The Relinquishing-Adopting Patient and the Family Physician

Sandy Wherley, MA, Peggy Hauser, MSW, and Richard E. Anstett, MD, PhD
Denver, Colorado

DR. RICHARD ANSTETT (*Family Physician*): Today we have the opportunity to learn what the primary care physician needs to know about issues related to adopting, parenting, and relinquishing babies. This forum is intended to allow for an open discussion between panel members and the audience, who are students, family practice residents, and faculty at the Saint Joseph Family Practice Residency Program in Denver, Colorado.

On this panel we have people who work professionally in the area of adoption and relinquishment; and we also have people who have experienced these issues in a very personal way. We will begin by introducing the panelists:

MARY (*Adoptive Mother*): I am an adoptive mother. I am here to talk about my experiences with health care professionals during the process of adopting our son.

LEANNE (*Relinquishing Mother*): I relinquished my son to Mary and Ron.

RON (*Adoptive Father*): As an adoptive father, I am willing to share my views about the role of health care professionals in the adoption of our son.

PATTI (*Foster Mother*): I am a foster mother, and I am adopting a baby that I have had in my care as a foster child.

JENNIFER (*Single Parent*): I was thinking about relinquishing, but I decided to be a single parent instead.

MS. PEGGY MARTIN (*Adoption Agency Representative*): I am the program director for Adoption Connection through Jewish Family Services and The Children's Hospital in Denver. I work with relinquishing parents and parents who are considering relinquishing as well as prospective adoptive parents.

MS. SANDY WHERLEY (*Psychotherapist, Family Practice Residency, Saint Joseph Hospital*): I work with people who are having difficulty coping with family stresses and life changes. I believe that the primary care physician is in an excellent position to offer support and guidance to patients who are in the process of relinquishing, adopting, and parenting.

MS. PEGGY HAUSER (*Social Worker, Saint Joseph Hospital*): I am a hospital social worker, and I receive referrals on young women who may be ambivalent about their decision to parent or to make an adoption plan for their child.

DR. ANSTETT: Let me start out by asking the adoptive parents, Mary and Ron: What were you looking for when you first approached the medical profession with the issue of wanting to have children and exploring alternatives? What did you want your physician to do in helping you through the process?

MARY (*Adoptive Mother*): I think that, because we are a classic example of an infertile couple, we spent a lot of time having people tell us that we could not do something that we had never thought would be a problem. We spent a lot of time going through the tests. By the time we got to where we were willing and interested in considering adoption, we had been sort of abused. So, the more sensitive a doctor can be, the better.

DR. ANSTETT: Could you explain your statement about feeling "abused"?

MARY (*Adoptive Mother*): People suggested many alternatives to facing the issue of infertility. First of all, we felt abused physically after being tested, and we felt abused emotionally from struggling with our decision to go through the tests. Then, we felt frustrated and abused about the fact that in Colorado a typical adoption can take from five to seven years to complete.

RON (*Adoptive Father*): From my perspective, I thought the most important aspect in being treated by a physician was the trust that is established between patient and physician. Mary and I were typical—apprehensive at first about the request to meet with Leanne (the relinquishing mother), and worried about whether we would be seen as acceptable parents. That our physician recognized our concerns was very helpful. In retrospect, it was a very good experience. Most people have a fear of the unknown and must choose, in this kind of a process,

Submitted, revised, December 21, 1988.

From the Family Practice Residency Program, Saint Joseph Hospital, Denver, Colorado. Requests for reprints should be addressed to Ms. Sandy Wherley, Family Practice Center, 1201 E 17th Ave, Suite 200, Denver, CO 80218.

whether to give in to the fear and avoid meeting the birth mother and possibly not adopting, or to go ahead and take the risk of meeting her. Once we did get to meet each other, I knew that all of us were making the right decision. What became important to me from that day on is that we had a doctor who gave the special attention to Leanne that I felt she needed. He gave it to us, also. It is important to have a doctor that you feel you can trust because you are putting your life, and in a sense your emotions, those things that most of us do not want to bare very often, out on the table.

LEANNE (*Relinquishing Mother*): When I was about six months pregnant, I told my physician that I felt I was not capable financially and emotionally at the time to take care of another child, and I wanted to relinquish my baby. I also said that I wanted to meet the parents, and that, if I could not meet the parents, I did not want to relinquish. I was warned that very few, if any, adoptive parents would be willing to take the risk of meeting the birth mother because it is such an emotional risk to both parties. We found Mary and Ron, and it has worked well. So I think that if a patient should tell you this is what they want to do, it is important to be supportive and to say yes. It can be a very positive experience.

PATTI (*Foster Mother*): I think in the 1980s there are so many unique opportunities. Leanne was able to get her needs fulfilled. If it had not been for a doctor who was willing to take the extra time to put these families together, this situation might not have worked. Each of these people had their needs fulfilled because someone in the medical profession was able to take the time and effort to work with them.

DR. ANSTETT: Jennifer, how was your physician helpful in your decision making concerning parenting?

JENNIFER (*Single Parent*): When I first went to my physician, I went with my father, my boyfriend, and my baby. I still was not sure whether I wanted to keep my baby or relinquish her. My doctor kept me open to my options and understood that I still was unsure. He did not push me into making a decision, and he understood my ambivalence. He also directed me to another adoption agency because the first one was not meeting my needs.

DR. ANSTETT: Physicians involved in these adoption-relinquishment situations have to assume a triple advocacy role. They are advocating for the birth parents, for the potential adoptive parents, and of course for the baby. I would like to hear from the people who understand this position from the agency level. How can physicians use the agencies to make these kinds of things work? Obviously, this area is not part of the training for physicians, but there are people who have had training in these skills and have expertise.

MS. MARTIN (*Adoption Agency Representative*): I have worked with many physicians in the adoptive process, and agencies also are placed in the position of having to play a triple advocacy role. It is a very difficult role. The advantage of the adoption agency is that I can assign one social worker to work with the birth parents and another to work with the prospective adoptive parents. I usually take on a role as mediator and negotiator, and try to keep everything running smoothly. It is important that the physician is familiar with the adoption agency with which he or she is working, and with how the agency handles different situations. Physicians should also be aware that it is often necessary to repeat information many times before the patient understands what is being said. People are very anxious when they are making adoption decisions because the situation is extremely emotional.

Certainly, if a physician has any questions, it is important to feel there is easy access to the adoption agency. Communication is extremely important because feelings are intense and decisions are made often under urgent conditions. It is, therefore, important that the physician work with an adoption agency that is responsive. If agency personnel are responsive to the physician, then they are going to be responsive to the patient. I would also look for an agency whose personnel are willing to meet with the physician in his office to tell him about the agency's program because the physician is a key person in this process.

MS. HAUSER (*Social Worker*): I think we should explain that by Colorado law as of October 1, 1987, any birth parent who relinquishes a child for adoption must receive relinquishing counseling. If both parents are involved, they must both have counseling by a private or public agency. Under this new law, no one can legally adopt without some counseling by an agency. In the long run this law will be beneficial to everyone because counseling addresses such important questions as, Are you making this decision fully aware of the future ramifications? Have you discussed your decision with your family and with the father of the child? Are you sure you can live with this decision? Since these issues are critical when the decision has lifelong impact, the more the parents can come to terms with their feelings through counseling, the more likely they will make a good decision. The adoption agency can also be available to relinquishing parents after the adoption is finalized. Sometimes, they may want to be in contact with the agency for many years afterward. Good counseling is critical to a successful adoption.

In addition, adoptive parents have to complete an adoption study. Agencies have come a long way in acknowledging that people cannot be perfect parents, and they are now preparing people for the adoption issues that are likely to be experienced with their adopted children. Adoption is now more open than ever before, and we anticipate that this openness will continue with the children who are involved in adoptions. These areas are some

continued on page 260

continued from page 258

of those with which adoption agencies can help. The physician often cannot spend the time needed with all the parties involved. Physicians can be supportive, but agencies are in the best position to provide counseling.

DR. ANSTETT: I think that the family physician is able to provide some beneficial counseling to the parents because of the long-standing relationship with the patient and family. Also, if adoption agencies are looking for babies for families to adopt, how do I know that somebody is getting an objective counseling experience?

MS. HAUSER (*Social Worker*): Sometimes birth parents do not feel comfortable with a certain agency. They may feel some pressure, and if so, you should suggest that they talk with another agency. There are probably 20 agencies in Colorado.

MS. MARTIN (*Adoption Agency Representative*): It is important to look for an agency that is willing to address the needs of the adoption triad. Also important is choosing an agency that works within the boundaries of the law, to protect the birth parents, the baby, and the adoptive parents.

MARY (*Adoptive Mother*): Although adoptive parents may feel like they are constantly having to prove themselves, going through the agency process is probably the most valuable thing that we did. Having had a physician I could talk with about how I felt was invaluable. There were frustrations and anxieties that I was reluctant to admit. Family physicians have the opportunity to bridge that gap by allowing and facilitating discussions of these emotions.

MS. WHERLEY (*Psychotherapist*): In particular, it is important for the family physician to be aware of the mourning process that the relinquishing parents experience. There is also a unique sense of loss on the part of the adoptive parents, who have had to let go of the dream of having their own biologic child. The family physician should be aware of these issues and be able to discuss them in an empathic way.

JENNIFER (*Single Parent*): Having an unbiased doctor was really important for me. The first adoption agency that I was using was very biased. I felt that all they wanted was my baby. My physician helped me get in touch with a better adoption agency. In the end, when I told him I had decided to keep my baby, my doctor was really supportive of that.

MS. MARTIN (*Adoption Agency Representative*): I encourage adoptive parents to develop as many support systems for themselves as they can. Encourage patients to talk with people who are experienced in areas relevant and pertinent to the issues. I have worked with a number of women who have become involved with Social Services because they have either abused or neglected their child. Rather than having Social Services proceed with an involuntary relinquishment, some have elected to relinquish voluntarily and choose a family for their child. If a family physician should encounter a birth mother who is involved with Social Services, voluntary relinquishment could be presented as a possible option to her. In this way she can have some control over her child's future. The mother must be mentally competent, however.

DR. TARY SANDQUIST (*Resident in Family Practice*): What are the agency guidelines for the ages of the prospective adoptive parents?

MS. MARTIN (*Adoption Agency Representative*): Most agencies set 70, 71, or 72 years for the combined ages. Age limitations vary, too, with the kind of adoption. A designated adoption is much more flexible. A designated adoption means that an adoptive couple and a birth mother or birth couple become aware of each other and want to proceed with an adoption knowing each other. A physician, friend, or attorney has brought the two parties together; they then work through the agency regarding counseling and the legal aspects. Not everyone chooses to do what Mary, Ron, and Leanne have chosen. Another option is the more traditional adoption in which the birth mother or couple makes some choices regarding the adoptive parents, but does not want to know their names. The birth mother may not want to meet the adopting couple, she may want to meet them, or she may want ongoing contact with them through the agency. There is quite a range of options.

DR. MARK ROJEC (*Resident in Family Practice*): Have there been instances where designated adoptions have been carried through, and some conflict ensued later?

MS. MARTIN (*Adoption Agency Representative*): Those instances do occur, although they are fairly rare. Certainly people's feelings change as the situation unfolds; some people will withdraw because they feel that they invested too much and become frightened. We try to spend a lot of time with people beforehand to make sure that they are going through the adoption process because they really believe in it. As you can imagine, when these agreements do not work out, the amount of time required is phenomenal.

For example, if there are serious medical problems with the baby, the prospective adoptive couple may choose not to honor their placement agreement. The agency then must search for another suitable family who can meet the baby's needs. Even when adoptions run smoothly, because so many people are involved, it takes a great deal of time. Physicians need to be aware of the time investment if they choose to get involved in any way. The physician should define his role in the adoption process and carefully consider his limitations.

DR. GEORGE QUICK (*Resident in Family Practice*): What is the best way for an adoptive couple to go about getting an adoption arranged without having to wait for years?

MS. MARTIN (*Adoption Agency Representative*): I tell people to tell everybody and anybody that they are interested in adopting.

MARY (*Adoptive Mother*): We would never have been able to adopt had Ron and I not committed ourselves to telling everybody we know, in one way or another.

RON (*Adoptive Father*): We found it useful to write primarily to doctors, attorneys, and people in the professional area who come in contact with parents who may be considering relinquishing.

PATTI (*Foster Mother*): I was pregnant almost two years ago, and when I miscarried, I was desperate for a child. A nurse suggested that I become a foster mother, and the experience has been very rewarding. As family physicians, you may come into contact with patients who want a baby today, tomorrow, next week. Foster parenting can fulfill a great need, both for the foster parent and the child.

MS. WHERLEY (*Psychotherapist*): A key point for all of us to remember is that this whole process is really for the good of the child. We need to be sure not to lose sight of that goal. In addition, physicians should be aware that good reading material is available to recommend to patients dealing with some of the issues we have discussed. Examples of some excellent books include *The Adoption Triangle* and *Dear Birthmother: Thank You for Our Baby.*

Suggested Readings

Arms S: To Love and Let Go. New York, Alfred A. Knopf, 1983

Hansen C: Your Choice: A Young Woman's Guide to Making Decisions About Unmarried Pregnancy. New York, Avon Books, 1983

Krementz J: How It Feels to Be Adopted. New York, Alfred A. Knopf, 1982

Lindsay JW: Pregnant Too Soon. St. Paul, EMC, 1980

Melina L: Raising Adopted Children. New York, Harper & Row, 1986

Powledge F: The New Adoption Maze. St. Louis, CV Mosby, 1985

Silber K, Speedlin P: Dear Birthmother: Thank You for Our Baby. San Antonio, Corona Press, 1983

Sorosky A, Baran A, Pannor R: The Adoption Triangle. New York, Anchor Press, 1979