1982); *Continental Cas. Co. v. Empire Cas. Co.*, 713 P.2d 384 (Colo. App. 1985).

105. The cases also indicate that recovery for these expenses can only be awarded once. In *Procanik v. Cillo*, 97 N.J. 339, 478 A.2d 755 (1984), the court recognized that the child's right of action was independent rather than derivative from that of the parents, whose action had already been barred by the statute of limitations.

conceived or, if conceived, should not have been allowed to have been born alive."¹⁰⁶

Another special liability problem that pediatricians may have to face stems from the uncertainty concerning their duty or discretion to communicate with parents of their minor patients, discussed earlier in a different context.¹⁰⁷ The issue raised by this problem is whether revealing such information about the child's medical treatment can be used as the basis for a tort action based on breach of the duty to maintain confidentiality.¹⁰⁸ A further concern is the issue of what standard a physician must follow in obtaining informed consent from a minor whose comprehension may be limited due to age.¹⁰⁹ Because all of these problems create uncertainty, they may have a substantial impact on insurance rates.

IV. POTENTIAL INTERACTION BETWEEN FAMILY LAW RULES AND COST RESTRAINTS: SOME CONJECTURAL ASSESSMENTS

Major governmental assistance for medical care is now geared to children in the neediest families. Family law generally formulates more universally applicable duties, though some of its processes (such as those imposing criminal nonsupport sanctions) may be used most often against parents with the least ability to pay. Both family law support provisions and Medicaid, through their strong but differing relationships to public assistance programs such as AFDC, often have the greatest impact on children of broken families. In Medicaid it is seen in terms of eligibility, while in family law the concern is with minimizing state payments by enforcing support obligations against absent parents.

Key family law doctrines which require parents to provide medical care (especially those provisions dealing with medical neglect) are geared toward intervention primarily in extreme cases, such as

106. CAL. CIV. CODE § 43.6 (West 1982). The statute further provides that "[t]he failure or refusal of a parent to prevent the live birth of his or her child shall not be a defense in any action against a third party, nor shall the failure or refusal be considered in awarding damages in any such action."

107. See *supra* note 57 and accompanying text.

108. For further elaboration of the nature of this duty, see *Horne v. Patton*, 291 Ala. 701, 287 So.2d 824 (1974). In a somewhat unusual variation, in *Humphers v. Interstate Bank*, 298 Or. 706, 696 P.2d 527 (1985), a physician was alleged to have written a false letter about DES exposure to help an adopted child locate her natural mother (the plaintiff in the action). The court held that the mother had an action for breach of confidentiality but not for invasion of privacy.

109. See *Competence to Consent*, *supra* note 22, at 64.

failure to provide necessary care or refusal to consent to treatment when a child is at serious risk. Cases involving defective neonates or children in need of an immediate procedure such as blood transfusion to avoid death are good examples.

While the law now recognizes the right to recover from parents for necessities extended to their children, the definition of "necessary" medical care is not always clear. Increased recognition of the capacity of an older child to consent to some important medical procedures without parental concurrence has come at the possible expense of diluting parental financial responsibility.

At a time when both government assistance and private insurance coverage may be diminishing, the financial burden on parents for children's medical care is likely to increase. Other factors, such as the demise of historic patterns of cost shifting through the rise of Health Maintenance Organizations and Preferred Provider Organizations, may increase the financial burden for some families more than might have been anticipated. Increased technology and specialization in the child care field, plus expanding costs from ancillary areas, such as professional liability exposure, could further compound the problem. At the same time, new and powerful support enforcement mechanisms, not necessarily adopted with medical care in mind but certainly covering it, will make it easier to collect child support from parents through procedures such as garnishment of wages, posting of security bonds, or liens against property.

It would be helpful if basic family law rules would reinforce provision for health care needs through private sources where governmental assistance is least likely. Unfortunately, the legal and funding systems do not complement each other very well in this manner. Neither basic preventive care needs nor the catastrophic needs of children in families previously without significant financial need are adequately addressed under most governmental programs. Basic preventive care needs do not fit well in the private system either, though private systems are now geared to ensure that the catastrophic needs of children are met.

The picture that is drawn by these observations is not an attractive one. Just as older persons may divorce to achieve eligibility for medical assistance, or may seek to divest themselves of assets to qualify for assistance before the most devastating stage of Alzheimer's disease develops, we may see parents trying to shift the economic burden of children with exceptional medical needs by relinquishing parental rights or through adoption. This is not neces-

sarily something that we can expect to witness only with the very poor. A family that does not qualify for public assistance but has inadequate health insurance could be hit the hardest and thus might be most likely to react in such a manner.

Several alternatives for long term planning seem desirable, though it is recognized that they are all politically difficult, if not untenable at this time. Consideration should be given to some form of "medical family allowance" that might eventually lessen the cost of Medicaid by focusing on preventive care. Consideration also should be given to development of a system of children's health care that would be nearly universal in eligibility and "expandable" in its coverage. Other measures to be considered would protect against financial ruin from catastrophic events, or would provide transitional health care coverage for young adults shortly after minority before they have entered the labor force. Such a "bridge" approach would be designed to reach a large population that loses parental insurance coverage at a time when opportunities for substitute coverage can be very limited.

Reorientation of private health insurance coverage so as to more adequately focus on minors' needs might be undertaken now with less political opposition than most of the suggestions made above.

Imaginative programs such as subsidized adoption should be further refined, with their development emphasizing both services to the children involved and potential cost savings. Innovative new programs should be encouraged, but with awareness of their potential impact on families and not simply of their potential for saving money.

Finally, current family law rules regarding children's medical care should be carefully reevaluated and clearly restated. Such a formulation should try to equitably balance the interests of all parties involved, and should include some statement of the role that cost concerns play in determinations of what care is appropriate under the circumstances.