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OUT OF SIGHT, OUT OF MIND, BUT NOT OUT OF DUTY: ADOPTION AGENCY'S DUTY TO DISCLOSE MEDICAL INFORMATION TO BIRTH PARENTS POST-RELINQUISHMENT

Wanda M. Temm*

I. INTRODUCTION

Today, the role of a child welfare agency is multi-faceted. An agency often provides adoption services, unwed parent services, and foster care services. As a result, agencies struggle to meet the often conflicting needs of three separate clients: the child, the adoptive parents, and the birth parents.

Each part of the adoption triangle[1] presents its own unique problems. From the child needing placement in a permanent family to the adoptive parents wanting a child, to the birth parents not ready or not willing to become parents, an agency works to meet all needs. In doing so, the agency often takes on the role of intermediary, serving to place the child of the birth parents with adoptive parents.

As an intermediary, one role of the agency is as an information conduit. The birth parents relay information about their medical history, family background, and reasons for relinquishment. In turn, the agency passes non-identifying information[2] on to the adoptive parents. As an adult, the child may return to the agency and receive this non-identifying information for him.

In modern adoptions, the birth parents also may receive information about the adoptive parents and the child. Indeed, post-placement information sharing is often heralded by agencies in their marketing efforts to recruit adoptable babies.

The law fully recognizes an agency's legal duty to disclose information to the child and adoptive parents. State statutes dictate what information must be shared.[3] Indeed, adoptive parents may recover damages against an agency for failure to disclose pertinent medical or social history information.[4]

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1. ARTHUR D. SOROSKY ET AL, THE ADOPTION TRIANGLE (1978).

2. This essay focuses on a traditional agency adoption in which identifying information usually is not shared, unlike open adoptions. *See infra* note 16. Non-identifying information typically includes age, physical description, extended family background, medical history, hobbies and interests, ethnic background, education, and reasons for relinquishment.

3. D. Marianne Blair, *Lifting the Genealogical Veil: A Blueprint for Legislative Reform of the Disclosure of Health-Related Information in Adoption*, 70 N.C. L. REV. 681, 714 nn.177-80 (1992).

4. Richard P. v. Vista Del Mar Child Care Serv., 165 Cal. Rptr. 370, 373 (Ct. App. 1980); M.H.

The law, however, inadequately protects birth parents. While some states have recognized the need for disclosure of medical information, the vast majority do not.[5] Medical information regarding the adopted child can be just as crucial to birth parents, however, in their later reproductive decision-making. Knowledge that an earlier child had a genetic illness may impact a birth parent's decision to have additional children, to undergo genetic counseling, and to undergo extensive prenatal testing. Birth parents seeking damages for an agency's failure to disclose medical information regarding the adopted child received post-adoption have, however, been turned away for lack of duty.[6]

This essay will examine whether an agency owes a duty to birth parents to disclose information received post-placement. First, this essay will consider the changing practices of modern adoption and their potential ramifications for agency duties. Second, it will examine the birth parents' need for information and the nature of an agency's duty. Last, this essay will consider four theories under which a duty to disclose to birth parents could be established. This essay will conclude that changed adoption agency practices result in an agency's acquired duty to disclose medical information received to birth parents. As a result, agencies may be held liable for failure to disclose information received to birth parents.

II. MODERN ADOPTION

Adoption practices have changed substantially over the last thirty to forty years. Gone are the days when the number of babies[7] waiting exceeded the number of adoptive parents. Birth parents typically no longer hide away, shamed by society, seeking refuge in unwed parent homes.

A number of factors contributed to the change in supply and demand. First, unwed parenthood is no longer scorned and unacceptable. Keeping a baby is not just acceptable, but often is preferred.[8] Nine out of ten pregnant

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v. Caritas Family Serv., 475 N.W.2d 94, 95 (Minn. Ct. App. 1991), *rev'd on other grounds*, 488 N.W.2d 282 (Minn. 1992); Foster v. Bass, 575 So.2d 967, 968 (Miss. 1990); Juman v. Louise Wise Serv., 608 N.Y.S.2d 612, 616 (N.Y. Sup. Ct. 1994); Meracle v. Children's Serv. Soc'y, 437 N.W.2d 532, 533 (Wis. 1989). *See* D. Marianne Blair, *Getting the Whole Truth and Nothing But the Truth: The Limits of Liability for Wrongful Adoption*, 67 NOTRE DAME L. REV. 851 (1992); Susan K. LeMay, Note, *The Emergence of Wrongful Adoption as a Cause of Action*, 27 J. FAM. L. 475 (1989); John R. Maley, Note, *Wrongful Adoption: Monetary Damages as a Superior Remedy to Annulment for Adoptive Parents Victimized by Adoption Fraud*, 20 IND. L. REV. 709 (1987); Deborah L. Miller, Note, *Are You Adopting a Child or Heartache? Adoption Agencies May Have to Disclose or Face a Claim for Wrongful Adoption*, 26 NEW ENG. L. REV. 1145 (1992).

5. Blair, *supra* note 3, at 730-31 n.259.

6. Olson v. Children's Home Soc'y, 252 Cal. Rptr. 11, 13 (Ct. App. 1988).

7. Many factors impact the availability of children for adoption. Age, race, and special needs generally are the most significant. While the proposed duty to disclose information to birth parents would apply to all relinquishing parents, the need for the duty is best illustrated by focusing on the changing practices related to healthy Caucasian infants.

8. JEROME SMITH & FRANKLIN I. MIROFF, YOU'RE OUR CHILD: THE ADOPTION EXPERIENCE 4 (1987).

teens decide to raise their children themselves rather than to relinquish them.[9] Second, legalized abortion and more effective birth control methods resulted in a decrease in the number of newborn infants available for adoption.[10] Finally, at the same time, couples are marrying later and/or delaying child bearing in order for women to start careers.[11] Moreover, infertility increases with age.[12] As a result, more couples are looking to adopt.

Prior to this shift in supply and demand, adoptive parents waited only a brief time to adopt a child. In some cases, they could choose among available children. Now, couples generally wait years before they reach the top of an agency's waiting list.[13]

As a result, adoptable babies are at a premium.[14] Agencies now compete to attract prospective relinquishing parents. Indeed, agencies now market their services. Telephone book ads abound with promises of "Confidential Communication with Adoptive Family," "Choice of Adoptive Family," "You Play an Active Role in All Decisions," "Your Needs are Important," "We Respect Your Feelings and Choices," "Choose and Meet Your Baby's Parents," "Open, On[-]Going Relationship with Adoptive Family & Child, Available."[15]

Birth parents have expanded control and input in the decision-making process. In addition to open adoption,[16] birth parents can now choose which family will adopt their child. As part of this increased input, agencies promise birth parents correspondence with the adoptive family and often pictures, not just at birth, but throughout the baby's childhood.

No longer is the expectation that once the child is relinquished, the birth parents' contact with the agency ends. Agencies hold themselves out as being the conduit for continued contact with the child through the adoptive family. Agencies may, therefore, be placed under a duty to relay medical information to birth parents in an accurate and timely manner.

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9. *Id.*

10. SOROSKY, *supra* note 1, at 35; Marsha Garrison, *Why Terminate Parental Rights?* 35 STAN. L. REV. 423, 443 (1983).

11. Richard A. Posner, *The Regulation of the Market in Adoptions*, 67 B.U. L. REV. 59, 61 (1987).

12. *See id.*

13. SMITH & MIROFF, *supra* note 8, at 4.

14. As a solution to the problems of the adoption system and the shortage of babies, Judge Richard Posner advocates a market in babies. *See* Elizabeth Landes & Richard A. Posner, *The Economics of the Baby Shortage*, 7 J. LEGAL STUD. 323 (1978). This controversial theory proposes legalizing compensation and establishing a free market in the area of adoption. As a result, the supply of adoptable babies will arguably increase. Posner theorizes that most of the parties would benefit: birth parents' suffering at relinquishment would decrease because of compensation, incentives would exist for birth parents to take better care of themselves while pregnant, abortion would decrease, and children would be placed with "parents who value them most." Margaret F. Brinig, *The Effect of Transactions Costs on the Market for Babies*, 18 SETON HALL LEGIS. J. 553, 555 (1994).

15. Southwestern Bell Yellow Pages - Greater Kansas City, *Adoption Servs.* at 10-11 (1994).

16. In an open adoption, the birth parents meet the adoptive parents and may maintain direct contact and communication. Annette Baran & Reuben Pannor, *Perspective on Open Adoption*, 3 THE FUTURE OF CHILDREN119 (Spring 1993).

III. THE NEED TO KNOW

One of the first questions a physician asks when diagnosing a medical problem or concerns the individual's medical history. This history includes not only the individual's own background but that of the family. The linkages between the illnesses of our ancestors and ourselves are more recognized than ever.

Many couples now seek genetic counseling before conception. Knowledge of potential genetic disorders aids couples in their reproductive decision-making.[17] At the same time, prenatal diagnostic testing has advanced to the point where many genetic conditions, some fatal, may be diagnosed in utero.[18] Even if a couple does not have prior counseling, undergoing testing, such as amniocentesis,[19] would reveal possible problems. Amniocentesis, however, is not a routine prenatal test. If no risk factors are known, chances are that this and other higher level tests will not be ordered.[20]

The need to know about prior genetic markers and family illnesses for the adopted child is not questioned. Yet, the same need exists for birth parents and has not generally been recognized.[21] Not all genetic disorders are diagnosed at birth. Thus, the birth parents may relinquish their baby without knowing of the disorder. Once a genetic defect is diagnosed, the issue becomes whether the agency has a duty to reveal that information to the birth parents post-placement. Certainly, the existence of the disorder is essential information.[22]

Illustrative is *Olson v. Children's Home Society of California*.[23] The birth mother relinquished her apparently healthy newborn son for adoption to a licensed private adoption agency in 1967. She later married and had two children. Her second son born in 1983, sixteen years after the relinquishment of her first son, died at the age of six months from a genetic disorder, combined severe immune deficiency or CSID.[24] CSID strikes infants and is associated with a propensity to overwhelming infection. Death usually occurs

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17. *See* Naccash v. Burger, 290 S.E.2d 825, 827 (Va. 1982) (if parents had had knowledge they were carriers of the genetic disease Tay-Sachs, they would have insisted on amniocentesis and if tested positive, they would have had an abortion).

18. Michael T. Mennuti, *Prenatal Diagnosis -- Advances Bring New Challenges*, 320 NEW ENG. J. MED. 661, 661 (1989).

19. "Amniocentesis involves the analysis of amniotic fluid withdrawn from the mother's uterus. The analysis reveals whether there are gross chromosome defects present in the fetus." *Naccash*, 290 S.E.2d at 827 n.1.

20. *See* Munro v. Regents of the Univer. of Cal., 263 Cal. Rptr. 878, 882 (Ct. App. 1989) (holding physician not liable in malpractice when "plaintiffs were unaware of any information concerning their genetic background which would have placed them" at risk).

21. *See supra* text accompanying notes 4-5.

22. Diane Plumridge et al., *Heredity and Adoption: A Survey of State Adoption Agencies*, 46 AM. J. HUM. GENET. 208, 209 (1990).

23. 252 Cal. Rptr. 11 (Ct. App. 1988).

24. *Id.* at 12.

before the child reaches its first birthday.[25] Male offspring of female carriers are at risk for the disorder.

Upon learning she was a carrier of this disorder, she contacted the adoption agency to learn about the health of the adopted son. She was informed that her son was alive, but also had CSID.[26] The agency originally learned of the diagnosis of a genetic disorder[27] in 1971, four years after the relinquishment and twelve years before the birth and death of the second son.

In the birth mother's wrongful death suit against the agency, the trial court summarily dismissed the complaint for lack of duty, which ruling was affirmed on appeal.[28] The California Court of Appeals found that no special relationship existed between the agency and the birth mother and that the agency never "expressly or impliedly suggest[ed]" that it would inform the birth mother of health information received post placement.[29] The court failed to recognize that the tortious conduct was the failure to accurately relay information, not the genetic condition of the child itself.

Duties based on informational acquisition are not new. Other courts have imposed duties based on the acquisition of information and the failure to relay or to accurately relay that information to persons in dependent situations.[30] In *Molien v. Kaiser Foundation Hospitals*,[31] a physician mistakenly informed his patient that she had contracted a sexually transmitted disease. The physician knew that information would be relayed to her spouse. The California Supreme Court held that this tortious conduct was directed to the spouse as well as to the patient.[32] Similarly, in *Tresemer v. Barke*, a physician learned of the dangerous effects of the Dalkon Shield after he had prescribed it for his patient.[33] The California Court of Appeals imposed a duty to warn on the physician to inform the patient of these effects although that information was received after he had treated the patient.[34] Likewise, in *Tarasoff v. Regents of the University of California*, the court imposed on a psychotherapist the duty to warn others of a patient's threats to kill a specific victim.[35] The psychotherapist had a duty to warn based on the acquisition of information during the course of treatment.

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25. CSID is a condition in which antibody formation and cellular immunity are deficient. Bone marrow transplants may be an effective treatment. *See* 11 INTERNATIONAL DICTIONARY OF MEDICINE & BIOLOGY 1406 (1986); STEDMAN'S MEDICAL DICTIONARY 766-67 (1990).

26. *Olson*, 252 Cal. Rptr. at 12.

27. The adopted child was originally diagnosed with disgammaglobulin anemia in 1971. Some uncertainty existed whether that diagnosis was equivalent to CSID. No question exists the agency knew of the child's health problems as early as 1971, if not before. *Id.*

28. *Id.*

29. *Id.* at 13.

30. Tarasoff v. Regents of the Univ. of Cal., 131 Cal. Rptr. 14 (1976); Tresemer v. Barke, 150 Cal. Rptr. 384 (Ct. App. 1978).

31. 167 Cal. Rptr. 831 (1980).

32. *Id.* at 835.

33. 150 Cal. Rptr. at 392.

34. *Id.* at 394.

35. 131 Cal. Rptr. at 23-25.

The *Olson* court mistakenly concluded that no nexus existed between "the impending peril and the specific duties undertaken by the "agency and thus these cases were inapposite."[36] While the agency's actions or lack of action did not cause the child's genetic illness, that was not the injury sought to be compensated. An agency's lack of action impacts the birth parents' decision-making process whether to have a child at all or to undergo prenatal testing. The nexus exists between the failure to disclose information and the birth parents' reliance on the agency to provide them with available information to assist in their decision-making.

Had the birth mother known of her first son's ailment, that information would have been invaluable in her decision-making process. Moreover, if that information had been known, her second son might have been diagnosed sooner and received needed medical care. While it may not have made a difference in that child's survival with this particular disorder, it could well impact other disorders and their treatment such as cystic fibrosis.

IV. DUTY TO DISCLOSE

An essential element of a cause of action for negligent conduct is duty. The scope of the duty determines liability.[37] Courts determine the existence of a legal duty "as a matter of law."[38] Generally, at issue is "whether the defendant has any obligation to avoid negligent conduct for the benefit of the plaintiff."[39]

> A person's duty to act with reasonable care does not extend to the world at large, but, rather, is defined and limited by various considerations such as the relation between the parties, the gravity and foreseeability of the harm, the utility of the challenged conduct and the burden of guarding against the injury.[40]

The scope of a tort duty may be circumscribed by the activities, prior conduct, relationship responsibilities, or promises of an entity. Adoption agencies provide prospective relinquishing parents numerous services.[41] The agency worker provides information on various options including relinquishment and keeping the infant. Relinquishment information revolves

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36. *Olson*, 252 Cal. Rptr. at 13.

37. Horak v. Biris, 474 N.E.2d 13, 18 (Ill. App. Ct. 1985).

38. Wimmer v. Koenigseder, 484 N.E.2d 1088, 1090 (Ill. 1985).

39. Duvall v. Goldin, 362 N.W.2d 275, 277 (Mich. Ct. App. 1984) (citing Moning v. Alfono, 254 N.W.2d 759 (Mich. 1977)).

40. *Horak*, 474 N.E.2d at 17; *see* Orrico v. Beverly Bank, 440 N.E.2d 253, 256 (Ill. App. Ct. 1982).

41. *See* CHILD WELFARE LEAGUE OF AMERICA, STANDARDS FOR SERVICES FOR PREGNANT ADOLESCENTS AND YOUNG PARENTS (rev. ed. 1986).

around describing the process[42] and explaining the legal significance of relinquishment. The worker assists with arranging medical care, housing, and other daily living needs. Counseling services include not only dealing with the psychosocial ramifications of each option and decision-making, but dealing with family members and the father of the child. Thus, the agency representative is both counselor and social worker.

Post-relinquishment contact may include continued counseling to deal with the emotional aftermath of relinquishment. This counseling may last a few weeks or a few months. Contact typically diminishes with time.

The agency sets itself up as the intermediary between the birth parents and the adoptive parents. The agency acts, taking affirmative measures which have intended long-reaching consequences. The agency engages in a relationship with the birth parents who envisions a duration into the future. The agency holds itself open through the promises of future information. The agency holds itself out as the information conduit, not only at placement, but indefinitely into the future.

A. Statutory Duty

Few states require disclosure of any information to birth parents at the time of relinquishment.[43] Substantially fewer require disclosure of information received post-relinquishment.[44] Rarely does a state place an affirmative statutory duty on an agency to make efforts to contact birth parents to relay information received. Exceptions include Minnesota and Wisconsin.

Minnesota's statute places a clear duty on the agency:

> Health information. When the agency receives information about a medical or genetic condition which has affected or may affect the physical or mental health of genetically related persons, the agency shall make a diligent effort to contact those persons in order to transmit the health information.[45]

Wisconsin is somewhat more restrictive, placing an affirmative duty only when the information is received from a physician.[46] Neither Wisconsin nor Minnesota courts have, however, been faced with a cause of action based upon these statutes. With little question, such statutory provisions place a duty on the agency that upon breach may find it liable to birth parents for

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42. The birth parent's role in choosing the adoptive parents for her child varies with each agency and the kind of adoption. In an open adoption, the birth parent usually meets with the adoptive parents at least once prior to birth. In a traditional adoption, the birth parent chooses the adoptive parents from profiles and/or pictures.

43. Blair, *supra* note 3, at 731 n.259.

44. ARIZ. REV. STAT. ANN. § 8-129B(3)(e) (1989); MINN. STAT. ANN. § 259.2591(2) (Supp. 1995) (formerly § 259.47(2)); WIS. STAT. ANN. § 48.432(7)(b) (Supp. 1994).

45. MINN. STAT. ANN. § 259.2591(2).

46. WIS. STAT. ANN. § 48.432(7)(b). Wisconsin also provides for immunity from liability for those individuals who "participate[] in good faith in any requirement of this section." § 48.432(8).

failure to disclose. Unfortunately, the vast majority of states do not place a statutory duty on adoption agencies to disclose information to birth parents post-relinquishment.

The Uniform Adoption Act recognizes the need for an affirmative duty to be placed on agencies to relay medical information to birth parents.[47] The Act has only recently been formally approved by the American Bar Association House of Delegates, but is too soon for adoption by any state. Section 8-103(e) provides:

> If the court or agency receives information from an adoptee or an adoptive parent about a health or genetic condition of the adoptee that may affect the health of the adoptee's parent at birth or the adoptee's former relatives, the court or agency shall make a diligent effort to notify these individuals that the information is available and may be requested from the court or agency.[48]

Under this provision, the agency's duty would be to notify the birth parents of the availability of information and not to relay that information directly. While slightly different in scope, this provision would serve the same purpose—to inform birth parents of needed medical information and would place a duty to disclose on the agency.[49]

B. Social Worker Malpractice

In general, a professional who renders services "is required to exercise the skill and knowledge normally possessed by members of that profession or trade in good standing in similar communities."[50] A cause of action in professional malpractice mirrors the elements required in a negligence case—duty, breach, causation and damages.[51]

Courts disagree, however, whether a social worker can be held liable in malpractice.[52] The dispute centers on the nature of social work.[53] First, determination of causation between the alleged injury and the social worker's conduct in a typical social work setting may be difficult to discern.[54] Second, "the damages a client might receive from the improper practice of social work

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47. UNIFORM ADOPTION ACT § 8-103(e) (1994).

48. *Id.*

49. Interestingly, the Uniform Adoption Act expressly provides for a civil penalty and possible criminal sanctions for failure to disclose required information to prospective adoptive parents. *Id.* § 9-105. The Act is silent, however, on liability to birth parents for the same failure to disclose information.

50. RESTATEMENT (SECOND) OF TORTS § 299A (1965).

51. Horak v. Biris, 474 N.E.2d 13, 17 (Ill. App. Ct. 1985).

52. *Compare* Martino v. Family Serv. Agency, 445 N.E.2d 6, 9 (Ill. App. Ct. 1983) *with Horak*, 474 N.E.2d at 19. *See also* Janet B. Jones, Annotation, *Social Worker Malpractice*, 58 A.L.R.4TH 977 (1992).

53. *See* Engstrom v. State, 461 N.W.2d 309, 316-17 (Iowa 1990) (no malpractice action available for adoption agency's failure to determine whether the birth father was living and thus available to contact to request consent for adoption).

54. *Martino*, 445 N.E.2d at 9.

are unlikely to be pecuniary in nature and extremely unlikely to be physical in nature."[55] The contrary view focuses on those areas of social work with more well-defined professional standards and principles, specifically marriage and family counseling due to its close relationship with psychology.[56] Indeed, psychotherapist or counselor malpractice is well-established.[57]

When an adoption social worker engages in counseling services, he or she may be exposed to potential liability in malpractice. Pecuniary damages are much more likely for the failure to disclose information, including medical expenses for birth parents and their children. Acting as an information conduit, however, probably does not fall under "counseling." While there may be a counseling component upon the sharing of critical information, the agency's major role and duty would be to accurately and timely transmit information received to the birth parents. Thus, the agency would not be liable for failure to disclose information under the guise of social worker malpractice as that tort is construed today.

The Child Welfare League of America ("CWLA") has, however, promulgated professional standards for social workers associated with adoption services.[58] The CWLA recognizes that the agency has continuing involvement with birth parents post-relinquishment.[59] Moreover, the CWLA acknowledges that receipt of medical information about the child should be relayed to the birth parents.[60] Arguably, the presence of this professional standard defines the social worker's duty to include acting as the information conduit. As a result, malpractice may be a viable cause of action.

C. Special Relationship

The Restatement recognizes that a duty of care may arise from a "special relationship."[61] "Special relationship" is a developing concept in tort law. A duty is recognized "to aid or protect in any relation of dependence or

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55. *Id.*

56. *Horak*, 474 N.E.2d at 19; *see also* Wogelius v. Dallas, 504 N.E.2d 791 (Ill. App. Ct. 1987).

57. Rowe v. Bennett, 514 A.2d 802, 807 (Me. 1986) (psychotherapist); Gasper v. Lighthouse, Inc., 533 A.2d 1358, 1361 (Md. Ct. App. 1987) (marriage counselor), *cert. denied*, 537 A.2d 272 (Md. 1988).

58. CHILD WELFARE LEAGUE OF AMERICA, STANDARDS FOR ADOPTION SERVICE (rev. ed. 1988).

59. *Id.* Standard 0.13. Under this standard an agency's responsibilities to birth parents post-placement are recognized including "[a]ssisting birth parents with unresolved feelings of loss and grief, their need to know about the child's welfare, and the impact of the placement on their marriage and other child rearing and family relationships." *Id.*

60. "Social services to birth parents after termination or transfer of parental rights"

Services should be available to birth parents after their rights and responsibilities are terminated, as well as after the adoption is legalized.

These services can assist birth parents by:

•Helping with the finality of the transfer and immediate plans for their own lives.

•Receiving from them, or **informing them of, newly learned medical or genetic information** that is important for the adopted child and family or for the birth parents and their present children."

Id. Standard 2.6 (emphasis added).

61. RESTATEMENT (SECOND) OF TORTS § 315 (1965).

of mutual dependence."[62] Common characteristics of a "special relationship" include confidence, treatment, and control.[63] The key is control. "In each situation one person entrusts himself to the control and protection of another, with a consequent loss of control to protect himself. The duty to protect is imposed upon the person in control because he is best able to provide a place of safety."[64]

What greater trust can there be than placing one's newborn infant in the care of an agency to find a good home for the child? As the birth parent, one relinquishes all control to another and becomes dependent on that entity to provide for the child and care for that child's best interests. In a modern adoption, the birth parent relies on the agency to provide the information expressly promised, such as letters and pictures, and to be there when the parent has questions or concerns or just needs a listening ear. The agency is the only entity that serves as intermediary.[65] As a result, the agency is in the best position to funnel information between the parties. One year, two years, even ten years later, the adoptive parents are most likely to contact the agency with additional medical information about the adopted child.[66]

As the controller of information, the agency continues in its special relationship with the birth parents. Once received, the agency has control of the information and determines if and when it should be shared. As a result, the agency's failure to disclose crucial medical information in an accurate and timely fashion should expose it to potential liability to the birth parents based upon its special relationship status.

D. Assumed Duty

Duties are also imposed when the actor assumes responsibility for certain actions.[67] When a party aids another, taking charge and control of the situation, "he is regarded as entering voluntarily into a relation which is attended with responsibility."[68] As a result, "he must use due care or act so as not to unreasonably endanger the person or property of another."[69]

Assumption of duty is one theory which has been proposed to support imposing liability upon agencies for failure to disclose information to the

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62. Mann v. State, 139 Cal. Rptr. 82, 86 (Ct. App. 1977).

63. Madley v. Evening News Ass'n, 421 N.W.2d 682, 684 (Mich. Ct. App. 1988); *see* Stiver v. Parker, 975 F.2d 261, 271 (6th Cir. 1992).

64. Williams v. Cunningham Drug Stores, Inc., 418 N.W.2d 381, 383 (Mich. 1988).

65. Obviously, the court which handled the adoption is also in the middle. The adoptive parents are more likely, however, to turn to the agency to share additional information. While the court may be in a position to also act as an information conduit, in all likelihood its role will remain limited without statutory authorization and funding.

66. *See* Blair, *supra* note 3, at 770.

67. W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 56, at 378-92 (5th ed. 1984).

68. *Id.* at 378.

69. Bell & Hudson, P.C. v. Buhl Realty Co., 462 N.W.2d 851, 853 (Mich. Ct. App. 1990).

adoptive parents.[70] No question exists that the agency is not the guarantor of the adopted child's health nor required to discover latent medical conditions. When, however, "the adoption agency took on that duty . . . [and] stood up and said to the world that it would thoroughly investigate the health and medical condition of the children adopted through it," then duty is imposed.[71] The scope of the duty is determined by the agency's own "policies and the representations it made to prospective parents . . . ."[72]

Likewise, when the agency stands up and says to the world that it will be the intermediary between the birth parents and the adoptive parents, that the birth parent will receive on-going information about the child, and that it will be there throughout to serve as that conduit, then the agency has assumed the duty to relay information received in an accurate and timely manner. Birth parents rely on these representations. Their ability to make fully informed decisions about future reproduction is seriously undermined without information concerning the genetic condition of prior children. Critically, neither the birth parents nor their physicians can obtain the medical information directly from the adoptive parents in most adoptions.[73] Thus, the agency is the only party involved who can share the information. As a result, adoption agencies assume a duty to relay that information in an accurate and timely fashion.

V. CONCLUSION

Changed adoption agency practices in response to the changes in the supply and demand of adoptable infants has resulted in a duty to relay medical information received about the adopted child to the birth parents in a timely and accurate manner. While the limitations on any cause of action by the birth parents against the agency are beyond the scope of this essay, birth parents should be able to hold agencies accountable for failure to disclose critical information regarding the adopted child. Some agencies will have this duty imposed statutorily; others through their assumption of responsibility or their special relationship with the birth parents.

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70. Foster v. Bass, 575 So. 2d 967, 986 (Miss. 1990) (Sullivan, J., dissenting).

71. *Id.*

72. *Id.*

73. In an open adoption, a greater likelihood exists that the birth parents will have direct contact with the adoptive parents and would learn of medical conditions of the child through that relationship and would not have to rely on the adoption agency.