The rôle of the medical panel in adoption

by Dr W S Winship

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The legal requirements for a child to be placed in Adoption are fulfilled if a Commissioner for Child Welfare is satisfied that both the child and the parents are suitable.

The Commissioner has clear guide lines with regard to race, religion and age, i.e. adopting parents must be over 25 and he will usually require some evidence of the financial status of the parents BUT he is not obliged to enquire about the health of either the adopting parents or the child who is to be placed with them

This has led to some unfortunate and tragic placements e.g. twins placed with a women with advanced cancer of the breast who died shortly thereafter and young couples being unwittingly saddled with hopeless neurologically compromised children.

Most child welfare agencies in South Africa are aware of the hazards of arranging adoptions without medical advice and in 1975, the National Council for Child and Family Welfare introduced a system of accreditation for its affiliated societies which stipulated that inter alia only those societies who had the services of a Medical Panel could undertake adoptions.

A Medical Panel to advise on adoptions has existed in Durban since 1960. I have been a member of this panel for ten years.

At present there are nine doctors who serve voluntarily on this panel, two physicians, two obstetricians, three paediatricians and two General Practitioners.

The primary function of the Panel is to meet once a month to peruse the various Medical Certificates pertaining to:-

1 The natural mothers (pregnancy and delivery).
2 The natural fathers (if possible).
3 The infants given for adoption (immediate and final).
4 The applicant adoptive parents.

. These certificates have been drawn up and improved over the years by experienced members of Medical Advisory Panels from different centres in the Republic and when carefully completed, enable the Medical Panel to assess the medical suitability of both progressive adoptive parents and infants given for adoption.

Of particular importance are the histories of the natural parents in order to assess possible genetic disorders and information relating to the quality of the mother's pregnancy and the delivery of the baby.

Assessing a newborn infant is like looking at an iceberg. Only the grossest of abnormalities are apparent immediately. Some problems can be resolved by careful examination and by investigations such as urine examination and blood tests for syphilis and thyroid function.

These are the intermediate problems seen just below the surface effected in the Preliminary Certificate but there are many factors which may affect a child's life in the future which are not revealed immediately and it is important that all children who are placed in adoption be re-examined before the adoption is finalized.

At six weeks most congenital heart lesions will have become apparent and by three months a reasonable assessment of the infant's neurological status can be made.

The Final Certificate required by the National Council is completed when the child is more than three months old.

As most of these examinations are

conducted by family practitioners who rarely make this detailed assessment, a guide to neurological development devised by Molteno et al in Cape Town is included with this certificate.

The certificates pertaining to applicant parents are modelled on insurance examination forms and require the Practitioner to give a guide to the Medical Panel as to the general health of the couple.

When reviewing these forms Panel Members must be able to assess whether there is any factor which might shorten either parent's life span and it is imperative that information be supplied on any operation that has been undertaken e.g. Why was a hysterectomy done? Was there a carcinoma of the cervix perhaps?

We have had certificates simply stating that the husband had a thoracotomy scar.

We need to know why and what was found. Chest X-ray and urine results must be seen by the panel.

'To achieve the goal of a well-placed infant in a happy family, there must be lots of room to manoeuvre and a multi-disciplinary team approach.'

Should any doubts exist the panel will refer the certificate back to the family Doctor with a request for further details or will ask for Specialist Reports.

During the ten years that I have been a member of the Durban Child and Family Welfare Society Medical Advisory Panel, 688 couples have been considered.

Of these only 30 were rejected on medical grounds.

The majority, 22, were for conditions which were considered likely to shorten the life expectancy of one or both of the applicants significantly, i.e. that the individual was unlikely to survive until the child they wished to adopt would reach adulthood.

Obviously the age of the applicants is important and as a rule no applicant over the age of 40 is considered.

The other eight applicant couples were not accepted for psychological or social reasons.

In the past an attempt was made to ensure that all babies who were adopted were normal but as I have indicated there are many babies who will manifest problems in later life which cannot be detected early, e.g. Epilepsy and learning problems which are only discovered after the child goes to school.

Certain risk factors however are identifiable and whereas many infants considered at risk used to be consigned to institutional care, it is our policy to try and place such infants with carefully selected parents.

These are always parents seeking an additional child and many of them have indicated their willingness to accept a possibly compromised child in response to a circular sent to members of the adoptive parents association.

During the ten year period under review 602 babies were placed in adoption and only one (Down's Syndrome with an Endocardial Cushion Defect of the heart) was rejected. 48 "At risk infants" were placed in selected families.

Of these 32 had potential neurological problems. In some more than one factor was evident resulting in a total of 45 factors, e.g. the baby on whom an abortion had been attempted was small for gestational age and some of the preterm infants had low Apgar scores, or the Respiratory Distress Syndrome but all had received expert neonatal care.

A further 14 had anatomical defects — some more severe than others, e.g. two of the Cardiac defects had Tetralogy of Fallot, one of which has had a successful surgical correction, as will the other in due course. Another with a Type 4 Truncus Arteriosus died when she was 14 months old but she had a happy albeit short life with devoted and loving parents.

It is our experience that well motivated and well supported couples can adopt "at risk children" most successfully.

A little girl born to a mother who presented in labour and did not inform anyone that she was a diabetic, developed severe hypoglycaemia causing a convulsion shortly after birth.

She was extremely floppy thereafter and could not be passed as a normal baby for adoption. She was placed with a couple for two years before her adoption was finalized by which time they had recognised her limitations but were prepared to give her every chance of a happy life.

She is now six and has specific learning problems requiring special education — but she has had occupational therapy since she was three and is a happy and much loved daughter and sibling in a well adjusted family instead of being another lonely statistic in the records of an institution — a burden to society.

Over a ten year period, out of 688 couples considered only 30 were rejected on medical grounds

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The Medical Advisory Panel has therefore more than a selective function but also a responsibility to ensure the best possible opportunity for the children they consider and the parents with whom they place them.

This can only be achieved by good long-term cooperation with the Social Workers of the Society or Adoption Agency which the Panel serves.

In this paper I have outlined the functions and responsibilities of the Medical Profession in the Adoption process. It is entirely a medical function and should always remain so.

The investigation of the social aspects and matching of parents and children is a matter for social workers.

I believe very strongly that Doctors who indulge in placing infants privately in adoption engage in a hazardous game with a very narrow fairway, surrounded by impenetrable rough and intersected by numerous traps. Furthermore he is likely to come short because he has no follow through.

To achieve the goal of well placed infant in a happy family there must be lots of room to manoeuvre and a multi-disciplinary team approach.

Dealing with a wide selection of prospective parents and babies allows the most suitable placements in the most satisfactory families with the minimum of errors. □