



# **Handbook of Law for Michigan Ob/Gyns**

***From the U-M Sexual Rights and Reproductive Justice Program***

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## **DISCLAIMER**

This is a general document that should never be used in place of formal legal advice. All legal advice must come from your lawyer. For employees of the University of Michigan, all legal advice should be obtained from the Office of the General Counsel.

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# ABOUT THIS HANDBOOK

*This document provides a general introductory review. Because this area of the law can change rapidly, for current advice on specific issues please consult the Health System Legal Office ([http://www.ogc.umich.edu/healthsystems\\_office.html](http://www.ogc.umich.edu/healthsystems_office.html)) at 764-2178.*

## **Introduction**

The Sexual Rights and Reproductive Justice Program, part of the University of Michigan Department of Obstetrics and Gynecology, has created this handbook to assist Michigan health care professionals in providing care to women in Michigan. As an introduction to Michigan law and ethical rules, it is not a substitute for legal advice, but rather is designed to provide basic information that allows providers to understand the issues and ask better questions. Any legal questions must be addressed by the provider's legal advisors. For UMHS, all legal advice is provided by the Office of the General Counsel and its Health System Legal Office (764-2178). In cases in which the law is unsettled, this handbook will note areas in need of clarification but cannot provide resolutions.

The handbook is available online at the Internal Resources page for the Department of Obstetrics and Gynecology (<http://www.med.umich.edu/i/obgyn/>) and is managed by Ed Goldman ([egoldman@umich.edu](mailto:egoldman@umich.edu)). Readers with questions, comments, or ideas for improvement, are asked to please contact Ed. The hope is that this handbook will assist providers as they care for their patients, respond to patient questions, and deal with areas where medical care and law intersect.

This handbook was designed so that each section can stand alone. That means there is intentional repetition throughout the handbook. For example, the Michigan Born Alive Infant Protection Act is discussed wherever it is relevant in multiple sections, including sections 9 and 10. While the handbook can certainly be read from cover to cover, it is best used as a guide to pertinent information when the reader has a specific question regarding a topic listed on the [Table of Contents](#).

This handbook was first created in January 2011 by Ed Goldman, J.D. with the invaluable assistance of Kavitha Shah, J.D. and Deborah Fisch, then a third-year law student and now a practicing lawyer. Both Deborah and Kavitha worked extremely diligently on this project and are well on their way to an exciting life in the practice of law. We want to thank Joanne Bailey, C.N.M., Cynthia Brincat, M.D., Susan Ernst, M.D., Katherine Gold, M.D., Michael Lanham, M.D., Audrey Lance, M.D., Clark Nugent, M.D., Kirsten Salmeen, M.D., Suneeta Senapati, M.D., and Sarah Wallet, M.D. for reviewing this material in draft form and helping to make it relevant to a health professional audience.

## Constitutional Law and Case Captions

In this handbook formal legal citations have been kept in the background. But should the reader be interested, the mechanics of the law are described in the following three paragraphs.

### WHAT IS A STATUTE?

A **statute** is a law passed by a legislature. Michigan statutes are usually cited as MICH. COMP. LAWS § 333.5430, standing for Michigan Compiled Laws, followed by the "section" symbol (§) and a number that locates the law within a certain title: Here, Title 333 is Michigan's Public Health Code, while section 5430 of the Public Health Code concerns the establishment of the state's newborn screening committee.

Federal statutes are usually cited as 23 U.S.C. § 1234 or 45 C.F.R. § 46. The United States Code (U.S.C.) contains laws passed by Congress. The Code of Federal Regulations (C.F.R.) contains regulations passed by federal agencies such as Health and Human Services.

### WHAT IS A CASE?

A **case** is a dispute decided by a court. It is cited with the name of the parties and the court, and a set of numbers indicating where the actual opinion can be located. For example *Jones v. Smith*, 45 Mich. App. 3rd 435, 442 (1995) means the case of Jones v. Smith was decided in 1995 by the Michigan Court of Appeals and can be found in volume 45 of the 3rd series of Michigan case reports beginning at page 435. The particular item being cited is on page 442. While "Mich. App." signifies the Michigan Court of Appeals, "Mich." alone denotes the Michigan Supreme Court. The Sixth Circuit ("6th Cir.") is the federal appeals court for Michigan. "U.S." indicates the United States Supreme Court.

### WHAT IS "BINDING LAW?"

State court decisions are **binding** (i.e. definitively determine the law) only on the state in question. Federal cases decided by the Sixth Circuit Court of Appeals are binding on Michigan because the Sixth Circuit includes the states of Kentucky, Ohio, Tennessee, and Michigan. Constitutional cases decided by the U.S. Supreme Court are the law of the land for all states. For example, *Roe v. Wade* made any state law forbidding abortion in the first two trimesters unconstitutional and therefore unenforceable. Where this handbook cites cases decided by state courts outside Michigan, it is only because these cases are instructive and not because they are the law in Michigan.



# **ISSUES INVOLVING PREGNANCY: GETTING PREGNANT, BEING PREGNANT, AND AVOIDING PREGNANCY**

## **A Woman's Right to Directly Access an ObGyn Provider**

In Michigan, health insurance companies cannot require authorization for a woman to see an in-network ObGyn. The Michigan law addresses access by insured to ObGyns, stating that a health insurer “that requires an insured to designate a participating primary care provider and provides for annual well-woman examinations and routine obstetrical and gynecologic services shall permit a female insured to access an [ObGyn] for annual well-woman examinations and routine obstetrical and gynecologic services.” The insurer “shall not require prior authorization or referral for access...to an [ObGyn] who is participating with the insurer. An insurer may require prior authorization or referral for access to a nonparticipating [ObGyn].”<sup>1</sup>

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<sup>1</sup> MICH. COMP. LAWS § 500.3406m (1998)

# **Enhancing Fertility: Assisted Reproductive Technology Law**

## **Introduction**

Of the many topics encompassed by fertility enhancement, the older ones, such as sperm donation, are more likely to be legally regulated, while newer techniques, such as egg donation, tend to be unregulated. Professional organizations provide some guidelines and citizen advocacy contributes additional guidance, but a great portion is left to the physician's discretion.

## **Egg/Sperm Donation and Recruitment of Donors**

### **SPERM DONATION**

**Anonymous sperm donation** is subject to only **one Michigan law**: any facility providing artificial insemination with anonymous donor sperm must use only **frozen sperm** that is **more than six months old** and, furthermore, must **test the sperm donor for HIV** not only **before the donation**, but **also six months later**, to ensure that the donor had not been exposed to HIV when the donation was made and did not seroconvert in the period shortly after.<sup>2</sup>

Sperm donation and cryopreservation is also regulated under the authority of the **federal Public Health Services Act**<sup>3</sup> by the **FDA Center for Biologics Evaluation and Research**.<sup>4</sup>

- All sperm donation and cryopreservation facilities must register with the FDA and renew that registration annually.<sup>5</sup>
- Donor eligibility must be determined by screening and testing for relevant **communicable disease agents and diseases**,<sup>6</sup> and apply to both **anonymous** and **directed** donations, but *not* to donations where there is an **intimate sexual relationship** between the two parties (i.e. a married couple freezing sperm for their own future use).<sup>7</sup>

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<sup>2</sup> MICH. COMP. LAWS § 333.16273, 333.20179 (1989).

<sup>3</sup> 42 U.S.C. § 264 (2010).

<sup>4</sup> F.D.A., Vaccines, Blood & Biologics, *Tissue and Tissue Products*, <http://www.fda.gov/BiologicsBloodVaccines/TissueTissueProducts/default.htm>, Nov. 9, 2009. Regulation is authorized by 42 U.S.C. § 262 (2003) and 21 C.F.R. § 1271 (2001). Tissue that was collected before May 2005 is covered by 21 C.F.R. § 1270 (2001).

<sup>5</sup> 21 C.F.R. § 1271.21 (2009).

<sup>6</sup> 21 C.F.R. § 1271.45(b) (2009).

<sup>7</sup> Vanessa L. Pi, Note, *Regulating Sperm Donation: Why Requiring Exposed Donation is Not the Answer*, 16 DUKE J. OF GENDER LAW & POLICY 379, 383 (2009).

- The regulations set forth provisions for "**Current Good Tissue Practice**," including requirements relating to facilities, environmental controls, equipment, storage, and labeling, among others.<sup>8</sup>

ASRM/SART views the federal regulations as minimum requirements and recommend a much longer list of procedures for clinics to follow, including:<sup>9</sup>

- **Check communicable disease or antibody status** in the intended **female recipient**: Rh factor, rubella, varicella, gonorrhea, Chlamydia, HIV, syphilis, hepatitis B and C, among others.
- **Carry out genetic evaluation of the donor** for cystic fibrosis and other conditions as suggested by the individual's health history and ethnic background.
- Make a **detailed examination of the donor's health and social history** with limiting factors, including the donor's sexual relationships, substance abuse, hemophilia, prostitution, contact with hepatitis B or C-infected individuals, recent tattoos, needle sharing, jail time, and many others factors.
- **Fresh semen** should be used for insemination **only for sexually intimate couples**; for all other donor/recipient pairs, frozen semen should be used. Even **sexually intimate couples should undergo testing** for communicable diseases.
- The **number of times** a donor may **donate sperm should be limited** in order to avoid the chance of inadvertent consanguineous conception among grown children born from the donor's sperm in a given geographical region.
- **No owner or employee of a clinic may serve as a donor** in that practice, **nor may the patient's physician** or the individual performing the actual insemination.

The guidelines from the two professional medical organizations naturally assume that all sperm donors will work through a medical practitioner, including **directed donors** (e.g. a man donating sperm non-anonymously to a lesbian friend). However, **no Michigan law mandates that a physician be involved**. In contrast, California law requires that directed donation take

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<sup>8</sup> 21 C.F.R. § 1271.150 (2009).

<sup>9</sup> Practice Committee of the American Society for Reproductive Medicine, and the Practice Committee of the Society for Assisted Reproductive Technology, *2008 Guidelines for Gamete and Embryo Donation*, 90 FERTILITY & STERILITY S30, S32-6 (2008), available at [http://www.asrm.org/uploadedFiles/ASRM\\_Content/News\\_and\\_Publications/Practice\\_Guidelines/Guidelines\\_and\\_Minimum\\_Standards/2008\\_Guidelines\\_for\\_gamete%281%29.pdf](http://www.asrm.org/uploadedFiles/ASRM_Content/News_and_Publications/Practice_Guidelines/Guidelines_and_Minimum_Standards/2008_Guidelines_for_gamete%281%29.pdf).

place with the assistance of a physician in order to exempt the donor from possible paternity claims and subsequent child support obligations.<sup>10</sup>

**Directed donors** in Michigan are **protected from allegations of paternity** if the **woman's husband consents to the use of ART** in the child's conception;<sup>11</sup> the husband is registered as the father of the child at birth. In the case of **unmarried** women, directed donors are **not protected** from allegations of paternity.

## EGG DONATION

- 1) **Michigan law does not regulate egg donation.**
- 2) **Federal law for sperm donation applies also to egg donation.** (See above)
- 3) **ASRM/SART egg donation guidelines** mirror those for sperm donation, with **several notable additions**:
  - **Informed consent** must be obtained **before the start of the cycle** of retrieval. The **conditions** governing the sharing of oocytes should be specified in advance and included in the informed consent.<sup>12</sup>
  - If an **agency** is used to recruit oocyte donors, no individual who has a **financial interest** in that agency may be used as an oocyte donor.<sup>13</sup>
  - Donors should undergo a complete **physical examination** before acceptance as a donor, and every six months after acceptance during the time when remaining active donors. The following findings preclude acceptance as a donor: sexually transmitted diseases, substance abuse, recent tattooing or piercing, and others.<sup>14</sup>

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<sup>10</sup> "The donor of semen provided to a licensed physician for use in artificial insemination of a woman other than the donor's wife is treated in law as if he were not the natural father of a child thereby conceived." *Jhordan C. v. Mary K.*, 224 Cal.Rptr. 530 (Cal. Ct. App. 1986).

<sup>11</sup> "A child conceived by a married woman with consent of her husband following the utilization of assisted reproductive technology is considered to be the legitimate child of the husband and wife." MICH. COMP. LAWS § 333.2824(6) (1997).

<sup>12</sup> Practice Committee of the American Society for Reproductive Medicine, and the Practice Committee of the Society for Assisted Reproductive Technology, *2008 Guidelines for Gamete and Embryo Donation*, 90 FERTILITY & STERILITY S30, S37 (2008), available at [http://www.asrm.org/uploadedFiles/ASRM\\_Content/News\\_and\\_Publications/Practice\\_Guidelines/Guidelines\\_and\\_Minimum\\_Standards/2008\\_Guidelines\\_for\\_gamete%281%29.pdf](http://www.asrm.org/uploadedFiles/ASRM_Content/News_and_Publications/Practice_Guidelines/Guidelines_and_Minimum_Standards/2008_Guidelines_for_gamete%281%29.pdf).

<sup>13</sup> *Id.*

<sup>14</sup> *Id.* at S39.

The question of **payments to egg donors** is often fiercely debated, but there is no legal restriction on such payments. ASRM recommends certain limits on payments.<sup>15</sup>

## Surrogacy

### COMMERCIAL SURROGACY

**Commercial surrogacy contracts**, in which a surrogate is paid a fee to bear and deliver a child, **are not valid** in Michigan.<sup>16</sup> Not only are such contracts unenforceable under state law, but acting as a paid surrogate or hiring a surrogate is a **criminal felony offense**.<sup>17</sup> For a **third party**, such as a **physician**, to **facilitate the formation of such a contract** constitutes a lesser **felony**.<sup>18</sup>

### ALTRUISTIC SURROGACY

**Altruistic surrogacy arrangements**, in which surrogates are paid only for expenses related to the pregnancy, are not fully prohibited,<sup>19</sup> but **any arrangements** made between surrogates and intended parents are **legally unenforceable**. Should a dispute arise between the parties, the party who has physical custody of the child (typically the surrogate) will retain custody until the courts make a permanent custody decision based solely on the **best interests of the child**.<sup>20</sup>

### PARENTAGE DETERMINATIONS AFTER SURROGACY

Law that is unfavorable to surrogacy does not easily grant parentage to intended parents. In one recent Michigan surrogacy dispute, custody of twins was returned to the surrogate mother.<sup>21</sup> The twins were conceived from donor sperm and eggs, and so had no genetic relationship to the surrogate; nevertheless, Michigan law recognized her as the mother of the children.

Indeed, it was this lack of genetic connection with either the surrogate or intended parents that made the determination possible: giving birth imparts a presumption of parentage in the absence of a genetic relationship. In one Michigan case, in which the surrogate was inseminated

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<sup>15</sup> The Ethics Committee of the American Society for Reproductive Medicine, *Financial Incentives in Recruitment of Oocyte Donors*, 82 FERTILITY & STERILITY S40 (2004).

<sup>16</sup> MICH. COMP. LAWS § 722.855 (1988). The Michigan statute followed the lead of *In the Matter of Baby M*, 537 A.2d 1227 (N.J. 1988), which invalidated surrogacy contracts in New Jersey.

<sup>17</sup> MICH. COMP. LAWS § 722.857 (1988).

<sup>18</sup> MICH. COMP. LAWS § 722.859(3) (1988).

<sup>19</sup> Any such agreement may not include both a promise to conceive and bear a child and also a promise to terminate parental rights and relinquish the child. *Jane Doe v. Attorney Gen.*, 487 N.W.2d 484, 485 (Mich. App. 1992).

<sup>20</sup> MICH. COMP. LAWS § 722.861 (1988).

<sup>21</sup> Stephanie Saul, *Building a Baby, With Few Ground Rules*, N.Y. TIMES, Dec. 13, 2009, at A1.

with the intended father's sperm, the court permitted the intended father to file a claim of paternity for the resulting child even though the law initially named the surrogate's husband as the father of the child.<sup>22</sup> (For more details on this "husband presumption" of paternity, [see Parentage Determinations.](#))

## ACOG SURROGACY RECOMMENDATIONS

The American Congress of Obstetricians and Gynecologists (ACOG) has issued the following recommendations for physicians who wish to facilitate surrogacy arrangements:<sup>23</sup>

- **Medical, fertility, and psychological screening** should be carried out for the intended parents and the surrogate.
- **Counseling** should be provided for all parties before the initiation of the pregnancy.
- Surrogacy arrangements should be overseen by **private nonprofit agencies**.
- **Physicians** should be **compensated for medical costs only**, not for referrals.
- All parties should consider and **record in writing all preconditions and contingencies** regarding the pregnancy, birth, and subsequent care of the child.
- The **intended parents and the surrogate** should **not receive medical care from the same physician**.

[Note: ACOG recommendations regarding payments to surrogates do not reflect Michigan's exceptionally strict law against surrogacy contracts (*see above*). Michigan physicians should therefore ignore these recommendations.]

## ART Treatments

Most ART treatments are not bound by law beyond the regulations imposed by the federal government on the certification of ART facilities. Physicians should therefore follow their usual system of treating within the bounds of standard practice, as determined by custom and professional guidelines. A few notes on specific treatments are outlined below.

As of January 2015, the University of Michigan provides covers in vitro fertilization in most of its insurance plans. See <http://www.geo3550.org/category/healthcare/> for details.

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<sup>22</sup> *Syrkowski v. Appleyard*, 362 N.W.2d 211 (Mich. 1985).

<sup>23</sup> ACOG Committee on Ethics, *Surrogate Motherhood*, Feb. 2008, available at [http://www.acog.org/from\\_home/publications/ethics/co397.pdf](http://www.acog.org/from_home/publications/ethics/co397.pdf).

## ARTIFICIAL INSEMINATION BY DONOR OR INTRAUTERINE INSEMINATION

As discussed above, AID (or artificial insemination by husband, for that matter) can be carried out privately by the parties in question. IUI is naturally carried out by the physician, and standard practice guidelines apply.

## IN VITRO FERTILIZATION

The chief controversies in IVF are the **number of embryos to be implanted** and, consequently, the possible need for **pregnancy reduction**.

- **Number of embryos implanted per cycle.** While many other countries limit this number by law, the United States has refrained from federal regulation.
- **Multifetal pregnancy reduction.** This procedure, which selectively **destroys** one or more implanted **embryos or fetuses** in a multiple pregnancy in order to **afford the remaining fetus a better chance**, has often been compared to **abortion**. However, legal scholars have argued that the procedure is better compared to a **miscarriage**, since the "resulting loss of the fetus(es) is a necessary but not a desired result of the fertility enhancement treatments. As with miscarriage, there should be no room for selective reduction under the law's conception of abortion."<sup>24</sup> This view is supported by the Michigan Legislature's definition of abortion: "... the intentional use of an instrument, drug, or other substance or device to terminate a woman's pregnancy **for a purpose other than to increase the probability of a live birth, to preserve the life or health of the child after live birth...**"<sup>25</sup> These exceptions are the very essence of multifetal pregnancy reduction.

## PREIMPLANTATION GENETIC DIAGNOSIS

**Preimplantation genetic diagnosis** is not regulated by federal or Michigan statutes. Genetic testing in general is minimally regulated ([See Genetic Information Nondiscrimination Act](#) and special informed consent<sup>26</sup> in [Breast Cancer Law in Michigan](#)).

Because PGD assumes the possibility of destroying an embryo carrying unwanted genetic traits, the practice is somewhat controversial. However, a 2004 study found that only 19% of those surveyed would ban PGD.<sup>27</sup> The more contentious ethical questions concern the **selection**

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<sup>24</sup> Stacey Pinchuk, *A Difficult Choice in a Different Voice: Multiple Births, Selective Reduction and Abortion* 38 DUKE J. GENDER L. & POL'Y. 29, 38, (2000).

<sup>25</sup> MICH. COMP. LAWS § 333.17015(2)(a) (2006).

<sup>26</sup> MICH. COMP. LAWS §§ 333.17020 & 333.17520 (2000).

<sup>27</sup> Susannah Baruch, Presentation at John Hopkins University (Feb. 15, 2009): PGD: Genetic Testing of Embryos in the United States, Genetics and Public Policy Center, *available at* [http://ec.europa.eu/dgs/jrc/downloads/jrc\\_aaas\\_2009\\_03\\_baruch\\_pgd.pdf](http://ec.europa.eu/dgs/jrc/downloads/jrc_aaas_2009_03_baruch_pgd.pdf).

**of embryos for non-disease traits**, such as height, **non-medically indicated sex selection**, and **sibling donor compatibility selection**.

## CLONING

**Human cloning** or attempts at it are illegal in Michigan.<sup>28</sup> **No state funds** may be used to **finance** human cloning research.<sup>29</sup> Although cloning is **not prohibited by federal law**, **no federal funds** may be used to **finance** human cloning research.<sup>30</sup>

## Regulation of ART Programs

### PUBLICATION REQUIREMENT

The **Fertility Clinic Success Rate and Certification Act of 1992** charged the Secretary of Health and Human Services with developing a program through the Centers for Disease Control and Prevention to **identify and certify ART programs** (i.e. facilities) and to **publish each program's success rate**.<sup>31</sup> This rate was defined in two parts:<sup>32</sup>

- 1) **Basic live birth rate**: the number of pregnancies which result in live births divided by the number of ovarian stimulation procedures.
- 2) **Live birth rate per successful oocyte retrieval**: the number of pregnancies which result in live births divided by the number of successful oocyte retrieval procedures.

The resulting model certification program for embryo laboratories covers "in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer, embryo cryopreservation, oocyte or embryo donation, and gestational surrogacy."<sup>33</sup> The list of clinic success data is available at <http://www.cdc.gov/art/ARTReports.htm>.<sup>34</sup>

### RECORDS RETENTION

Once a tissue donor has been screened and tested for communicable diseases, the Fertility Clinic Success Rate and Certification Act mandates that all records of the tests and the

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<sup>28</sup> MICH. COMP. LAWS §§ 333.16274(1)(1978), 750.430a (1999).

<sup>29</sup> MICH. COMP. LAWS § 333.26403 (1999),

<sup>30</sup> William J. Clinton, Memorandum for the Heads of Executive Departments and Agencies, Prohibition on Federal Funding for Cloning of Human Beings, Mar. 4, 1997, *available at* [http://grants.nih.gov/grants/policy/cloning\\_directive.htm](http://grants.nih.gov/grants/policy/cloning_directive.htm). President Obama reaffirmed this prohibition at the same time he lifted President George W. Bush's ban on stem cell research. Sheryl Gay Stolberg, *Obama Lifts Bush's Strict Limits on Stem Cell Research*, NY TIMES, Mar. 10, 2010.

<sup>31</sup> Pub. L. 102-493, 42 U.S.C. §§ 263a-1 et seq. (2009).

<sup>32</sup> 42 U.S.C. § 263a-1(b)(2) (2009).

<sup>33</sup> 63 Fed. Reg. 60178 (Nov. 6, 1998).

<sup>34</sup> Centers for Disease Control and Prevention, *Annual ART Success Rates Reports*, <http://www.cdc.gov/art/ARTReports.htm>, Feb. 18, 2010.



subsequent eligibility status of the donor **must be retained for at least ten years.**<sup>35</sup> However, all of the **donor's identifying information must be deleted** from the record because the goal is to track the tissue, not the donor.<sup>36</sup>

### **Disposition of Embryos**

Because of the medical ability to preserve embryos, sperm, and even oocytes for long periods, disputes can arise about the disposition of these materials following a divorce, a death, or simply a disagreement. The most complicated scenarios concern embryos, since by definition more than one person's gametes were used in their formation.

#### **WHO OWNS THE EMBRYO?**

Michigan statutes are silent on the question of ownership of embryos created in the process of assisted reproductive technology. The Michigan Court of Appeals declined in 1999 to frame such disputes as a question of custody rights.<sup>37</sup> For that reason, ownership of these embryos typically is **determined by the contract** signed by the parties before beginning the ART program. The contract details disposition of the embryos in the event of death or divorce, loss of contact with the program, non-payment of storage fees, or by mutual decision of the parties. **Physicians should be sure that this contract is signed before beginning treatment.** If the parties wish to alter the contract before signing, they should be referred to the Health System Legal Office.

Courts in other states have tended to find that an embryo is neither human life nor property and that it should not be implanted unless both the parties who created the embryo agree to implantation.

#### **HOW DOES THE MICHIGAN PROBATE CODE TREAT CHILDREN CONCEIVED THROUGH THE USE OF ART?**

A child conceived by a married woman with the consent of her husband following utilization of assisted reproductive technology is considered their child for purposes of intestate succession.<sup>38</sup>

#### **IS POSTHUMOUS REPRODUCTION LEGAL?**

Can a woman have embryos implanted or undergo artificial insemination after the death of her husband, who consented to the creation of the embryos and/or contributed the sperm? Once the question of ownership is settled (*see above*), the answer is **yes**. However, most court

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<sup>35</sup> 21 C.F.R. § 1271.55(d)(4) (2009).

<sup>36</sup> 21 C.F.R. § 1271.55(c) (2009).

<sup>37</sup> *Bohn v. Ann Arbor Reproductive Med.*, 1999 WL 33327194, at 6 (Mich. App. 1999).

<sup>38</sup> MICH. COMP. LAWS § 700.2114(a) (2004).

cases on posthumous reproduction address whether a child so conceived can a) **inherit** from the deceased parent, and b) receive **Social Security payments** as the deceased parent's beneficiary.

#### CAN A POSTHUMOUS CHILD INHERIT FROM A DECEASED PARENT?

**Maybe. Inheritance rights** of posthumously conceived children are based on state law.<sup>39</sup> **Michigan courts have not addressed this question**, so it is uncertain whether a posthumously conceived child in Michigan would inherit from a deceased parent.

#### CAN A POSTHUMOUS CHILD RECEIVE SOCIAL SECURITY BENEFITS FROM A DECEASED PARENT?

**Maybe.** According to the U.S. Supreme Court, **state inheritance law** controls whether posthumously conceived children are granted **Social Security benefits**.<sup>40</sup> Since no specific Michigan law exists on this point, adjudications are based on the following **alternative criteria**:

- 1) The posthumous child must demonstrate that both parents went through a marriage ceremony that would have been valid except for certain legal impediments;<sup>41</sup> or
- 2) The deceased parent must have (a) acknowledged in writing that the person is his or her son or daughter, (b) been decreed by a court to be the person's father or mother, or (c) been ordered to pay child support;<sup>42</sup> or
- 3) The posthumous child must prove that the deceased individual was the child's parent and was living with or contributing to the child's support when the parent died.<sup>43</sup>

The law in this area is new, complex, and uncertain.<sup>44</sup> A physician should therefore advise any patient considering posthumous reproduction to **consult an attorney**.

#### MAY EMBRYOS BE SOLD OR DONATED?

While **no** federal or Michigan **law explicitly prohibits the sale of embryos**, it seems unlikely that any government would countenance such a sale: if embryos are considered

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<sup>39</sup> 42 U.S.C. § 416(h)(2)(A).

<sup>40</sup> *Astrue v. Capato*, 132 S. Ct. 2021, 566 U.S. 132 (2012).

<sup>41</sup> 42 U.S.C. § 416(h)(2)(B).

<sup>42</sup> 42 U.S.C. § 416(h)(3)(C)(i).

<sup>43</sup> 42 U.S.C. § 416(h)(3)(C)(ii).

<sup>44</sup> Joanna L. Grossman, *The Supreme Court on the Rights of Posthumously Conceived Children: State Law Controls Family Status*, VERDICT, May 29, 2012, available at <https://verdict.justia.com/2012/05/29/the-supreme-court-on-the-social-security-rights-of-posthumously-conceived-children>.

analogous to children, their sale falls under prohibitions on **human trafficking**;<sup>45</sup> if embryos are considered analogous to organs, their sale falls under prohibitions on **sale of human organs**.<sup>46</sup>

**Donating embryos is possible** in three contexts, subject to any restrictions placed by the ART program's standard contract:

- 1) **Directly to a relative or friend.**
- 2) **Through an agency** to known or unknown family. Agencies match women or families who seek to implant embryos with other families who wish to donate extra embryos. The practice is sometimes called "**snowflake adoption**"; however, ASRM emphasizes that the **use of "adoption" in this context is misleading**, as only born children can be adopted ([See Adoption](#)). Although embryos "should be accorded an elevated moral status compared with other human tissues," they should not be viewed as persons.<sup>47</sup>
- 3) To **stem cell researchers**. In a 2009 executive order, President Obama **lifted the limits placed on stem cell research** by President George W. Bush.<sup>48</sup> Likewise, in 2008 **Michigan voters passed a ballot proposal** that amended the state constitution to **permit donation for research of human embryos** that would otherwise be discarded because they were either in excess of clinical need or were not suitable for implantation.<sup>49</sup> The amendment as well as other Michigan statutes impose certain restrictions:
  - No stem cells may be taken from a human embryo more than 14 days after cell division begins.<sup>50</sup>
  - Embryos may not be sold or purchased for the purpose of research.<sup>51</sup>
  - Research may not be performed on a dead embryo without the mother's express consent.<sup>52</sup>
  - Research may not be performed on a live embryo in utero in cases where the mother is planning an abortion.<sup>53</sup>

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<sup>45</sup> 22 U.S.C. § 78 (2010).

<sup>46</sup> 42 U.S.C. § 201 (1984).

<sup>47</sup> The Ethics Committee of the American Society for Reproductive Medicine, *Defining Embryo Donation*, 92 FERTILITY & STERILITY 1818 (Dec. 2009).

<sup>48</sup> Exec. Order, *Removing Barriers to Responsible Scientific Research Involving Stem Cells*, Mar. 9, 2009, available at [http://www.whitehouse.gov/the\\_press\\_office/Removing-Barriers-to-Responsible-Scientific-Research-Involving-Human-Stem-Cells/](http://www.whitehouse.gov/the_press_office/Removing-Barriers-to-Responsible-Scientific-Research-Involving-Human-Stem-Cells/). An August 2010 injunction against stem cell research is stayed while a federal appeals court judges considers the case. Gardiner Harris, *Stem Cell Financing Ban Ends, For Now*, N.Y. TIMES, Sept. 10, 2010, at A14.

<sup>49</sup> Mich. Const. art. I, § 27(b).

<sup>50</sup> Time during which the embryo is frozen does not count against this limit. Mich. Const. art. I, § 27(a).

<sup>51</sup> Mich. Const. art. I, § 27(c).

<sup>52</sup> MICH. COMP. LAWS § 333.2688(1) (1978).

<sup>53</sup> MICH. COMP. LAWS § 333.2685(1) (1978).

- An abortion may not be performed where payment for performing the procedure is that the alive or dead embryo may be used for research.<sup>54</sup>

Federal law controls federal funding for research and use of embryos in research.<sup>55</sup>

#### MAY EMBRYOS BE DESTROYED?

**Yes.** The circumstances under which embryos may be destroyed should be outlined in the ART contract (See WHO OWNS THE EMBRYO? above). Embryos are typically destroyed if they are **defective**; if the ART patients **request** it; or if both patients **die**, fall **out of contact** for a specified period of time, or **neglect to pay** storage fees.

Medical **malpractice** suits can be filed if embryos were mistakenly destroyed; suits have been filed in cases of "misplaced embryos, diseased gametes or unauthorized use of sperm."<sup>56</sup>

### Rights to ART Treatment

#### DO PATIENTS HAVE A RIGHT TO INSURANCE AND/OR FINANCIAL SUPPORT?

**No.** There is **little financial support for ART treatments** beyond a patient's own resources. **Michigan law does not require coverage** of infertility treatment by either private insurers or Medicaid.<sup>57</sup> As of 2015, U-M includes IVF coverage in most of its insurance policies.

The Ninth Circuit Court of Appeals has likewise ruled that under the Earned Retirement Income Security Act (ERISA), insurance plan participants are **not necessarily entitled to reimbursement for IVF**.<sup>58</sup> In another case, however, the Seventh Circuit granted reimbursement because the plan in question authorized reimbursement for "illness," and the plan administrator had described infertility as "illness" in plan guidelines.<sup>59</sup> Neither of these cases formally guide Michigan law (in the Sixth Circuit) but may be influential nevertheless.

#### DO PRISONERS HAVE A RIGHT TO ART TREATMENT?

**No.** The Eighth and Ninth Circuits have ruled that the Federal Bureau of Prisons need not allow male inmates to provide their wives with sperm specimens for artificial insemination.<sup>60</sup>

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<sup>54</sup> MICH. COMP. LAWS § 333.2689 (1978).

<sup>55</sup> See 45 C.F.R. § 46 (2009) (on research) and the Dickey-Wicker Amendment, Omnibus Appropriations Act, Pub. L. No. 111-8, 123 Stat. 2009 (on funding).

<sup>56</sup> Charles P. Kindregan, *Thinking About the Law of ART*, 27 WIS. J. FAM. L. 123, 126 (2007).

<sup>57</sup> Fourteen other states require insurers to either cover or offer coverage for infertility treatment. National Conference of State Legislatures, *State Laws Relating to Insurance Coverage for Infertility Treatment*, <http://www.ncsl.org/default.aspx?tabid=14391>, March 2010.

<sup>58</sup> *Winters v. Costco Wholesale Corp.*, 49 F.3d 550 (9th Cir. 1995).

<sup>59</sup> *Egert v. Connecticut General Life Ins. Co.*, 900 F.2d 1032 (7th Cir. 1990).

<sup>60</sup> *Goodwin v. Turner*, 908 F.2d 1395 (8<sup>th</sup> Cir. 1990) and *Gerber v. Hickman*, 291 F.3d 617 (9th Cir. 2002).

## Maternal-Fetal Interests

### INTRODUCTION

In the last fifty years, U.S. law has often asserted that in a pregnancy, two patients must be considered. This resulting case decisions and legislation frame the relationship between a woman and her fetus as one of **conflict**. Once a conflict is identified, the legal system sets out to balance the two “competing” sets of interests. In reality, **there is generally no conflict**, since mothers are overwhelmingly protective of their children's interests.<sup>61</sup> Occasionally, however, patients and physicians disagree about what course of treatment is best. This creates tension between the patient's right to make an informed choice for both herself and her fetus versus the physician's desire to provide the best possible care to mother and fetus. ([See Informed Choice](#))

Extremely rarely, a physician may question whether the law should be used to compel a pregnant patient to follow medical advice (for example, complete bed rest, c-section, treatment for addiction to illegal drugs, etc.), with the most difficult cases occurring when quick decisions must be made—such as during labor and delivery. **As a general rule, a physician must respect a competent patient's right to informed choice, which includes the right to pursue or refuse a course of treatment.** In very rare and extreme cases, where ending the relationship will not endanger the mother's health, a physician's corresponding right could be to sever the doctor-patient relationship, provided that several conditions are met. See materials on the doctor-patient relationship and abandonment at <http://www.med.umich.edu/u/medlaw/ABANDON.htm>.

Once a child is born, it has independent rights and a different set of laws applies. ([See Health Care Rights of Minors](#)).

### MAY A PREGNANT PATIENT REFUSE PRE-CONCEPTION OR PRENATAL TESTING?

**Yes.** A woman may refuse tests such as ultrasound, amniocentesis, or specific genetic tests. The risks and benefits of such tests should be thoroughly explained to the patient so that she can make an informed choice to accept or reject a proposed intervention. Documentation of the choice and the explanation is critical.

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<sup>61</sup> "...in the majority of cases, the interests of the pregnant woman and her fetus converge rather than diverge." ACOG Committee on Ethics, *Maternal Decision Making, Ethics, and the Law*, No. 321 (2005).

## MAY A PHYSICIAN INVOKE THE LAW IF LIFESTYLE CHOICES IMPERIL THE FETUS?

**No.** A physician will naturally inform patients of the dangers that smoking, alcohol, other substance abuse, poor nutrition, exposure to toxins, and lack or surfeit of exercise might pose to the fetus, and attempt to convince the patient of the wisdom of avoiding such behavior. However, despite a history of state intervention in such issues, courts have ruled that legal intervention in such cases is unacceptable.<sup>62</sup> The current legal trend is that **a competent mother has the ability to make her own medical decisions and cannot be forced to make decisions solely for the potential benefit of the fetus.**

## MAY A PATIENT REFUSE A LIFE-SAVING FETAL THERAPY?

**Yes. A competent mother may refuse any suggested treatment during her pregnancy,** as long as she is provided with sufficient information to understand the risks and benefits of proceeding with or refusing a course of treatment so she can make an unforced, informed choice.<sup>63</sup>

## MAY A PATIENT IN LABOR REFUSE STANDARD TREATMENTS?

**Legally, yes. A patient need not consent to any treatment commonly given in labor,** such as use of electronic fetal monitoring, placement of an IV, administration of Pitocin, performance of vaginal exams or episiotomy. She may also legally insist on remaining mobile and eating and/or drinking during labor. All of these options are included in the patient's right to informed choice. ([See Refusal of Treatment by Competent Patients](#))

However, the difficulty arises when this right conflicts with a physician's duty of care to the patient. In this situation, in addition to wishing to deliver the best care possible, a physician may fear that acceding to the patient's demands will put the physician or hospital at risk of liability in the case of an adverse event. **A patient cannot force a physician to practice below the standard of care; if a patient demands un-validated care, the physician is under no obligation to provide such care.**<sup>64</sup> The real issue arises when a patient refuses standard care and

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<sup>62</sup> Before medical evidence proved that crack cocaine posed less than the extreme danger to the fetus previously believed, many states prosecuted drug-addicted pregnant women. The prosecution tended to be weighted heavily along racial lines. Testing women for drugs for the purpose of law enforcement, rather than for their safety, was held to be a violation of the Fourth Amendment. *Ferguson v. City of Charleston, SC*, 186 F. 3d 469 (4th Cir. 1999). *But see State v. McKnight*, 576 S.E.2d 168 (S.C. 2003), which held that a mother could be charged with homicide of stillborn for in utero cocaine use.

<sup>63</sup> A pregnant woman was allowed to refuse a blood transfusion. *In re Brown*, 689 N.E.2d 397 (Ill. 1997).

<sup>64</sup> ACOG recognizes that "physicians are not obligated to provide futile care" and goes on to define futile care occurring in situation where "[e]vidence exists that the suggested therapy

## Maternal-Fetal Interests

the physician believes that it would be malpractice to proceed. In this situation, Risk Management and the Health System Legal Office must be consulted to discuss options, especially if the patient's choice places her at risk.

### WHAT IS THE LEGAL FORCE OF BIRTH PLANS?

**None.** The physician is not legally mandated to commit in advance to follow the patient's birth plan; rather, the birth plan is a snapshot of a patient's desires before labor begins. **Patients should be informed that this is the case.**

### WHAT IS A PHYSICIAN'S LEGAL DUTY FOR OUT-OF-HOSPITAL BIRTH TRANSFERS?

The Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA) requires that hospital emergency rooms and labor and delivery departments accept any patient who is in active labor or in any emergency condition.<sup>65</sup> ([See EMTALA](#)) Care provided outside UMHS (including care provided at births at other hospitals or at the patient's home) is not the responsibility of the physician who assumes care of the patient; the physician cannot be held liable for the earlier care.

### MAY A PATIENT REFUSE A RECOMMENDED C-SECTION?

**Yes.** This position is supported by the patient's right to informed choice described above, ACOG Ethics Opinion 321,<sup>66</sup> and leading case law, *In re A.C.*<sup>67</sup> **A woman may refuse a c-section even if that action puts the fetus's life in danger;** the law cannot balance (i.e. consider) the rights of the fetus against those of a competent woman.<sup>68</sup> *In re A.C.* offered another reason for disallowing court-ordered c-sections:

Rather than protecting the health of women and children, court-ordered caesareans erode the element of trust that permits a pregnant woman to communicate to her physician — without fear of reprisal — all information relevant to her proper diagnosis and treatment. An even more serious consequence of court-ordered intervention is that it drives women at high risk of complications during pregnancy and childbirth out of the health care system to avoid coerced treatment.<sup>69</sup>

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cannot achieve its physiologic goal" or the patient's or family's stated goals. ACOG Committee on Ethics, *Medical Futility*, No. 362 (2007).

<sup>65</sup> 42 U.S.C. § 1395dd (2010).

<sup>66</sup> "...judicial authority should not be used to implement treatment regimens aimed at protecting the fetus, for such actions violate the pregnant woman's autonomy." ACOG 321, *supra* note 404.

<sup>67</sup> *In re A.C.*, 573 A.2d 1235 (D.C. 1990) (en banc).

<sup>68</sup> *In re Baby Boy Doe*, 632 N.E.2d 326 (Ill. 1994).

<sup>69</sup> *In re A.C.*, 573 A.2d 1235 (D.C. 1990) (en banc).

## Maternal-Fetal Interests

The court further pointed out that court-ordered intervention during labor by definition did not allow enough time for proper representation of the parties and adequate deliberation.<sup>70</sup>

A suggested model for resolving these conflicts involves several options: first, "compassionate deliberation" between the patient and her caregivers; if this does not result in a shared decision, a hospital ethics committee consult and recommendation should be requested. See <http://www.med.umich.edu/adultethics/oncall.htm>. If the conflict persists, the patient's refusal should be honored. Legal intervention should rarely be pursued.<sup>71</sup>

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<sup>70</sup> *Id.*

<sup>71</sup> Lisa H. Harris, *Counselling women about choice*, 15 BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY 93, 198 (2001), citing J.V. Pinkerton & J.J. Finnerty, *Resolving the clinical and ethical dilemma involved in fetal-maternal conflict*, 175 AMER. J. OF OBSTETRICS & GYNECOLOGY 289 (1996).



# **Restricting Fertility: Contraception and Sterilization**

## **Contraception**

### INTRODUCTION

By 1972, the U.S. Supreme Court had ruled that the right to privacy implied in the Constitution allowed both married couples and unmarried individuals to acquire and use contraceptives and that states could not impede this right.<sup>72</sup> The barriers to using contraception then shifted to issues of access: whether women could obtain medical care and afford the cost of contraceptives and whether pharmacists were obliged to fill contraception prescriptions.

### ACCESS AND FINANCES

The Supreme Court decisions guarantee rights but do not guarantee access to or coverage for contraception. But because of the government's interest in helping families avoid unwanted pregnancies, state family planning clinics and services are **subsidized** by federal dollars through **Title X of the Public Health Services Act**.<sup>73</sup> Note that Title X does not cover abortions and that the funds for Title X have not been increased in several years.

Michigan's **Plan First!** program, funded by the **Michigan Medicaid Family Planning Waiver Program**, was established to serve Michigan residents who were between 9 and 44 years old, possessed a family income at or below 185% of the federal poverty level, met Medicaid citizenship requirements, but were not eligible for Medicaid.<sup>74</sup> **However**, with the expansion of Michigan Medicaid under the Affordable Care Act, **Plan First! coverage is now available only by waiver** to beneficiaries who:

- Were enrolled in Plan First! on April 1, 2014, or may have been enrolled in Plan First! after April, 2014, and
- Have not been determined eligible for comprehensive health care coverage.

Traditionally, many private **health insurance** policies **exempted all contraceptives from coverage**. Since 2000, if a health plan covers prescription **drugs and devices**, it **must** also

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<sup>72</sup> *Griswold v. Connecticut*, 381 U.S. 479 (1965). "If the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child." *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972)

<sup>73</sup> 42 U.S.C. § 300 (2009). For Michigan programs, see Mich. Dept. of Community Health, *Family Planning*, [http://www.michigan.gov/mdch/0,1607,7-132-2942\\_4911\\_4912\\_6216---,00.html](http://www.michigan.gov/mdch/0,1607,7-132-2942_4911_4912_6216---,00.html) (last visited Aug. 24, 2010).

<sup>74</sup> Mich. Dept. of Community Health, *Family Planning: Plan First!*, <http://www.michigan.gov/mdch/0,1607,7-132--146295--,00.html> (last visited Feb. 10, 2015).

cover contraception.<sup>75</sup> Although several states have passed legislation to create an enforcement mechanism for this federal policy, Michigan is not among them.<sup>76</sup> Moreover, this provision is countermanded by the U.S. Supreme Court *Hobby Lobby* decision of 2014, which allows an employer of a closely held corporation or a religious organization to refuse to provide coverage for any contraceptive the employer believes can cause an abortion. The decision negates the Affordable Care Act's contraceptive mandate.<sup>77</sup> Furthermore, a considerably broader 2015 Michigan federal district court ruling allows Michigan employers to refrain from providing its employees with health coverage for "contraceptive methods, sterilization procedures, and related patient education and counseling to which plaintiff objects on religious grounds."<sup>78</sup>

## Emergency Contraception

### PLAN B AND ELLA

**Plan B** (levonorgestrel), the "Morning After Pill," is classified as emergency contraception (EC). It is not an abortifacient because it does not interrupt an established pregnancy or harm a developing embryo.<sup>79</sup> Therefore, laws regarding abortion do not apply to Plan B/EC.

Plan B has been **available without a prescription or age restriction** since June 2013.<sup>80</sup> A newer EC, **ella**, is **effective** when taken **up to five days after unprotected sex**.<sup>81</sup> It has been available in the United States since late 2010.<sup>82</sup> Like Plan B, ella is not an abortifacient.

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<sup>75</sup> U.S. Equal Employment Opportunity Commission, *Decision*, <http://www.eeoc.gov/policy/docs/decision-contraception.html>, Dec. 14, 2000.

<sup>76</sup> Adam Sonfield, et al., *U.S. Insurance Coverage of Contraceptives and the Impact Of Contraceptive Coverage Mandates*, 2002, 36 PERSPECTIVES ON SEXUAL AND REPRODUCTIVE HEALTH 72 (2004), available at <http://www.guttmacher.org/pubs/journals/3607204.html>.

<sup>77</sup> *Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. \_\_\_\_ (2014).

<sup>78</sup> *Autocam Corp. v. Burwell*, [Proposed] Injunction and Judgment, Case No. 1:12-cv-01096-RJJ, (W.D. Mich. Jan. 5, 2015), available at <http://www.scribd.com/doc/251861190/Federal-Court-Rules-that-Michigan-Firm-Autocam-Not-Required-to-Provide-Abortion-Coverage>.

<sup>79</sup> World Health Organization, *Fact sheet on the safety of levonorgestrel-alone emergency contraceptive pills (LNG ECPs)*,

[http://whqlibdoc.who.int/hq/2010/WHO\\_RHR\\_HRP\\_10.06\\_eng.pdf](http://whqlibdoc.who.int/hq/2010/WHO_RHR_HRP_10.06_eng.pdf), 2010.

<sup>80</sup> Memorandum of June 12, 2013, *Tummino v. Hamburg*, 936 F.Supp.2d 162 (2013).

<sup>81</sup> U.S. Food & Drug Administration, *FDA approves ella™ tablets for prescription emergency contraception*, <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm222428.htm>, Aug. 13, 2010.

<sup>82</sup> Watson Pharmaceuticals, *Watson Launches ella(R) (ulipristal acetate) Emergency Contraceptive*, <http://phx.corporate-ir.net/phoenix.zhtml?c=65778&p=irol-newsArticle&ID=1501974>, Dec. 1, 2010.

## Restricting Fertility: Contraception and Sterilization

RU-486

**RU-486** (mifepristone), in contrast, *is* an abortifacient and is therefore subject to the restrictions outlined in [Abortion Laws in Michigan](#). Woman of any age in Michigan may legally use medications for a medical abortion.

### EMERGENCY ROOM ACCESS

State law does not mandate that emergency rooms offer EC to sexual assault victims of childbearing age. Institutional policies may vary.

### CONSCIENCE LAWS

Although Michigan law expressly allows health care workers to decline to perform an abortion, ([See Conscience Laws](#)) there is no similar provision authorizing a refusal to prescribe or dispense contraceptives.<sup>83</sup> However, physicians and pharmacists are not expressly *prevented* from refusing to prescribe or dispense contraceptives, and some have in fact done so.

### LEGALLY-ORDERED CONTRACEPTION

Judges have ordered a form of contraception as a **condition of parole** following a conviction for an offense such as child abuse/neglect<sup>84</sup> or failure to pay child support.<sup>85</sup> None of these probation orders have survived court challenges.<sup>86</sup> Similarly, some **welfare plans** have tried to condition receipt of benefits on use of Norplant or Depo-Provera.<sup>87</sup>

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<sup>83</sup> A series of Michigan bills were proposed in 2003, but not voted on in the Senate. H.B. 5006, 5276-8, 92<sup>nd</sup> Leg., Reg. Sess. (Mich 2003).

<sup>84</sup> *People v. Johnson*, 1992 WL 685375 (Cal. Ct. App. 1992). *See also* the case of Renee Gamez, *In re J.N.G.*, 2003 WL 22299795 (Mich. App. 2003), in American Civil Liberties Union, *ACLU brief*, <http://www.aclu.org/reproductive-freedom/judge-imposes-birth-control-prevent-michigan-woman-having-more-children>, Jul. 8, 2003.

<sup>85</sup> *State v. Oakley*, 629 N.W.2d 200 (Wisc. 2001).

<sup>86</sup> Justice Corrigan of the Michigan Supreme Court stated in a concurrence that "...the trial court ordered defendant, who pleaded nolo contendere to ... child abuse, to use Norplant or Depo-Provera as a method of birth control during the term of probation. That condition of probation was clearly unlawful and invalid under MICH. COMP. LAWS § 771.3(4); MSA 28.1133(4)." *People v. Walsh*, 593 N.W.2d 558 (Mich. 1999), cited in *Pregnancy and Reproductive Rights Related Sentencing and Probation Conditions*, National Advocates for Pregnant Women, Mar. 8, 2004, available at

[http://advocatesforpregnantwomen.org/issues/procreation\\_penalties/pregnancy\\_and\\_reproductive\\_rights\\_related.php](http://advocatesforpregnantwomen.org/issues/procreation_penalties/pregnancy_and_reproductive_rights_related.php). *See also* DOROTHY ROBERTS, *KILLING THE BLACK BODY* 195 (1997).

<sup>87</sup> The compelled use of Norplant as a condition of receiving welfare benefits has fallen out of favor due to the discovery of side-effects of the drug. The current trend is abstinence programs, particularly for teenagers. Anna Marie Smith, *The Sexual Regulation Dimension of Contemporary Welfare Law: A Fifty State Overview*, 8 MICH. J. GENDER & L. 121, 170, n177 (2001-2002).

## Sterilization

### INTRODUCTION

American women have traditionally struggled both for the right to be sterilized and the right *not* to be sterilized. Most often, these struggles have diverged along lines of race and class.

### WHEN MAY A PHYSICIAN PERFORM A STERILIZATION ON A COMPETENT ADULT?

#### *History*

Any account of sterilization in America must note the struggle of **poor women and women of color**, particularly African-American and Native American women, to **avoid involuntary sterilization**, as contrasted with the attempts of **white women to gain access to sterilization** before birth control was widely available.<sup>88</sup> Public awareness of sterilization abuse aided by state funds perpetrated on poor women and women of color<sup>89</sup> provided the policy rationale for the use of safeguards, such as the long waiting periods required by the Michigan Medicaid sterilization special consent form.<sup>90</sup>

#### *Current Law*

Women's **right to voluntary sterilization** has been legally recognized since 1973.<sup>91</sup> This right applies, of course, to a competent adult patient making an **informed choice**. ([See Informed Choice](#)) **Spousal consent** for the sterilization of a married woman is **not required**; such requirements have regularly been struck down by the courts.<sup>92</sup> The patient need not have **previously borne children** in order to obtain a voluntary sterilization.<sup>93</sup>

A woman's right **not to be sterilized against her will** is protected by the same **Constitutional** right to privacy that supports abortion rights ([See Right to an Abortion](#))<sup>94</sup> and the

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<sup>88</sup> Jael Silliman, et. al, UNDIVIDED RIGHTS: WOMEN OF COLOR ORGANIZE FOR REPRODUCTIVE JUSTICE 8-12, 111-112 (2004).

<sup>89</sup> In the 1960s, private advocacy groups urging sterilization of the "unfit" lobbied state governments for Medicaid coverage of the operation. Rebecca Marie Kluchin, FIT TO BE TIED: STERILIZATION AND REPRODUCTIVE RIGHTS IN AMERICA, 1950-1980 68 (2009).

<sup>90</sup> Mich. Dept. of Community Health, *Consent for Sterilization, MSA-1959*, [http://www.michigan.gov/documents/Msa-1959\\_41619\\_7.pdf](http://www.michigan.gov/documents/Msa-1959_41619_7.pdf) (last visited Jan. 1, 2011).

<sup>91</sup> *Hathaway v. Worcester City Hospital*, 475 F. 2d 701 (1<sup>st</sup> Cir. 1973).

<sup>92</sup> Kluchin, *supra* note 275, at 142. For an analogy to spousal consent for abortion, see also *Planned Parenthood of Central Mo. v. Danforth*, 428 U.S. 52 (1976).

<sup>93</sup> Until 1969, the ACOG "120 Rule" specified that "before a woman could be voluntarily sterilized, her age multiplied by the **number of children she had borne** must equal at least 120." Richard K. Sherlock & Robert D. Sherlock, *Voluntary Contraceptive Sterilization: The Case for Regulation*, 1976 UTAH L. REV. 115, 120 n. 33 (1976) (emphasis added). By August 1970, ACOG had revised its recommendations so that the only prerequisite to the surgery was the consent of the patient and her physician. See Kluchin, *supra* note 275, at 117.

<sup>94</sup> *Downs v. Sawtelle*, 574 F. 2d 1, (1st Cir. 1978).

**fundamental right to procreation.** Both federal statutory law<sup>95</sup> and state implementation of that law<sup>96</sup> emphasize the voluntary, non-coercive requirement of those providing family planning services.

## WHEN MAY A PHYSICIAN PERFORM A STERILIZATION ON AN INCOMPETENT ADULT OR MINOR?

### *History*

The **sterilization of incompetents** has a checkered and eugenics-influenced history in U.S. law. The Supreme Court ruled in *Buck v. Bell* (1927) that the institutionalized mentally ill could be involuntarily sterilized.<sup>97</sup> Carrie Buck, the unmarried, institutionalized mother of a one-month-old child, was herself the daughter of an institutionalized mother. Justice Oliver Wendell Holmes, Jr. famously ruled, "Three generations of imbeciles is enough," suggesting that insanity, promiscuity and criminality were heritable and that it was sound public policy to prevent people like Buck from reproducing. Recent studies have shown that Buck probably was not developmentally disabled (nor was her daughter), but was simply a poor, unmarried mother.<sup>98</sup> Although **this case is no longer good law**, it has never expressly been overruled. In 1942 the Court **ruled against the involuntary sterilization of certain repeat criminals** and articulated the **fundamental constitutional right of marriage and procreation.**<sup>99</sup>

### *Law*

In 1974 Michigan **repealed** its law allowing sterilization of "mental defectives."<sup>100</sup> **Currently, a guardian<sup>101</sup> of an adult child with a developmental disability must have a court**

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<sup>95</sup> "The acceptance by any individual of family planning services ... provided through financial assistance under this subchapter ... shall be voluntary and shall not be a prerequisite to eligibility for or receipt of any other service or assistance from, or to participation in, any other program of the entity or individual that provided such service or information." 42 U.S.C. § 300a-5 (2009).

<sup>96</sup> "Acceptance of [family planning] services must be solely on a voluntary basis and may not be made a prerequisite to eligibility for, or receipt of, any other services, assistance from or participate in any other program. 42 C.F.R. CH. 1 (10-1-00 Edition) §59.5 (a)(2)." MDCH, *Family Planning: Minimum Program Requirements*, [http://www.michigan.gov/documents/mdch/Family\\_Planning\\_MPRS\\_2006\\_278846\\_7.pdf](http://www.michigan.gov/documents/mdch/Family_Planning_MPRS_2006_278846_7.pdf), Apr. 2005.

<sup>97</sup> *Buck v. Bell* 274 U.S. 200 (1927). For a description of a similar Michigan case, see Christa Piotrowski, *Dark Chapter of American History: U.S. Court Battle Over Forced Sterilization*, <http://www.commondreams.org/views/072100-106.htm>, Jul. 21, 2000.

<sup>98</sup> In fact, evidence now suggests Buck was institutionalized to cover up the rape that resulted in the birth of her daughter, and that her lawyer was complicit with her institutionalization, as he had governing ties to the mental institution. PAUL A. LOMBARDO, *THREE GENERATIONS, NO IMBECILES: EUGENICS, THE SUPREME COURT, AND BUCK V. BELL* ix-xi (2008).

<sup>99</sup> *Skinner v. Oklahoma*, 316 U.S. 535 (1942).

<sup>100</sup> Sterilization of Mental Defectives, Act 281 of 1929, MICH. COMP. LAWS §§ 720.301-720.310 (repealed 1974).

**order** if the guardian wishes that child to be sterilized.<sup>102</sup> The Supreme Court of Michigan affirmed this interpretation of the statute in the 1998 case *In re Lora Faye Wirsing*.<sup>103</sup> The Court allowed the parents/guardians of Wirsing, a profoundly developmentally delayed 22-year-old, to consent to sterilization. Wirsing did not understand the use of or need for contraception and would not reliably use contraception. She lived in a facility with men and women and was at risk of an unwanted pregnancy, while suffering from cardiac issues which made pregnancy dangerous for her health. The Court held that it was permissible for the Probate Court to authorize the parents to consent to sterilization of their daughter. The medical risk of pregnancy to the ward was an important issue in the judge's ruling. (*See also generally Sterilization of Women, Including Those with Mental Disabilities*, ACOG Committee Opinion, No. 371, July 2007 (reaffirmed 2009), at [http://www.acog.org/from\\_home/publications/ethics/co371.pdf](http://www.acog.org/from_home/publications/ethics/co371.pdf).)

This approach would also apply to sterilization of a **developmentally disabled minor**. In general, sterilization would be considered by a court only if the patient was fertile, if the patient was unable to parent, if no other means of contraception was available, and if sterilization was necessary to protect the health of the patient.<sup>104</sup>

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<sup>101</sup> The guardian might be a parent or a *plenary guardian*, such as an administrator of the facility at which the child is institutionalized.

<sup>102</sup> Although the parent may functionally order any procedure at all, obtaining a court order exempts the parent from any subsequent civil liability. M.C.L. § 330.1629(1),(3) (1978).

<sup>103</sup> *In re Lora Faye Wirsing*, 573 N.W.2d 51 (Mich. 1998).

<sup>104</sup> Christine Ryan, Note, *Revisiting the Legal Standards that Govern Requests to Sterilize Profoundly Incompetent Children*, 77 FORDHAM L. REV. 287 (2008).

# ISSUES INVOLVING TERMINATION OF A PREGNANCY

## Abortion Laws in Michigan

### Introduction

#### OVERVIEW

Because abortion is a sensitive topic with moral and political implications, there are several laws governing this medical procedure. This section discusses the nature and scope of a woman's right to an abortion, informed consent requirements in the abortion context, the rights of minors seeking an abortion, the ban on partial-birth abortions, and conscience laws.

#### WHAT IS AN ABORTION?

An abortion is the intentional use of an instrument, drug, or other substance or device to terminate a woman's pregnancy for a purpose other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead fetus.<sup>105</sup>

#### WHAT IS *NOT* AN ABORTION?

Removal of a stillbirth and surgery to save the life of the mother do not legally constitute abortion. While it can be argued that removal of a fetus with a condition incompatible with life is not an abortion, this interpretation cannot be considered settled law because courts have not ruled on this matter. Consultation with an attorney is necessary should this issue arise. Documentation must be clear about the rationale for the procedure. Stillbirth occurs when a physician can determine that the fetus has died *in utero*.

#### IS THE USE OF A CONTRACEPTIVE CONSIDERED AN ABORTION?

No, abortion does not include the use or prescription of a drug or device intended as a contraceptive.

#### WHAT IF AN ABORTION ATTEMPT RESULTS IN A LIVE BIRTH, AND THE MOTHER DOES NOT WANT THE BABY? ([SEE THE MICHIGAN BORN ALIVE INFANT PROTECTION ACT](#))

If an abortion results in a live birth, the provider is required to do what is necessary to save the life of the infant. If the mother chooses not to assume custody and responsibility of the child, the newborn will be covered by the [Born Alive Infant Protection Act](#). According to the law, the provider must:

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<sup>105</sup> MICH. COMP. LAWS § 333.17015 (2006).

- 1) Make no attempt to directly contact the parent(s) of the newborn.
- 2) Provide humane comfort care if the newborn is determined to have no chance of survival due to gestational immaturity in light of available neonatal medical treatment or other condition incompatible with life.

## The Right to an Abortion

### CONSTITUTIONAL RIGHT TO AN ABORTION

Prior to the 1973 U.S. Supreme Court decision, *Roe v. Wade*,<sup>106</sup> abortions were illegal in Michigan. In the landmark *Roe* decision, the Court found that a woman has a **qualified constitutional right to an abortion until the point of fetal viability**. After viability, states can regulate or even ban abortion EXCEPT where necessary to preserve the life or health of the mother. **The right is “qualified” because states can safeguard a women’s health, maintain medical standards, and AFTER THE POINT OF VIABILITY protect potential life.** *Roe* held that after viability a state could “go so far as to proscribe abortion during that period, except when it is necessary to preserve the life or health of the mother.”<sup>107</sup>

*Roe* balanced the interests of a state to regulate abortion and to protect the fetus against the privacy and health rights of the pregnant women. Later cases (culminating in *Planned Parenthood of Southeastern Pennsylvania v. Casey*) created a new standard—undue burden—and held that **states could pass laws regulating abortion so long as those laws did not create an undue burden on a woman’s rights.**<sup>108</sup> Courts have held that the requirements of 24-hour waiting periods and of viewing pictures of fetuses do not create an undue burden.<sup>109</sup>

Notably, the Court did not address then or since the issue of when human life actually begins. The Court held that fetuses are not legally considered persons that have a right to life, but that the State has a compelling interest in protecting potential life at the point of viability.

### THE PRE-ROE MICHIGAN LAW ON ABORTION AND ITS STATUS POST-ROE

Public Act 328 of 1931 banned all abortions EXCEPT those necessary to save the **life** of the mother. Post-*Roe*, the Michigan Supreme Court said held that the law must be read to include the exceptions required under *Roe*, i.e. an exception for the **health** of the mother as well as for the life of the mother.<sup>110</sup> The Michigan statute (although still on the books) is no longer valid as written.

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<sup>106</sup> *Roe v. Wade*, 410 U.S. 113 (1973).

<sup>107</sup> *Id.* at 163-64.

<sup>108</sup> *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992).

<sup>109</sup> *Id.* at 886.

<sup>110</sup> *People v. Bricker*, 208 N.W.2d. 172 (1973).



Public Act 323 of 1931 banned all abortions “after quickening”. That law is unconstitutional for all pre-viability abortions and for any abortion necessary to preserve a women’s health.

Michigan law protects clinics from violence. **The Clinic Violence Law** (Public Act 210 of 1998) states that any individual who enters a clinic intending to cause people to feel frightened is committing a misdemeanor.

#### WHAT IS VIABILITY?

**Neither the Supreme Court nor the State of Michigan has defined viability.** When the opinion in *Roe v. Wade* was issued, the point of viability was generally considered to be at the end of the first trimester or 28 weeks. Advances in medical technology have reduced the point of viability to around 24 weeks. Courts have not determined a specific point of viability.

A medical determination of viability will often depend on factors such as the size of the fetus, lung maturity, presence of intracranial bleeding, and the availability of a neonatal ICU, ECMO and supporting surgical and other faculty. **UMHS has no specific policy on fetal viability nor is there specific written policy on abortions.**

#### DOES A WOMAN’S HUSBAND HAVE THE RIGHT TO INTERFERE WITH HER ABILITY TO HAVE AN ABORTION?

No, a woman seeking an abortion need not notify or **obtain consent from her spouse or the putative father** in order to have an abortion.<sup>111</sup>

#### **State and Federal Funding for Abortions—Hyde Amendment**

#### DOES THE RIGHT TO AN ABORTION MEAN THAT A WOMAN HAS THE RIGHT TO A FEDERALLY-FUNDED ABORTION?

No, the right to an abortion is a negative right, i.e. a right that has **no corresponding governmental responsibility to fund that right.**

**In 1976, Congress passed the Hyde Amendment,<sup>112</sup> which bans the use of certain federal funds to pay for abortions.** The law particularly affects low-income people by excluding abortion from the health care services provided through Medicaid. HOWEVER, the

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<sup>111</sup> *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992). In this case, a Pennsylvania law provided that no physician should perform an abortion upon a married woman without a signed statement that her spouse had been notified, except in a medical emergency. The Supreme Court held that the law was unconstitutional because it caused an undue burden by placing a substantial obstacle in the path of a woman’s right to an abortion.

<sup>112</sup> Consolidated Appropriations Act of 2008, H.R. 2764, Pub. L. No. 110-161.

current federal Medicaid program **allows funded abortions in cases of rape, incest, or when a pregnant woman’s life is endangered by a physical disorder, illness, or injury.**

In March 2010, President Obama issued an executive order that reinforces the Hyde Amendment’s restrictions on the use of federal funds for abortion.<sup>113</sup>

#### NO STATE COVERAGE OF ABORTIONS UNDER MEDICAID IN MICHIGAN

Michigan does not permit **state Medicaid funding for abortions** except to save a woman’s life.<sup>114</sup> Abortions in Michigan can receive federal funding under the Hyde Amendment in cases of rape, incest, or endangerment of life.

#### INSURANCE COVERAGE OF ABORTIONS IN MICHIGAN

Michigan Public Act 191 of 2002 permitted K-12 schools and community colleges to provide abortion coverage for their employees, repealing prior legislation prohibiting it.

Michigan’s “Abortion Insurance Opt-Out Act” forbids Michigan insurance plans offered through the federal Health Insurance Exchange (a.k.a. Marketplace) from including coverage for “elective abortion.”<sup>115</sup> The Act permits abortion coverage only when the mother’s life (but not her health) is at stake, or in the case of miscarriage or ectopic pregnancy.<sup>116</sup> Abortion coverage may be purchased through a separate “rider” from an insurer outside the Exchange, but must be purchased prior to need. As of this writing, 7 of 42 Michigan insurers offer abortion riders to employers; none are available to individuals who purchased insurance plans on the Exchange.<sup>117</sup>

#### CAN WOMEN BE COUNSELED ABOUT ABORTION?

Yes, EXCEPT that under Michigan law **adolescent health clinics that receive state funding cannot provide abortion counseling** or make referrals for an abortion.<sup>118</sup> Public schools may not discuss abortion as a method of family planning or reproductive health in sex education classes.<sup>119</sup>

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<sup>113</sup> Exec. Order No. 13,535, 75 Fed. Reg. 15599 (Mar. 29, 2010).

<sup>114</sup> MICH. COMP. LAWS § 400.109a (1987).

<sup>115</sup> Abortion Insurance Opt-Out Act, Pub. Act 182 of 2013.

<sup>116</sup> MICH. COMP. LAWS § 550.551 (2013).

<sup>117</sup> Amy Lynn Smith, Legislation introduced to repeal Michigan abortion insurance law, Eclectablog, Jun. 16., 2014, <http://www.eclectablog.com/2014/06/breaking-legislation-introduced-to-repeal-michigan-abortion-insurance-law.html>.

<sup>118</sup> Public Act 519 of 2002.

<sup>119</sup> MICH. COMP. LAWS § 380.1507 – 1507b (2006).

## Informed Consent

### OVERVIEW OF THE LAW

The Michigan Legislature has enacted laws that require physicians to provide pregnant women with certain information about abortion before the procedure is performed. Informed consent statutes are constitutional because they are reasonably related to the state's objectives of ensuring that a woman's decision to obtain an abortion is informed, voluntary, and reflective, and to the state's interest in protecting the life of the fetus.<sup>120</sup> Current U.S. Supreme Court decisions hold that only laws that place an "undue burden" on a women's right to choose abortion are unconstitutional.<sup>121</sup> Because the Court has never defined "undue burden," it is determined on a case by case basis. For example, a 24-hour waiting period and a requirement to view pictures of a fetus at the gestational age of the women's fetus have not been seen as undue burdens by the Court.

### HOW DOES MICHIGAN CONVEY REQUIRED INFORMATION ABOUT ABORTION?

The Michigan Department of Community Health is responsible for developing and providing documents that must be given to a woman seeking an abortion. Patients can obtain a confirmation (a legal verification) that they have reviewed the required information by going to [MDCH's website](#) and examining the necessary information.

### WHAT MUST THE PHYSICIAN DO?

- 1) **Provide the woman with private, individual counseling.** Provide the woman with certain information to assist her in making an informed decision regarding abortion.
- 2) **Wait 24 hours** between the woman's receipt of the information provided to assist her in making an informed decision and the actual performance of the abortion (if the woman elects to have an abortion).
- 3) If a patient gets an ultrasound before the abortion and/or if a physician determines that ultrasound imaging will be used, the patient must be given the opportunity to view or decline to view an active ultrasound image of the fetus. The patient must be offered a **physical picture of the ultrasound image of the fetus** before the abortion is performed.
- 4) Obtain and retain a **signed acknowledgement and consent form**. Provide patient with a physical copy of the form.

### WHAT INFORMATION MUST THE PHYSICIAN PROVIDE?

**The physician should take into account the patient's age, level of maturity, and intellectual capability in providing her with the following information:**

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<sup>120</sup> *Mahaffey v. A.G.*, 564 N.W.2d 104 (Mich. App. 1997).

<sup>121</sup> *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992).

## Abortion Laws in Michigan

- 1) Probable gestational age of the fetus she is carrying.
- 2) A medically accurate depiction, illustration, or photograph and a description of a fetus at the gestational age of the patient's fetus.
- 3) A description of the abortion procedure that the patient will undergo.
- 4) Any known risks or complications that the procedure may involve.
- 5) Risks associated with live birth.
- 6) The specific risk, if any, of the abortion procedure based on the patient's particular medical condition and history.
- 7) The specific risk, if any, of continuing the pregnancy based on the patient's particular medical condition and history.
- 8) Patient's right to withhold or withdraw consent to the abortion at any time before the abortion is performed.
- 9) Information about what to do and whom to contact in the event that medical complications arise from the abortion.
- 10) How to obtain pregnancy prevention information and prenatal care/parenting information from the [Michigan Department of Community Health](#).

### HOW ARE WOMEN PROTECTED AGAINST COERCED ABORTION?

Physicians or qualified persons assisting must “orally screen the patient for coercion to abort.”<sup>122</sup> Rules have not yet been promulgated to define the details of the screening.

### WHAT IF THERE IS A MEDICAL EMERGENCY NECESSITATING ABORTION?

If the physician determines that a **medical emergency** exists and necessitates performance of an abortion before the informed consent and waiting period requirements can be met, the physician is **exempt** from those requirements and may perform the abortion.

The physician must create a **written record identifying the specific medical factors** upon which the determination of the medical emergency is based.

### WHAT IS A MEDICAL EMERGENCY?

A medical emergency is any condition which, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.

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<sup>122</sup> MICH. COMP. LAWS § 333.17015a (2013).

## Minors

### OVERVIEW OF THE LAW

The Parental Rights Restoration Act<sup>123</sup> requires parental consent for abortions performed on unemancipated minors, but also provides a judicial alternative to parental consent.

### WHO IS A MINOR?

A person **under 18** who is not emancipated. ([See Healthcare Rights for Minors](#))

### WHEN IS A MINOR EMANCIPATED?

A minor can be emancipated (granted the status of adulthood and allowed to make her own legally binding decisions including health care decisions) by marriage, active duty in the Armed Forces or a court order finding the minor is financially independent of her parents and able to make decisions on her own behalf.

### DOES THE STATE OF RESIDENCY OF THE MINOR MATTER?

The requirements of the Parental Rights Restoration Act apply regardless of whether the minor is a resident of Michigan.

### WHAT MUST A MINOR SEEKING AN ABORTION HAVE BEFORE THE PHYSICIAN PERFORMS THE PROCEDURE?

**The minor must have EITHER written consent of at least one parent or legal guardian OR a judicial decree waiving the parental consent requirement.**

### WHAT MUST THE PHYSICIAN DO?

- 1) Obtain informed consent from the minor.
- 2) Make sure that the minor has either parental consent OR the judicial waiver.
- 3) Comply with all the requirements listed in the [Informed Choice](#) section.

### WHAT IF A MINOR IS SEEKING A JUDICIAL DECREE TO WAIVE THE PARENTAL CONSENT REQUIREMENT?

Minors seeking judicial bypass should be instructed to seek legal assistance from the [University of Michigan Law School Clinic](#) or [Legal Services of South Central Michigan—Washtenaw County Office](#). A minor must persuade a judge that she is mature and thoughtful and that parental consent should not be required in her case or that an abortion is in the best interests of the minor. Information about judicial bypass is available from Planned Parenthood at <http://miplannedparenthood.org/courtconsent.htm>.

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<sup>123</sup> The Parental Rights Restoration Act, 1990 Mich. Pub. Acts 211 (codified at MICH. COMP. LAWS §§ 722.901-909).

#### WHAT IF THERE IS A MEDICAL EMERGENCY NECESSITATING ABORTION?

If the physician determines that a **medical emergency** exists and necessitates performance of an abortion before parental consent or the judicial bypass can be obtained, the physician is exempt from the consent requirements and may perform the abortion.

The physician must create a **written record identifying the specific medical factors** upon which the determination of the medical emergency is based.

#### WHAT IS A MEDICAL EMERGENCY?

A medical emergency is any condition which, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.

### **“Partial-Birth” Abortions**

#### WHAT IS A “PARTIAL-BIRTH” ABORTION?

A “partial-birth” abortion is a **dilation and extraction (D&X)** abortion, in which the physician (or individual acting under the delegation of authority of the physician) performing the abortion **partially vaginally delivers a living fetus before killing the fetus and completing the delivery**. Laws regulating such abortions are examples of how courts can sometimes dictate medical practice. These abortions are now prohibited nationwide.

#### MAY A PHYSICIAN PERFORM A PARTIAL-BIRTH ABORTION?

**No**, the U.S. Supreme Court has effectively banned this procedure.

#### MAY A PHYSICIAN PERFORM A PARTIAL-BIRTH ABORTION TO PROTECT THE MOTHER'S HEALTH?

**No, a physician may not perform a partial-birth abortion solely to protect the mother's health.**

#### STATE ATTEMPTS TO BAN PARTIAL-BIRTH ABORTIONS

- The **Infant Protection Act**<sup>124</sup> states that a live infant who is partially outside of his mother is a person, rather than a fetus or potential life, and criminalizes the performance of partial-birth abortions. A federal court ruled that Michigan's Infant Protection Act is unconstitutional because, while it permits partial-birth abortions

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<sup>124</sup> Infant Protection Act, 1999 Mich. Pub. Acts 107 (codified at MICH. COMP. LAWS § 750.90g).

when the life of the mother is at stake, it does not permit them when the mother's health is in danger.<sup>125</sup>

- Another attempt to ban partial-abortions is the **Legal Birth Definition Act**.<sup>126</sup> The Act defined birth to be at the point where any portion of a child is vaginally delivered outside the mother's body. This law was also held to be unconstitutional.<sup>127</sup>

#### STATE BAN ON PARTIAL-BIRTH ABORTIONS

- After numerous failed attempts, the Michigan Legislature passed the **Partial-Birth Abortion Ban Act**.<sup>128</sup> The Act makes performing a partial-birth abortion or assisting in the procedure a felony punishable by up to two years imprisonment or a \$50,000 fine. There is no exception to preserve the mother's health in the new law, but there is an exception to save the mother's life. This exception is the result of similar previous legislation that was found to be unconstitutional because it was vague, overbroad, and imposed an undue burden on a woman's right to seek a pre-viability second trimester abortion.<sup>129</sup> Partial-birth procedures are already illegal under federal law. However, now that Michigan has mirrored the federal language in a state law, partial-birth abortion will be illegal in Michigan even if the federal ban is overturned in the future.

#### FEDERAL BAN ON PARTIAL-BIRTH ABORTIONS

**In April 2007, the Supreme Court upheld the federal Partial-Birth Abortion Ban Act of 2003 in *Gonzales v. Carhart* (Carhart II).**<sup>130</sup> The federal law contains no health exception for the health of the mother and includes Congressional findings that partial-birth abortion is never medically necessary to protect the health of the mother.

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<sup>125</sup> *WomanCare of Southfield, P.C. v. Granholm*, 143 F. Supp. 2d 849 (E.D. Mich. 2001).

<sup>126</sup> Legal Birth Definition Act, 2004 Mich. Pub. Acts 135 (codified at MICH. COMP. LAWS § 333.1085).

<sup>127</sup> In *Northland Family Planning Clinic v. Cox*, 396 F. Supp. 2d 978 (2005), the federal court for the Eastern District of Michigan held that the Legal Birth Definition Act is unconstitutional because it places an undue burden on a woman's right to an abortion, does not provide a sufficient maternal health exception, requires the physician to balance the maternal and neonatal interests in the life exception, and fails to give clear notice of the activities that are prohibited. In 2007, the U.S. Sixth Circuit affirmed the decision and held the Act unconstitutional.

<sup>128</sup> Partial-Birth Abortion Ban Act, 2011 Mich. Pub. Acts 168, 169 (codified at MICH. COMP. LAWS § 750.90h).

<sup>129</sup> *Evans v. Kelley*, 977 F. Supp. 1283 (E.D. Mich. 1997).

<sup>130</sup> *Gonzales v. Carhart*, 550 U.S. 124 (2007).

## Conscience Laws

### OVERVIEW OF THE LAW

Some state laws (including those of Michigan) have conscience clauses that permit physicians, pharmacists, and other health care professionals to refuse to provide certain medical services on religious or moral grounds without being sanctioned. While these provisions are usually invoked in cases involving reproduction (such as contraception, abortion, or sterilization), conscience clauses can be drafted to apply to any phase of patient care.

### WHAT IF A PHYSICIAN HAS RELIGIOUS OR MORAL OBJECTIONS TO PERFORMING AN ABORTION?

A physician who states an objection to an abortion on professional, ethical, moral, or religious grounds may refuse to perform or participate in the performance of an abortion and will be **immune from any civil or criminal liability or penalty.**<sup>131</sup>

An objecting physician **may refuse to give advice** to a patient seeking an abortion, but **may not transmit false or inaccurate information** designed to persuade the patient not to get an abortion.

### WHAT SHOULD THE HOSPITAL DO IF A HOSPITAL EMPLOYEE HAS RELIGIOUS OR MORAL OBJECTIONS TO PERFORMING AN ABORTION?

A facility should not schedule an employee who is opposed to abortion to assist with an abortion. While hospital employees may decide not participate in an abortion, UMHS as an educational institution can provide education and information about abortion to its students, trainees, faculty, staff and patients.

### MUST A PATIENT SEEKING AN ABORTION BE ADMITTED?

No, a hospital or other health facility is not required to admit a patient for the purpose of performing an abortion.

## Constraints on Institutions

### MUST PRODUCTS OF CONCEPTION BE TREATED AS HUMAN REMAINS?

**No.** Recent legislation that threatened to require that the products of conception resulting from an abortion be treated as human remains did not succeed. Therefore, the products of conception may continue to be disposed of like other human tissues. A funeral director's

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<sup>131</sup> MICH. COMP. LAWS §§ 333.20181-20183 (1978).



participation is not required. The mother need not be consulted regarding the disposition of the products of conception unless she has given written consent for their use in research.<sup>132</sup>

#### WERE OTHER FACILITY RESTRICTIONS IMPOSED ON ABORTION CLINICS?

**Yes and no.** Proposed legislation would have required **clinics** that performed more than 6 surgical abortions per month to **meet construction and equipment standards** already established for **freestanding surgical outpatient facilities**. As enacted, however, the legislation altered the 6 per month criterion to **120 per year** and, more importantly, reinstated a **waiver** that may permit **clinics established before the end of 2012 to continue to operate**.<sup>133</sup>

The legislature nevertheless continued a disincentive to establish or expand clinics to offer *both* surgical abortions and other surgical procedures. The final statute, by excluding abortions from the count of the minimum number of surgical procedures required toward a Certificate of Need to open an outpatient surgical facility, strongly discourages facilities that offer surgical services from also offering surgical abortions.<sup>134</sup>

#### MAY PHYSICIANS PRESCRIBE ABORTIFACIENTS THROUGH TELEMEDICINE?

**No.** Michigan law now specifies that the physician who prescribes the medication abortion must also conduct the initial physical examination of the patient and be physically present when the medication is dispensed.<sup>135</sup>

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<sup>132</sup> MICH. COMP. LAWS §§ 333.2836 (2013).

<sup>133</sup> MICH. COMP. LAWS §§ 333.20115 (2013).

<sup>134</sup> MICH. COMP. LAWS §§ 333.22224 (2013).

<sup>135</sup> MICH. COMP. LAWS §§ 333.17017 (2013).

# PROTECTION OF FETUSES FROM VIOLENCE

## Michigan's Fetal Protection Act

### OVERVIEW OF THE LAW

Historically, the killing of an “unborn quick child” was considered to be manslaughter.<sup>136</sup> The Supreme Court of Michigan interpreted the criminal statute to apply only to unborn children who are viable.<sup>137</sup> Because fetuses are not considered to be legal persons, battery and murder and other charges related to harming or injuring people do not apply to fetuses.

However, like other states that implemented laws protecting fetuses, Michigan passed a 1999 law that imposes **penalties for actions that intentionally or in willful disregard cause a miscarriage, stillbirth, or aggravated physical injury to an embryo or fetus.**<sup>138</sup>

### APPLICABILITY TO MEDICAL PROCEDURES BY PHYSICIANS

While most conduct that results in intentional or grossly negligent harm to a fetus triggers legal penalties, certain actions by physicians and other licensed medical professionals are not punishable by law. The Michigan Fetal Protection Act provisions **do not apply to a medical procedure performed by a physician or other licensed medical professional** if it is:<sup>139</sup>

- 1) within the **scope of his or her practice AND**
- 2) **performed with the pregnant woman's consent** OR the consent of an individual who may lawfully provide consent on her behalf or without consent as necessitated by a medical emergency.

### APPLICABILITY TO MEDICATIONS

The Michigan Fetal Protection Act provisions **do not apply to the lawful dispensation, administration, or prescription of medication.**<sup>140</sup>

### APPLICABILITY TO ACTIONS TAKEN BY THE PREGNANT WOMAN

The Act's provisions **do not apply to acts committed by the pregnant woman.**

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<sup>136</sup> MICH. COMP. LAWS § 750.322 (1931).

<sup>137</sup> *Larkin v. Cahalan*, 208 N.W.2d 176 (Mich. 1973).

<sup>138</sup> MICH. COMP. LAWS § 750.90a-90f (1999).

<sup>139</sup> MICH. COMP. LAWS § 750.90f(1)(b) (1999).

<sup>140</sup> MICH. COMP. LAWS § 750.90f(1)(c) (1999).

## **The Federal Unborn Victims of Violence Act**

### OVERVIEW OF THE LAW

The Unborn Victims of Violence Act of 2004<sup>141</sup> is a federal law that recognizes a “child *in utero*” as a legal victim when injured or killed as a result of any of the enumerated violent crimes.<sup>142</sup>

### ARE FETUSES PROTECTED UNDER THIS LAW?

Yes, to some extent. Anyone who engages in conduct that **violates the violent crime provisions listed in the federal statute** and thereby causes the **death or bodily injury of a child who is *in utero*** at the time the conduct takes place can be found criminally liable under this act.<sup>143</sup>

In order to preserve constitutional principles of federalism, **federal criminal law is not applicable to crimes prosecuted by the individual states.** ([See Michigan’s Fetal Protection Act](#))

### WHO IS A “CHILD IN UTERO”?

An unborn child, or “**child *in utero***,” is a member of the species homo sapiens, at any stage of development, who is carried in the womb.<sup>144</sup>

### WHAT DOES “BODILY INJURY” INCLUDE?

“**Bodily injury**” can be:<sup>145</sup>

- a) a cut, abrasion, bruise, burn, or disfigurement
- b) physical pain
- c) illness
- d) impairment of the function of a bodily member, organ, or mental faculty, OR
- e) any other injury to the body, no matter how temporary

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<sup>141</sup> Unborn Victims of Violence Act of 2004, Pub. L. No. 108-212.

<sup>142</sup> 18 U.S.C. § 1841(c) (2010).

<sup>143</sup> 18 U.S.C. § 1841(a)(1) (2010).

<sup>144</sup> 18 U.S.C. § 1841(d) (2010).

<sup>145</sup> 18 U.S.C. § 1365(h)(4) (2010).

DOES THE UNBORN VICTIMS OF VIOLENCE ACT ALLOW FOR THE PROSECUTION OF CONDUCT RELATING TO CONSENSUAL ABORTION?

No, nothing in the Unborn Victims of Violence Act should be construed to permit the prosecution of the following persons:<sup>146</sup>

- 1) **Any person engaged in conduct relating to an abortion for which the consent of the pregnant woman (or someone authorized by law to act on her behalf) has been obtained OR for which consent is implied by law.**
- 2) **Any person providing medical treatment** to the pregnant woman or her unborn child.
- 3) **Any woman who acts with respect to her unborn child.**

MUST THE PERSON ENGAGING IN THE CONDUCT KNOW THAT THE VICTIM OF THE UNDERLYING OFFENSE WAS PREGNANT?

No, **to be held liable** under the Act, the offender **does not need to have knowledge**; however, acting with knowledge may subject the offender to harsher penalties.<sup>147</sup>

MUST THE PERSON ENGAGING IN THE CONDUCT HAVE INTENT TO CAUSE THE DEATH OF OR BODILY INJURY TO THE UNBORN CHILD?

No, **to be held liable** under the Act, the offender **does not need to have intent**; however, acting intentionally may subject the offender to harsher penalties.

CAN THE DEATH PENALTY BE IMPOSED FOR A VIOLATION OF THE UNBORN VICTIMS OF VIOLENCE ACT?

No, the **death penalty shall not be imposed**, notwithstanding any other provision of law.

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<sup>146</sup> 18 U.S.C. § 1841(c) (2010).

<sup>147</sup> 18 U.S.C. § 1841(a)(2)(B) (2010).

# ISSUES THAT ARISE UPON DELIVERY

## Safe Delivery of Newborns Law

### OVERVIEW OF THE LAW

The Safe Delivery of Newborns Law encourages the release of unwanted babies into a safe environment by allowing parents to relinquish a newborn without any penalty during the first three days after birth.

### WHO IS A NEWBORN?

Under the law,<sup>148</sup> a **newborn** is a child whom a physician reasonably believes to be not more than 72 hours old.

### WHAT DOES IT MEAN TO SURRENDER A NEWBORN?

To **surrender** a newborn under this law means to leave a newborn with an emergency service provider without expressing an intent to return for the newborn.

### WHAT PRIMARY ACTIONS MUST THE PHYSICIAN TAKE?

**If a parent surrenders a newborn to an emergency service provider, the emergency service provider must make a reasonable effort to do all of the following:**

- 1) Take action necessary to protect the newborn's health and safety.
- 2) Inform the surrendering parent that the parent is releasing the newborn to a child placing agency to be placed for adoption.
- 3) Inform the parent that the parent has 28 days to petition the court to regain custody of the newborn.
- 4) Provide the parent with written material approved by the department.<sup>149</sup>

### WHAT MUST THE PHYSICIAN DO NEXT?

**After providing a parent with the information described in subsection (1), an emergency service provider must make a reasonable attempt to do all of the following:**

- 1) Encourage the parent to provide any relevant family or medical information.

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<sup>148</sup> Safe Delivery of Newborns Law, 2006 Mich. Pub. Acts 488 (codified at MICH. COMP. LAWS §§ 712.1-17).

<sup>149</sup> MICH. COMP. LAWS § 712.3(1)(d) (2006).

- 2) Provide the parent with written material and inform the parent that he or she can receive counseling or medical attention.
- 3) Inform the parent that information that he or she provides will not be made public. Ask the parent to identify himself or herself.
- 4) Inform the parent that the state must make a reasonable attempt to identify the other parent, and then ask the parent to identify the other parent, in order to place the newborn for adoption.
- 5) Inform the parent that the child placing agency that takes temporary protective custody of the newborn can provide confidential services (such as social work and counseling services) to the parent.
- 6) Inform the parent that the parent may sign a release for the newborn that may be used at the parental rights termination hearing under this chapter.

WHAT SHOULD BE DONE IF AN ABORTION ATTEMPT RESULTS IN A LIVE BIRTH AND THE MOTHER DOES NOT WANT THE BABY? ([See Born Alive Infant Protection Act](#))

**If an abortion results in a live birth and the mother chooses not to assume custody and responsibility of the child, the newborn will be covered by the Born Alive Infant Protection Act. In addition to the requirements listed above, the emergency service provider must:**

- 1) Make no attempt to directly contact the parent(s) of the newborn.
- 2) Provide humane comfort care if the newborn is determined to have no chance of survival due to gestational immaturity in light of available neonatal medical treatment or other condition incompatible with life.

WHAT SHOULD THE WRITTEN MATERIAL PROVIDED BY THE DEPARTMENT INCLUDE?

**The physician should give the parent written material approved by or produced by the department. The material should address the following:**

- 1) By surrendering the newborn, the parent is releasing the newborn to a child placing agency to be placed for adoption.
- 2) The parent has 28 days after surrendering the newborn to petition the court to regain custody of the newborn.
- 3) After the 28-day period to petition for custody lapses, there will be a hearing to determine and terminate parental rights.
- 4) A public notice of this hearing will be issued without the parent's name.
- 5) The parent will not receive personal notice of this hearing.

- 6) Information the parent provides to an emergency service provider will not be made public.
- 7) A parent can contact the safe delivery line (a toll-free, 24-hour telephone line) for more information.<sup>150</sup> The number for the line (1-866-733-7733) should be prominently displayed on the written material.

WHAT INFORMATION SHOULD THE SAFE DELIVERY LINE PROVIDE?

**The safe delivery line is a toll-free, 24-hour telephone line. Information provided through this line should include, but is not limited to, the following:**

- 1) Information on prenatal care and the delivery of a newborn.
- 2) Names of health agencies that can assist in obtaining services and support for the pregnancy-related health of the mother and the health of the baby.
- 3) Information on adoption options and the contact information of a child placing agency that can assist in obtaining adoption services.
- 4) Information that the safest place for the delivery of a child is in a hospital, hospital-based birthing center, or accredited birthing center.
- 5) An explanation that prenatal care and delivery services are routinely confidential within the health care system, if requested by the mother.
- 6) Information that a hospital will take into protective custody a newborn that is surrendered as provided for in this chapter and, if needed, provide emergency medical assistance to the mother, the newborn, or both.
- 7) Information regarding legal and procedural requirements related to the voluntary surrender of a child as provided for in this chapter.
- 8) Information regarding the legal consequences for endangering a child, including child protective service investigations and potential criminal penalties.
- 9) Information that surrendering a newborn for adoption as provided in this chapter is an affirmative defense to charges of abandonment
- 10) Information about resources for counseling and assistance with crisis management

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<sup>150</sup> MICH. COMP. LAWS § 712.20 (2003).

## Routine Procedures for Newborn Infants

### OVERVIEW OF THE LAW

Many common treatments for newborn infants fall under the province of Pediatrics rather than Obstetrics. This section is nevertheless included here for the edification of health care professionals wishing to counsel parents on these issues before their babies are born.

### IS NEWBORN SCREENING REQUIRED BY LAW?

**Yes.** Michigan law suspends parental rights of informed consent for the narrow purpose of obtaining blood samples from newborns, to enable screening for metabolic and genetic disorders.<sup>151</sup> Birth attendants who do not fulfill this duty may be charged with a misdemeanor.<sup>152</sup>

**Nevertheless, the state allows parents to refuse screening,**<sup>153</sup> provided they sign a waiver releasing the hospital and the Michigan Department of Community Health from any liability resulting from the failure to screen. MDCH provides a sample form for the purpose.<sup>154</sup> Parents who refuse screening by heel stick may agree to collection of a sample from cord blood.

### MAY PARENTS OPT OUT OF RETENTION OF NEWBORN BLOOD SPOTS?

**Yes.** Some parents may object to neither the blood collection nor the screening itself, but instead to the state's **retention of blood spots**. MDCH urges providers to advise such parents to instead sign a form directing the state to destroy the specimen after screening is completed.<sup>155</sup>

### HOW LONG ARE BLOOD SPOTS RETAINED?

**Potentially forever.** The legislature authorized the retention of blood spots for the purpose of medical research.<sup>156</sup> The specimens are collected by the MDCH Michigan Biotrust

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<sup>151</sup> MICH. COMP. LAWS § 333.5431(2) (2003).

<sup>152</sup> MICH. COMP. LAWS § 333.5431(5) (2003).

<sup>153</sup> “There is no parental opt-out statute in Michigan because the public health code directs birthing hospital and birth attendant compliance with the statute. Parents may refuse testing, though this rarely happens.” Michigan Department of Community Health, *Newborn Screening Guide for Homebirths* 21, Oct. 2014, [http://www.michigan.gov/documents/mdch/NBS\\_Guide\\_for\\_Homebirths\\_FINAL\\_10-29-13\\_438649\\_7.pdf](http://www.michigan.gov/documents/mdch/NBS_Guide_for_Homebirths_FINAL_10-29-13_438649_7.pdf).

<sup>154</sup> Michigan Department of Community Health, *Newborn Screening Guide for Hospitals* 38, Oct. 2014, [http://www.michigan.gov/documents/mdch/MI\\_NBS\\_Guide\\_368636\\_7.pdf](http://www.michigan.gov/documents/mdch/MI_NBS_Guide_368636_7.pdf)

<sup>155</sup> *Id.* at 8.

<sup>156</sup> MICH. COMP. LAWS § 333.5431(7)(b) (2003).



## Routine Procedures for Newborn Infants

for Health<sup>157</sup> and stored by the Michigan Neonatal Biobank, a non-profit charitable organization that oversees the availability of dried blood spots for approved research.<sup>158</sup>

### WHAT OTHER NEWBORN PROCEDURES ARE MANDATED BY LAW?

Michigan statute requires testing for **Critical Congenital Heart Disease (CCHD)** using Pulse Oximetry.<sup>159</sup> The law encourages newborn **hearing testing** by requiring the reporting of results of “all hearing tests and screens conducted on infants who are less than 12 months of age... The report shall include the type, degree, and symmetry of the diagnosis, along with where and when the diagnosis was made.”<sup>160</sup>

Licensed health care professionals in charge of newborn infants must by law administer **prophylactic eyedrops**.<sup>161</sup>

### WHAT ARE THE LEGAL RAMIFICATIONS OF UNMANDATED PROCEDURES?

Injections of **Hepatitis B** vaccine and **Vitamin K** are given to newborns as standard practice, but are **not** mandated by statute or administrative rules. **Parents may legally refuse** these and any other common post-delivery procedures, including but not limited to immediate cord clamping, removal of the baby to an isolette, bathing the baby, and disposal of the placenta.

### MUST PROVIDERS TELL PARENTS ABOUT “SAFE SLEEP”?

**Yes.** Hospitals must provide parents with “**readily understandable information and educational and instructional materials regarding infant safe sleep practices.**” The materials “must explain the risk factors associated with infant death due to unsafe sleep practices and emphasize infant safe sleep practices.”<sup>162</sup> By signing a statement acknowledging receipt of the materials, parents immunize the hospital and attending health care professional against liability “for the action or inaction of a parent with regard to infant safe sleep practices pursuant to materials given to the parent...”<sup>163</sup>

### ARE PROVIDERS RESPONSIBLE FOR PATERNITY DETERMINATIONS?

**To some extent.** [See Parentage Determinations.](#)

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<sup>157</sup> State of Michigan Department of Community Health, *Policy and Procedure Manual: Newborn Screening Specimens*, Sept. 8, 2008, available at [https://www.michigan.gov/documents/mdch/11.1\\_NBSspecimenretentionpolicy\\_316310\\_7.pdf](https://www.michigan.gov/documents/mdch/11.1_NBSspecimenretentionpolicy_316310_7.pdf).

<sup>158</sup> Michigan Neonatal Biobank, <http://www.mnbb.org/about-us> (accessed Jan. 2, 2015).

<sup>159</sup> The mandate falls under the clause specifying screening for “Other treatable but otherwise disabling conditions as designated by the department.” MICH. COMP. LAWS § 333.5431 (2006).

<sup>160</sup> MICH. COMP. LAWS § 333.5432 (2006).

<sup>161</sup> MICH. COMP. LAWS § 333.5125 (1989).

<sup>162</sup> MICH. COMP. LAWS § 333.5885 (2014).

<sup>163</sup> MICH. COMP. LAWS § 333.5886 (2014)

## **Born Alive Infant Protection Act**

### OVERVIEW OF THE LAW

Michigan’s Born Alive Infant Protection Act<sup>164</sup> prescribes responsibilities and procedures for when a live birth results from an abortion. **If an abortion attempt results in a live birth and the mother expresses a desire not to assume custody and responsibility for the newborn—** by refusing to authorize all necessary life sustaining medical treatment for the newborn or by releasing the newborn for adoption—the newborn **shall be considered a newborn** who has been surrendered to an emergency service provider **under the [Safe Delivery of Newborns Law](#).**

### WHAT ARE THE THREE ELEMENTS OF THE LAW?

- 1) Abortion attempt**
- 2) Live birth**
- 3) Mother does not want custody of newborn**

### WHAT IS A “LIVE BIRTH?”

A **live birth** is the complete expulsion or extraction of a product of conception from its mother that exhibits evidence of life, including, but not limited to, one or more of the following: breathing, heartbeat, umbilical cord pulsation, or definite movement of voluntary muscles.

### WHAT ARE THE LEGAL IMPLICATIONS OF A “LIVE BIRTH?”

If an abortion results in a live birth of a newborn, that newborn is a legal person for all legal purposes. Once the baby is born, the woman’s right to terminate pregnancy ends and the state may assert its interest in protecting the infant.

The Michigan Legislature attempted to define “live birth” in the **Legal Birth Definition Act**,<sup>165</sup> but that law was ruled **unconstitutional**.<sup>166</sup> The relevant Michigan law defining “live birth” is the Born Alive Infant Protection Act.

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<sup>164</sup> Born Alive Infant Protection Act, 2002 Mich. Pub. Acts 687 (codified at MICH. COMP. LAWS §§ 333.1071-1073).

<sup>165</sup> Legal Birth Definition Act, 2004 Mich. Pub. Acts 135 (codified at MICH. COMP. LAWS § 333.1085).

<sup>166</sup> In *Northland Family Planning Clinic v. Cox*, 396 F. Supp. 2d 978 (2005), the federal court for the Eastern District of Michigan held that the Legal Birth Definition Act is unconstitutional because it places an undue burden on a woman's right to an abortion, does not provide a sufficient maternal health exception, requires the physician to balance the maternal and neonatal interests in the life exception, and fails to give clear notice of the activities that are prohibited. In

## WHAT MUST THE PHYSICIAN DO?

Under the Born Alive Infant Protection Act, with respect to abortions performed in a hospital setting:

### **A physician attending an abortion that results in a live birth must:**

- 1) Provide immediate medical care to the newborn.
- 2) Inform the mother of the live birth.
- 3) Request transfer of the newborn to a resident, on-duty, or ER physician, who shall provide medical care to the newborn. An appropriate interpretation of the law is that the newborn may be transferred to any qualified clinical health professional, such as a nurse practitioner.
- 4) Transmit to the mother of the newborn any information provided to the attending physician by the emergency service provider who received custody of the newborn under the safe delivery law.

## WHAT MUST THE HOSPITAL DO?

Under the Born Alive Infant Protection Act, with respect to abortions performed in a hospital setting:

### **The emergency service provider must:**

- 1) **Provide humane comfort care** if the newborn is determined to have no chance of survival due to gestational immaturity in light of available neonatal medical treatment or other condition incompatible with life.
- 2) Report the live birth in the usual manner,<sup>167</sup> except that the **parents must be listed as "unknown" and the newborn must be listed as "Baby Doe."**
- 3) Keep the identity of the newborn's parents confidential.
- 4) **Make a reasonable effort to do the following:**<sup>168</sup>
  - a) Take action necessary to protect the newborn's health and safety.
  - b) Inform the surrendering parent that the parent is releasing the newborn to a child placing agency to be placed for adoption.
  - c) Inform the parent that the parent has 28 days to petition the court to regain custody of the newborn.

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2007, the U.S. 6th Circuit Court of Appeals, affirming the decision in Northland, held that the Legal Birth Definition Act is unconstitutional.

<sup>167</sup> MICH. COMP. LAWS § 333.2822(1)(a) (2003) (outlining how live births should be reported).

<sup>168</sup> MICH. COMP. LAWS § 712.3(1) (2006).

- d) Provide the parent with written material approved by the department.<sup>169</sup>
- 5) **Make a reasonable attempt to:**<sup>170</sup>
  - a) Encourage the parent to provide any relevant family or medical information.
  - b) Provide the parent with written material and inform the parent that he or she can receive counseling or medical attention.
  - c) Inform the parent that information that he or she provides will not be made public.
  - d) Ask the parent to identify himself or herself.
  - e) Inform the parent that the state must make a reasonable attempt to identify the other parent, and then ask the parent to identify the other parent, in order to place the newborn for adoption.
  - f) Inform the parent that the child placing agency that takes temporary protective custody of the newborn can provide confidential services (such as social work and counseling services) to the parent.
  - g) Inform the parent that the parent may sign a release for the newborn that may be used at the parental rights termination hearing under this chapter.
- 6) Make no further attempts to directly contact the parent or parents of the newborn.

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<sup>169</sup> MICH. COMP. LAWS § 712.3(1)(d) (2006).

<sup>170</sup> MICH. COMP. LAWS § 712.3(2) (2006).

# POST-DELIVERY ISSUES

## Family and Medical Leave Act (FMLA)

### OVERVIEW OF THE LAW

The purpose of the FMLA is to balance obligations that people might have to their places of work and to their families. Foreseeable and unforeseeable situations arise in which employees need to take a leave of absence. **Most of the time, an employee who returns after an FMLA leave of absence is restored either to the position held before the leave began or another position that has similar pay, benefits, and conditions of employment.**<sup>171</sup>

The FMLA requires larger employers (NOT all employers) to give unpaid leave for up to 12 weeks in a 12 month period to employees who need to 1) care for a new child, 2) care for a family member who has a serious health condition, or 3) recover from the employee's own serious health condition.<sup>172</sup> The Act also provides leave for covered service members and leave for caregivers who are tending to a covered service member with a serious illness or injury.<sup>173</sup>

### WHAT IS FMLA LEAVE?

An eligible employee can take an UNPAID leave from work for **12 weeks during any 12 month period** for one or more of the following reasons:<sup>174</sup>

- 1) The **birth of a child** and to care for this child,
- 2) The **placement of a child** with the employee through adoption or foster care,
- 3) To care for the **spouse, child, or parent** of the employee ONLY IF that person has a **serious health condition, OR**
- 4) For a **serious health condition** that makes the employee **unable to do his job.**

### TO WHICH EMPLOYERS DOES THE FMLA APPLY?

The FMLA covers:<sup>175</sup>

- 1) Employers who employ **50 or more employees in 20 or more workweeks** of the year.

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<sup>171</sup> 29 U.S.C. § 2614(a) (2004).

<sup>172</sup> 29 U.S.C. § 2612(a) (2004).

<sup>173</sup> 29 U.S.C. § 2612(a) (2004).

<sup>174</sup> 29 U.S.C. § 2612(a) (2004).

<sup>175</sup> 29 U.S.C. §§ 2611(4), 2618(a) (2004).

## Family and Medical Leave Act (FMLA)

- 2) All public agencies, including **state, local, and federal employers,**
- 3) **AND local educational agencies and private primary and secondary schools.**

### WHICH EMPLOYEES ARE ELIGIBLE FOR FMLA LEAVE?

An employee is eligible for FMLA leave if the employee:<sup>176</sup>

- 1) Employed by a **covered employer,**
- 2) Has been employed by the employer for **at least 12 months,**
- 3) Has been employed for **at least 1,250 hours during the 12 month period before the beginning of the leave,**
- 4) **AND** is employed at a worksite **where 50 or more employees** are employed by the employer **within 75 miles of that worksite.**

### ARE EMPLOYEES WHO WORK OUTSIDE OF THE UNITED STATES ELIGIBLE?

No, the FMLA **does not apply** to employees who **work outside the United States.**<sup>177</sup>

### WHEN DOES LEAVE FOR THE BIRTH OR PLACEMENT OF A CHILD EXPIRE?

Leave for the birth or placement of a child **expires at the end of the 12 month period beginning on the date of the birth or placement.**<sup>178</sup>

### WHAT DOES AN EMPLOYEE SEEKING FMLA LEAVE FOR A SERIOUS HEALTH CONDITION OF HIS OWN NEED TO KNOW?

- 1) The employee has the **burden of proving** he has a serious health condition.
- 2) The serious health condition must be something that makes him **unable to perform his job.**
- 3) An employer can request a [medical certification](#) to verify that the leave is necessary.

### WHAT COUNTS AS A “SERIOUS HEALTH CONDITION?”

A serious health condition is one that involves **inpatient care** in a hospital, hospice, or residential medical care facility or **continuing treatment by a health care provider.**<sup>179</sup> While

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<sup>176</sup> 29 U.S.C. § 2611(2) (2004).

<sup>177</sup> 29 C.F.R. § 825.105(a) (2008).

<sup>178</sup> 29 U.S.C. § 2612(a) (2004).

<sup>179</sup> 29 U.S.C. § 2611(11) (2004).

## Family and Medical Leave Act (FMLA)

the existence of a serious health condition is generally determined by considering the relevant factual circumstances, Congress intended that these illnesses be covered by the FMLA:<sup>180</sup>

- 1) Heart attacks and heart conditions requiring surgery
- 2) Most cancers
- 3) Back conditions that need extensive therapy or surgery
- 4) Strokes
- 5) Severe respiratory conditions
- 6) Spinal injuries
- 7) Appendicitis
- 8) Pneumonia
- 9) Emphysema
- 10) Severe arthritis
- 11) Severe nervous disorders
- 12) Injuries caused by serious accidents
- 13) Miscarriages, complications during pregnancy, or illnesses related to pregnancy

A “serious health condition” ALSO includes an **illness, injury, impairment, or physical or mental condition** that involves:<sup>181</sup>

- 1) Any period of **incapacity or treatment in connection with inpatient care**, such as an overnight stay in a hospital, hospice, or residential medical care facility,
- 2) **Any period of incapacity, longer than 3 days, requiring absence from work, school, or other regular daily activities** that involves **continuing treatment** or relating to **pregnancy or prenatal care**,
- 3) **OR continuing treatment for a chronic condition** that, if not treated, would result in a period of incapacity of more than 3 days.

### WHAT CONDITIONS DO NOT COUNT AS “SERIOUS HEALTH CONDITIONS?”

The following conditions are **NOT considered to be “serious health conditions”** under the FMLA, unless complications arise:<sup>182</sup>

- 1) Cosmetic treatments (plastic surgery, acne treatments, etc.)
- 2) Common cold or flu
- 3) Ear aches
- 4) Upset stomach
- 5) Minor ulcers

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<sup>180</sup> H.R. REP. NO. 103-8, pt. 1, at 29 (1993), *reprinted in* 1993 U.S.C.C.A.N. 31.

<sup>181</sup> 29 C.F.R § 825.113 (2008).

<sup>182</sup> 29 C.F.R § 825.113 (2008).

## Family and Medical Leave Act (FMLA)

- 6) Headaches other than migraines
- 7) Routine dental problems

### WHAT IS MEDICAL CERTIFICATION?

**Employers can verify that reason for leave is legitimate by requesting a medical certification.** An employee's supervisor CANNOT contact a health care provider, but the health care provider can be contacted by the employer's HR representative, health care provider, leave administrator, or other management official to obtain a medical certification.<sup>183</sup> The Department of Labor provides a medical certification form at [www.dol.gov/esa/regs/compliance/whd/fmla](http://www.dol.gov/esa/regs/compliance/whd/fmla).<sup>184</sup>

### WHAT MUST AN EMPLOYEE DO WHEN THERE IS A FORESEEABLE NEED FOR FMLA LEAVE?

Generally, the **birth or placement of a child and planned medical treatment** are circumstances in which it will be foreseeable that the employee will need FMLA leave.

The employee should:<sup>185</sup>

- 1) **Provide 30 days notice** before the date the FMLA leave is to begin,
- 2) Schedule any planned treatment so as to **minimize disruption of the workplace**,
- 3) Make a reasonable effort to **balance the needs of the employer**.

HOWEVER, notice may be given "**as soon as practicable**" if:<sup>186</sup>

- 1) A **pregnant** employee's **medical condition** makes **30 days notice** before leave **impractical**,
- 2) If there is **not enough opportunity for notice** before **placement of a child** with the employee,
- 3) OR if leave for **medical treatment** requires leave to begin in **less than 30 days**.

### WHAT SHOULD AN EMPLOYEE DO IF THE NEED FOR LEAVE IS NOT FORESEEABLE?

If an employee cannot or did not foresee the need for leave, the employee should:<sup>187</sup>

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<sup>183</sup> 29 C.F.R. § 825.307 (2008).

<sup>184</sup> U.S. Dept. of Labor, *View ESA-WHD's Form WH-380 Online*, [www.dol.gov/esa/regs/compliance/whd/fmla](http://www.dol.gov/esa/regs/compliance/whd/fmla) (last visited Dec. 23, 2010).

<sup>185</sup> 29 U.S.C. § 2612(e) (2004); 29 C.F.R. § 825.302(a) (2008).

<sup>186</sup> 29 C.F.R. § 825.302(a) (2008).



## Family and Medical Leave Act (FMLA)

- 1) **Provide notice** (in person or by phone, fax, e-mail, etc., or through a family member) to the employer within a day or two of learning of the need for leave, except in emergency circumstances.<sup>188</sup>
- 2) **Provide sufficient information** for an employer to determine whether the FMLA applies. *Example:* Information about a condition that makes the employee unable to do his job, an employee's pregnancy or overnight hospitalization, whether the employee or a family member is undergoing continued treatment by a health care provider, anticipated duration of the absence if possible, etc.
- 3) **AND comply with the employer's usual notice and procedural requirements for requesting leave**, unless there are unusual circumstances.

### MUST THE EMPLOYEE SPECIFICALLY STATE THAT FMLA LEAVE IS NEEDED?

No, the employee does not have to mention the FMLA at all. The employee must state that leave is needed and should give the employer enough information to figure out whether the FMLA applies to the leave.<sup>189</sup>

### WHAT JOB PROTECTION DOES AN EMPLOYEE RECEIVE UNDER THE FMLA?

- 1) When an employee returns from FMLA leave, he is entitled to be returned to the **same position OR an equivalent position with the same benefits, pay, and other terms and conditions of employment.**<sup>190</sup>
- 2) If the employee is not qualified for the position anymore because of the inability to attend necessary training, renew a license, etc., then the employer must give the employee **reasonable time to complete those requirements** upon return to work.<sup>191</sup>
- 3) If an employee can no longer perform an **essential function of the job** upon return from FMLA leave, **the employer does NOT have to restore the employee to the same position** or even an equivalent position under the FMLA.<sup>192</sup> **HOWEVER**, the employer might need to place the employee in another position as a **reasonable accommodation under the ADA.** ([See Americans with Disabilities Act](#))

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<sup>187</sup> 29 C.F.R. § 825.303(b) (2008).

<sup>188</sup> 29 C.F.R. § 825.303 (2008).

<sup>189</sup> 29 C.F.R. § 825.303(b) (2008).

<sup>190</sup> 29 C.F.R. § 825.214 (2008).

<sup>191</sup> 29 C.F.R. § 825.215(b) (2008).

<sup>192</sup> 29 C.F.R. § 825.214(b) (2008).

WHAT LIMITATIONS ARE THERE ON FMLA JOB PROTECTION?

- 1) An employer can **deny reinstatement** to a **highly compensated employee** when it is **necessary to prevent substantial and grievous economic injury** to the employer's operations.<sup>193</sup>
  - a) A **highly compensated employee** is one who is among the **highest paid 10%** of employees within 75 miles of the worksite.<sup>194</sup>
- 2) **Reinstatement is not required for layoffs.** If an employee is laid off during the FMLA leave, the employer does not need to restore the employee's job or provide benefits unless those obligations exist under some other agreement.<sup>195</sup>
- 3) **Reinstatement is not required for shift elimination.** If a shift has been eliminated or **overtime decreased**, an employee does not have the right to work that particular shift or the original overtime hours when he returns to work.<sup>196</sup>
- 4) **Reinstatement is not required for specific term employment.** If an employee was hired for a **specific term** or to work on a **particular project**, the employer does not need to restore the employee to his job if that term or project is over.<sup>197</sup>
- 5) If the **employee does not return to work within 12 weeks** and is therefore terminated, the employer is NOT violating the FMLA.<sup>198</sup>
- 6) If an employee can no longer perform an **essential function of the job** upon return from FMLA leave, **the employer does NOT have to restore the employee to the same position** or even an equivalent position under the FMLA.<sup>199</sup> **HOWEVER**, the employer might need to place the employee in another position as a **reasonable accommodation under the ADA.** ([See Americans with Disabilities Act](#))

WHAT NOTICE REQUIREMENTS DOES THE FMLA IMPOSE ON THE EMPLOYER?<sup>200</sup>

- 1) FMLA covered employers are required to **conspicuously post a notice explaining the Act's provisions** and information on how to file complaints of FMLA violations.
- 2) When an employee requests FMLA leave OR when the employer finds out that the employee's leave would be covered by the FMLA, the employer must **notify the**

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<sup>193</sup> 29 C.F.R. §§ 825.217-219 (2008).

<sup>194</sup> 29 C.F.R. § 825.217 (2008).

<sup>195</sup> N. Peter Lareau, Labor and Employment Law §169.06 (2010); 29 C.F.R. § 825.216 (2008).

<sup>196</sup> *Id.*

<sup>197</sup> *Id.*

<sup>198</sup> Lareau, *supra* note 464, at §169.07.

<sup>199</sup> 29 C.F.R. § 825.214(b) (2008).

<sup>200</sup> 29 C.F.R. § 825.300 (2008).

## Family and Medical Leave Act (FMLA)

**employee of FMLA leave eligibility within 5 business days**, unless there are extenuating circumstances.

- 3) The employer should provide **written notice** detailing:
  - a) The specific expectations and obligations of the employee,
  - b) That FMLA leave is being designated and will count against the annual FMLA leave entitlement,
  - c) Any requirements to furnish certification of a serious health condition,
  - d) The employee's right to substitute paid leave or whether the employer will require substitution of paid leave,
  - e) Employee's status as a highly compensated employee (if applicable) and the potential denial of restoration following FMLA leave,
  - f) Employee's rights to maintain benefits and restoration of the same or equivalent job,
  - g) Any requirement to make premium payments to maintain health benefits,
  - h) Any potential liability for payment of health insurance premiums if employee fails to return to work after the FMLA leave,
  - i) Any other required certification forms or information regarding periodic follow-ups as to employee's status, intent to come back to work, etc.

## Breastfeeding Law in Michigan

### OVERVIEW OF THE LAW

Federal and Michigan laws on breastfeeding address a woman's right to breastfeed in public, mandate accommodations for breastfeeding or breast milk pumping mothers in the workplace, provide for government assistance for breastfeeding mothers, and, to a lesser degree, address the impact of breastfeeding on family law cases and on jury duty.

### WHAT IS BREASTFEEDING?

Breastfeeding occurs when a child receives breast milk direct from the breast or expressed. Legal issues arise when women breastfeed in public or wish to express milk in the workplace.

### WHAT MUST A PHYSICIAN DO?

**A physician has no legal obligation in connection with breastfeeding.** In keeping with national and state health policy, however, a physician can encourage and facilitate breastfeeding.

### IS IT LEGAL TO BREASTFEED IN PUBLIC?

**Yes.** Public breastfeeding is not criminalized anywhere in the United States. Women may be concerned that breastfeeding in public puts them at risk of prosecution under indecent exposure or public nudity laws. To counter that risk, Michigan law excludes breastfeeding from any definition of nudity contained in city, township or village statutes and further specifies this is the case "whether or not the nipple or areola is exposed during or incidental to the feeding."<sup>201</sup>

**Women can breastfeed in public places in Michigan without fear of prosecution.**

Michigan recently passed a Breastfeeding Antidiscrimination Act that establishes a right to breastfeed in any place of public accommodation or public service. **Businesses**, institutions, and transportation facilities open to the public now **may not refuse service** or otherwise impede someone in the act of breastfeeding.<sup>202</sup> One notable exception is in prisons and jails, as applied to incarcerated individuals.<sup>203</sup> Injured parties may recover a nominal amount in a civil suit.<sup>204</sup>

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<sup>201</sup> MICH. COMP. LAWS §§ 67.1 (1994), 117.4i (1999), 117.5h (1994).

<sup>202</sup> MICH. COMP. LAWS §§ 37.232 (2014).

<sup>203</sup> MICH. COMP. LAWS §§ 37.231 (2014).

<sup>204</sup> MICH. COMP. LAWS §§ 37.233 (2014).

## Breastfeeding Law in Michigan

The Act stopped short of recognizing a **fundamental right** to breastfeed<sup>205</sup> in any public or private location,<sup>206</sup> a change that would have required amendment of Michigan's civil rights act. As a result, actions in the workplace that are hostile to breastfeeding cannot at present be challenged under sex discrimination laws. While sex discrimination under federal law now covers issues of pregnancy,<sup>207</sup> the law does not extend to breastfeeding.<sup>208</sup> Michigan's law of public accommodation similarly forbids discrimination based on sex in "the full and equal utilization of public accommodations,"<sup>209</sup> but no Michigan court has linked sex discrimination with breastfeeding.

### ARE EMPLOYERS OBLIGATED TO PROVIDE ACCOMMODATIONS FOR BREASTFEEDING WOMEN TO EXPRESS MILK DURING THEIR WORKDAY?

**Yes, but with significant limitations.** The 2010 federal Patient Protection and Affordable Health Care Act requires an employer to provide reasonable break time for an employee to express breast milk for her nursing child for one year after the child's birth each time the employee has a need to express milk; the employer must also provide a place other than a bathroom for the employee to express milk.<sup>210</sup> The law was effective immediately when President Obama signed the bill, but there are as yet no rules for enforcement.<sup>211</sup>

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<sup>205</sup> This right was recognized as existing under the right to privacy, as read into the 9<sup>th</sup> and 14<sup>th</sup> amendments of the U.S. Constitution. *Dike v. Orange County Sch. Bd.*, 650 F.2d 783 (5<sup>th</sup> Cir. 1981).

<sup>206</sup> Alaska 's 1998 statutes §§ 29.25.080 and 01.10.060 contains such a provision. Nat'l Conference of State Legislatures, *Breastfeeding Laws* (2010) <http://www.ncsl.org/default.aspx?tabid=14389>.

<sup>207</sup> Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000d *et seq.* See also Pregnancy Discrimination Act of 1978, 42 U.S.C. § 2000e(k). For an analysis of this interpretation of the PDA and of *Wallace v. Pyro Mining Co.*, 789 F. Supp. 867 (W.D.Ky. 1990), *aff'd.*, 951 F.2d 351 (6<sup>th</sup> Cir. 1991), see Diana Kasdan, Note, *Reclaiming Title VII and the PDA: Prohibiting Workplace Discrimination Against Breastfeeding Women*, 76 N.Y.U. L. REV. 309, 309-10 (2001).

<sup>208</sup> *Derungs v. Wal-Mart Stores*, 374 F.3d 428 (6<sup>th</sup> Cir. 2004).

<sup>209</sup> Elliott-Larsen Civil Rights Act, 1976 Mich. Pub. Acts 453, § 37.2102(1).

<sup>210</sup> Patient Protection and Affordable Care Act, Pub. L. Nos. 111-148 & 111-152, § 4207, 111<sup>th</sup> Cong., Sess. 2 (2010).

<sup>211</sup> U.S. Breastfeeding Committee, *Health Care Reform Boosts Support for Employed Breastfeeding Mothers F.A.Q.*, <http://www.usbreastfeeding.org/Workplace/WorkplaceSupport/WorkplaceSupportinHealthCareReform/tabid/175/Default.aspx> (last visited May 19, 2010).

## Breastfeeding Law in Michigan

The Act currently contains no penalties for employers who fail to comply. In addition, the law applies only to hourly workers, not to salaried workers. The mandated break time is unpaid. Employers with fewer than 50 employees may claim a hardship exemption from the law.<sup>212</sup> These limitations may restrict the usefulness of the Act to breastfeeding working women.

Michigan law does not mandate workplace accommodation for breastfeeding women.<sup>213</sup>

### DOES THE GOVERNMENT PROVIDE ANY ASSISTANCE FOR BREASTFEEDING WOMEN?

**Yes.** Federal Medicaid regulations allow states to provide recipients with breastfeeding education and equipment rentals (e.g. breast pumps), but will not reimburse for lactation consultants. Since Medicaid pays for over half of Michigan births, it is worth reminding patients to check their insurance plans for coverage of these services. Many plans refer postpartum women to the Michigan Women, Infants, and Children Program.<sup>214</sup> WIC's Special Supplemental Nutrition Program provides income-qualified<sup>215</sup> breastfeeding women with extra food, breastfeeding advice from peer counselors, and breast pump rentals.<sup>216</sup>

The government also supports breastfeeding through its Baby-Friendly Hospital Initiative (BFHI), which suggests hospital policies based on Ten Steps to Successful Breastfeeding as outlined by UNICEF/WHO.<sup>217</sup> There are at present five BFHI hospitals in Michigan.<sup>218</sup>

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<sup>212</sup> Jake Aryeh Marcus, *Curb Your Enthusiasm About the New Federal Workplace Pumping Law*, SUSTAINABLE MOTHERING, (May 10, 2010) <http://www.sustainablemothering.com/2010/05/10/curb-your-enthusiasm-about-the-new-federal-workplace-pumping-law/>.

<sup>213</sup> Mothering, *Workplace Pumping and the Law*, March 6, 2010, <http://mothering.com/sites/resources/map.pdf>.

<sup>214</sup> WIC programs are facilitated through local health departments and other agencies. See Mich. Dept. of Community Health, *WIC Agency List*, [http://www.michigan.gov/mdch/1,1607,7-132-2942\\_4910\\_4920-14165--,00.html](http://www.michigan.gov/mdch/1,1607,7-132-2942_4910_4920-14165--,00.html) (last visited May 20, 2010).

<sup>215</sup> Mich. Dept. of Community Health, *Michigan WIC Program Guidelines*, [http://www.michigan.gov/mdch/0,1607,7-132-2942\\_4910\\_6329-12671--,00.html](http://www.michigan.gov/mdch/0,1607,7-132-2942_4910_6329-12671--,00.html), June 1, 2009.

<sup>216</sup> Mich. Dept. of Community Health, *WIC Helps Moms & Babies with Breastfeeding*, [http://www.michigan.gov/mdch/0,1607,7-132-2942\\_4910\\_4919-13921--,00.html](http://www.michigan.gov/mdch/0,1607,7-132-2942_4910_4919-13921--,00.html) (last visited May 20, 2010).

<sup>217</sup> BFHI USA, *The Ten Steps to Successful Breastfeeding*, <http://www.babyfriendlyusa.org/eng/10steps.html> (last visited May 20, 2010).

<sup>218</sup> BFHI USA, *Designated Facilities by State*, <http://www.babyfriendlyusa.org/find-facilities/designated-facilities--by-state> (last visited Jan. 5, 2015).

IS BREASTFEEDING A FACTOR IN FAMILY AND CRIMINAL LAW CASES?

**Yes, but only minimally.** Incarcerated women may find their right to breastfeed curtailed, as prisons have no legal duty to facilitate breastfeeding.<sup>219</sup> There have been no Michigan cases of breastfeeding women charged with child endangerment because of their use of controlled substances.<sup>220</sup>

ARE BREASTFEEDING MOTHERS EXCUSED FROM JURY DUTY?

**Yes.** On March 29, 2012, the Michigan Legislature successfully amended the state's juror qualifications to include, upon request, an exemption from jury service for the period during which a woman is nursing her child.<sup>221</sup> A nursing mother who requests the exemption shall be excused if she provides a letter from a physician or a certified nurse midwife verifying that she is a nursing mother. **However**, there is no federal legislation to exempt a breastfeeding mother from jury duty.<sup>222</sup>

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<sup>219</sup> Corey Silberstein Shdaimah, *Why Breastfeeding is (Also) a Legal Issue*, 10 HASTING WOMEN'S L.J. 409, 428-9 (1999).

<sup>220</sup> There have been cases in other jurisdictions, e.g. *State v. Nieberger*, 128 P.3d 1223 (Utah Ct. App. 2006).

<sup>221</sup> MICH. COMP. LAW § 600.1307a (2004) (amended 2012).

<sup>222</sup> Douglas Reid Weimer, Cong. Research Serv., *Breastfeeding and Jury Duty: State Laws, Court Rules, and Related Issues* (2005),

[http://maloney.house.gov/documents/olddocs/breastfeeding/20050517\\_CRS\\_Jury%20Duty.pdf](http://maloney.house.gov/documents/olddocs/breastfeeding/20050517_CRS_Jury%20Duty.pdf).

# Adoption and Parentage Determinations

## Adoption

### WHAT IS ADOPTION?

Adoption is a **two-step judicial process** in which (1) the **legal obligations and rights** of a child toward the biological parents are **terminated**, and (2) **new rights and obligations** are **created** between the child and the adoptive parents. Adoption is legislated and regulated for the most part by the **state** rather than federal government. Courts rule on adoption chiefly based on the **best interests of the child**.

### WHAT IS THE ADOPTION PROCESS?

The two-part adoption process consists of a **court order terminating the rights of the parents** and, later, an **order of adoption**. The process is described in more detail by the Michigan Department of Human Services (DHS):<sup>223</sup>

- The prospective **adoptive parent petitions** the court **to adopt** a specific child.
- The petition and other legal forms are normally accompanied by a **consent** signed by the parent, a child placing agency, a court or the DHS, depending on the type of adoption.
- The court orders an **investigation** to assure that the interests of the adoptee are protected.
- After the court has received a completed report of investigation and is satisfied that the adoptee's best interests are served, the **court will issue an order terminating the rights of the parent**, the child placing agency, court or the DHS. The court makes the adoptee a ward of the court, **orders placement in adoption**, and assigns a child placing agency, DHS, or an agent of the court to **supervise/monitor** the adoptive placement.
- Six months after the placement, or longer if the court finds it in the adoptee's best interest, the **court will enter an order of adoption**.

### HOW ARE ADOPTIVE PARENTS SELECTED?

All adoptions must be formalized through the state courts, in the process described above. The selection of the adoptive parents occurs in one of two ways:

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<sup>223</sup> STATE OF MICHIGAN DEPARTMENT OF HUMAN SERVICES, DHS-PUB-823, ADOPTING A CHILD IN MICHIGAN (2008), available at [http://www.michigan.gov/documents/dhs/DHS-PUB-0823\\_221566\\_7.pdf](http://www.michigan.gov/documents/dhs/DHS-PUB-0823_221566_7.pdf).



- 1) **Direct placement adoption.** The **birth parents** personally select the adoptive family, transfer physical custody of the child to the adoptive parents, and consent to the adoption.<sup>224</sup> An **adoption agency** or **attorney** may assist with identifying potential adoptive parents and fulfilling legal requirements. The same attorney may not represent both birth parents and adoptive parents.<sup>225</sup> Most infant adoptees are placed by direct adoption.
- 2) **State and court ward adoption.** When a court **terminates a parent's parental rights**, the child is placed **in the care of the state**. Either **DHS or agencies** under contract with the state work to place children in adoptive homes.

#### WHAT QUESTIONS MIGHT A PROSPECTIVE BIRTH MOTHER ASK?

*Will my child, once adopted, know my identity?* **Yes, if the birth mother does not file a denial.** The DHS maintains the Central Adoption Registry (CAR), where birth parents can file a statement of consent or denial to the release of identifying information.<sup>226</sup> **Unless a statement of denial has been filed, adults** who were adopted as children **can obtain** their original names, the names of their biological siblings at the time of termination of parental rights, and **the names of the birth parents.**<sup>227</sup> Once the adoption has been finalized, the records are closed to everyone else, except by court order.<sup>228</sup> The original birth certificate is sealed, and a new birth certificate is issued to the adoptive parents.<sup>229</sup> **The UM Office that manages birth and death certificates can be found at <http://www.med.umich.edu/i/him/About/bc.html>.**

*Will my child, once adopted, know my medical history?* **Yes.** The agency or court that retains the adoption record is **required to release** certain **non-identifying information** about the child's birth family to the adoptive family, before the child is placed. This information includes the **child's health record** and an account of the **health, psychological and genetic history of biological parents** and siblings.<sup>230</sup> Specifically required is information about the birth **mother's pregnancy and prenatal care**, including any **drugs or medications** taken during this time.<sup>231</sup>

*I am married; must my husband consent to releasing the child for adoption?* **Yes.** A husband is presumed to be the father of the wife's child, and so must also give consent to

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<sup>224</sup> MICH. COMP. LAWS § 710.23a (2004).

<sup>225</sup> MICH. COMP. LAWS § 710.55a (1995).

<sup>226</sup> MI Dept. of Human Services, Central Adoption Registry, *Parent's Consent/Denial To Release Information to Adult Adoptee (DHS-1919)*, [http://www.michigan.gov/documents/FIA1919\\_10574\\_7.pdf](http://www.michigan.gov/documents/FIA1919_10574_7.pdf) (last visited Aug. 20, 2010).

<sup>227</sup> MICH. COMP. LAWS § 710.27a(1) (1995).

<sup>228</sup> MICH. COMP. LAWS § 710.67(1) (1995).

<sup>229</sup> MICH. COMP. LAWS § 710.67(2)-(3) (1995).

<sup>230</sup> MICH. COMP. LAWS § 710.27(1)(c) (1995).

<sup>231</sup> MICH. COMP. LAWS § 710.27(1)(b) (1995).

## Adoption and Parentage Determinations

releasing the child for adoption.<sup>232</sup> However, if the birth mother claims that the husband is *not* the father of her child, a court hearing must be held to determine the identity of the father so that his paternal rights can be protected.<sup>233</sup>

*I am not married; must the father consent to releasing the child for adoption? Yes. But if consent cannot be obtained, the father's parental rights must be terminated by the court before the child can be released for adoption.*<sup>234</sup> An **unmarried pregnant woman** may file a **petition** with the court stating her **intention to release** her expected child for adoption. Her petition names the birth father (or possible fathers, should there be any uncertainty), whom the court will then notify of his right to claim paternity.<sup>235</sup> If the **father fails to respond or to claim paternity** before the birth of the child, he is presumed to have **denied interest in the custody** of the child, following which the court can **terminate his parental rights**.<sup>236</sup> Before this termination is final, however, the birthmother may execute a release which **terminates her parental rights**, upon which the **child is released to an agency**, which then files for custody for temporary care of the child.<sup>237</sup>

*Can the court release my child for adoption without my consent? Only if the birth parents' parental rights have been terminated by the court* (usually due to a finding of abuse or neglect).<sup>238</sup>

*I am under the age of 18; can I release the child for adoption? Yes, but only with the additional consent of the birth mother's parents or guardian,*<sup>239</sup> unless the birth mother is an emancipated minor. (See [Healthcare Rights of Minors](#)) If consent is given by a guardian, consent is also required from the court that appointed the guardian.<sup>240</sup>

*Are there any constraints on the adoptive parents I can choose? Yes.* If the birth mother is a registered member of a federally-recognized Indian (Native American) tribe,<sup>241</sup> the federal **Indian Child Welfare Act**<sup>242</sup> applies. Under the Act, the birth mother's tribal council has

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<sup>232</sup> MICH. COMP. LAWS § 710.43(1)(a) (1998).

<sup>233</sup> MICH. COMP. LAWS § 710.36(1) (1998).

<sup>234</sup> MICH. COMP. LAWS § 710.31(1) (1995).

<sup>235</sup> MICH. COMP. LAWS § 710.34(1) (1998). *See also* MICH. COMP. LAWS § 710.33 (1975).

<sup>236</sup> MICH. COMP. LAWS § 710.34(2)(d) (1998).

<sup>237</sup> MICH. COMP. LAWS § 710.31(2) (1995).

<sup>238</sup> MICH. COMP. LAWS § 710.28(1)(a)(i) (1998).

<sup>239</sup> MICH. COMP. LAWS § 710.28(2) (1998). *See also* MICH. COMP. LAWS § 710.43(4) (1998).

<sup>240</sup> MICH. COMP. LAWS § 710.28(4) (1998).

<sup>241</sup> The state provides a list of federally-recognized tribes in Michigan, as well as a map of their locations. Mich. Dept. of Civil Rights, *Michigan Indian Directory American Indian Organizations, American Indian Historic Tribes, Federally Recognized Tribes and other Indian Programs and Services* 5, 31, [http://www.michigan.gov/documents/MID05\\_125020\\_7.pdf](http://www.michigan.gov/documents/MID05_125020_7.pdf), 2005-6.

<sup>242</sup> Indian Child Welfare Act of 1978, 25 U.S.C. § 1901–1963.

## Adoption and Parentage Determinations

exclusive jurisdiction over the placement of the child if he or she was born or is domiciled on the reservation.<sup>243</sup> If the child's domicile (which follows the mother's domicile) is not on the reservation, the tribal court *may* move for jurisdiction over the placement.<sup>244</sup>

*Will I meet the adoptive family? Only if the birth mother chooses to.* In a **direct placement** adoption, the birth mother can choose whether to meet the adoptive family and whether, in the future, she wishes to remain in contact with the child. An **agency or state department** that has custody of the child *may* involve the child's parents in the selection of an adoptive parent and *may* facilitate the exchange of identifying information or meetings between the birth parent and the adoptive parent.<sup>245</sup>

*Can I receive free counseling following the adoption? Yes.* Adoptive parents are required to pay the costs of counseling for the birth parent unless the birth parent waives the counseling.<sup>246</sup>

*I have been offered money or gifts in exchange for placing my child for adoption. May I accept these?*<sup>247</sup> **No.** No one may charge a fee for referrals to potential adoptive parents or birth parents for the purpose of adoption, or for evaluation of potential adoptive parents.<sup>248</sup> Adoptive parents *may* pay for child placement agency services, health care costs of the birth mother relating to the birth of the child, counseling services for the birth parents, the birth mother's living expenses before the birth of the child and up to 6 weeks after the birth, and legal fees for consultation, legal advice, preparation of papers and representation in an adoption proceeding.<sup>249</sup>

### WHAT QUESTIONS MIGHT A PROSPECTIVE ADOPTIVE MOTHER ASK?

**Although the process of adopting a child concerns itself primarily with legal matters rather than a medical ones, the issues described below may provide physicians with a resource should they wish to counsel patients seeking to adopt.**

*Does the court determine my eligibility to adopt a child? Yes.* The birth mother or a state agency may select a family, but the child will not be permanently placed with that family until a

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<sup>243</sup> 25 U.S.C. § 1911(a) (2010).

<sup>244</sup> *Miss. Band of Choctaw Indians v. Holyfield*, 490 U.S. 30 (U.S. 1989).

<sup>245</sup> MICH. COMP. LAWS § 710.23b(2) (1995).

<sup>246</sup> MICH. COMP. LAWS § 722.956(1)(a) (1999).

<sup>247</sup> MICH. COMP. LAWS § 710.54(1) (1995).

<sup>248</sup> MICH. COMP. LAWS § 710.54(2) (1995).

<sup>249</sup> MICH. COMP. LAWS § 710.54(3) (1995).

## Adoption and Parentage Determinations

court-ordered investigation has determined that the family is a suitable one for the child.<sup>250</sup> The factors to be considered in an investigation are as follow:<sup>251</sup>

- The best interests of the child.
- The child's family background.
- The reason for the child's placement for adoption.

The prospective adoptive parent pursuing a direct placement adoption can request that a **pre-placement assessment** be prepared by a child placing agency, even before a potential adoptee is found.<sup>252</sup>

*Do any circumstances disqualify me from being an adoptive parent?* **Yes.** Convictions for **criminal sexual conduct** with a child disqualify the offender as an adoptive parent.<sup>253</sup>

*May I adopt a child of a different race from a state agency or department?* **Probably.** Federal law prohibits state bodies that receive federal funding from discriminating in a adoption placement based on the parent or child's race, color or national origin, as does Michigan DHS administrative policy. However, federal law does permit placement based on race in rare cases, where it is in the best interests of the child.<sup>254</sup>

*I am unmarried. May I adopt a child?* **Yes.** DHS explicitly writes: "A single parent is perfectly acceptable if all other criteria are met, and the parent is assessed as capable of meeting the needs of the child."<sup>255</sup>

*I am in a same-sex partnership. May we jointly adopt a child?* **No.** In Michigan only married (opposite-sex) couples or single people may legally adopt. No legal mechanism exists for a same-sex couple to adopt one child (second-parent adoption).<sup>256</sup> Those mechanisms *do* exist in several other states. Although Michigan will not recognize same-sex marriages

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<sup>250</sup> MICH. COMP. LAWS § 710.29(6) (1998). *See also* MICH. COMP. LAWS § 710.46 (1995).

<sup>251</sup> MICH. COMP. LAWS § 710.46(1) (1995). *See also* Mich. Dept. of Human Services, *Child Welfare Philosophy*, [http://www.michigan.gov/documents/DHS-Child-Welfare-Philosophy\\_167533\\_7.pdf](http://www.michigan.gov/documents/DHS-Child-Welfare-Philosophy_167533_7.pdf) (2006).

<sup>252</sup> MICH. COMP. LAWS § 710.23f (2006).

<sup>253</sup> MICH. COMP. LAWS § 710.22a (2003).

<sup>254</sup> Adoption.com Encyclopedia, *Multiethnic Placement Act (MEPA)*, <http://encyclopedia.adoption.com/entry/Multiethnic-Placement-Act-MEPA/233/1.html> (2000).

*See also*

<sup>255</sup> Mich. Dept of Human Services, *Frequently Asked Questions*, <http://www.michigan.gov/dhs/0,1607,7-124-8566-24130--F,00.html> (last visited Aug. 20, 2010).

<sup>256</sup> Proposed bills to extend permission to adopt to unmarried couples have been unsuccessful. H.B. 4131, 95<sup>th</sup> Leg. (Mich. 2009); H.B. 4060, 97<sup>th</sup> Leg. (Mich. 2013).

## Adoption and Parentage Determinations

performed in other states,<sup>257</sup> it will most likely recognize adoptions granted to same-sex couples in other states.<sup>258</sup>

*Is state law involved if I decide to adopt a child from another country?* **Yes.** Placement of a child in Michigan from a country **other than the United States or Canada** requires that the state conduct an **investigation** of the prospective adoptive parents, just as for an intra-state adoption. The prospective parents are charged a fee for this service.<sup>259</sup>

*Will the law treat my adopted child differently from a birth child?* **No.** Once the adoption order and a new birth certificate are issued, the adopted child has the **same legal rights as a birth child** in the adoptive family, including rights of **inheritance**.<sup>260</sup>

*Does the state provide assistance for families who adopt children with special needs?* **Yes.** Many children in **state custody** available for placement are classified as *special needs* children who might be particularly difficult to place. The federal government, in providing subsidies for states to use as **financial assistance and incentives** to prospective adoptive parents, defines **factors** for states to use in defining special needs:<sup>261</sup>

- The children are between 3-17 years old.
- They are of a certain ethnic or family background, or members of a minority racial or ethnic group.
- They are members of a sibling group being placed together.
- They have physical, mental, or emotional disabilities or medical conditions.

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<sup>257</sup> Mich. Att’y Gen. Memo 7160 (2004), available at <http://www.ag.state.mi.us/opinion/datafiles/2000s/op10236.htm>.

<sup>258</sup> An Oklahoma federal district court decided a similar case in which it held that the Constitution's Full Faith and Credit clause required the court to honor adoption orders from other states. *Finstuen v. Edmondson*, 497 F.Supp.2d 1295 (W.D.Okla. 2006). The Michigan Court of Appeals cited *Finstuen* as persuasive, when it found that an unmarried same-sex couple who had adopted by second-parent adoption in Illinois, must both be regarded as parents in Michigan. *Giancaspro v. Congleton*, 2009 WL 416301 (Mich. App. 2009). See also Leonard Link Blog, *Michigan Appeals Court Orders Respect for Second-Parent Adoption from Illinois*, <http://newyorklawschool.typepad.com/leonardlink/2009/02/michigan-appeals-court-orders-respect-for-secondparent-adoption-from-illinois.html>, Feb. 22 2009.

<sup>259</sup> MICH. COMP. LAWS § 710.46 (1995).

<sup>260</sup> MICH. COMP. LAWS § 710.60 (2006). See also MICH. COMP. LAWS § 333.2831 (1997).

<sup>261</sup> North American Council on Adoptable Children, *Michigan State Subsidy Profile*, <http://www.nacac.org/adoptionssubsidy/stateprofiles/michigan.html>, July 2007. See also 42 U.S.C. §§ 670-679 (2010).

Michigan also requires children to have been in foster care for at least four months immediately prior to placement for a special needs subsidy to be issued.<sup>262</sup>

### Parentage Determinations

#### WHAT MAKES SOMEONE A PARENT IN MICHIGAN?

Married parents are jointly responsible for their child's support. Unmarried parents are responsible not only for the child's support and education, but also for the medical expenses resulting from the mother's pregnancy and the child's birth;<sup>263</sup> a state court can order one or both parents to pay those expenses.<sup>264</sup> Because of this interest in establishing responsibility for the child's support, the state has a formal mechanism for determining parentage, the Affidavit of Parentage (AOP). A hospital's success in having unmarried parents complete the AOP is tied to federal funding for state child support programs.<sup>265</sup>

The different methods of **determining parentage** are as follow:

- 1) *Gestation*. A woman who gives birth is **automatically** held to be the child's parent. Her name is listed as the mother on the birth certificate. This is true regardless if the baby is genetically related to her, or even if she has signed a surrogacy contract. ([See Surrogacy](#)).
- 2) *Consent to ART*. When a husband **consents to his wife's use** of Assisted Reproductive Technology to conceive a child, **both parents** are considered to be the legal parents of the child.<sup>266</sup> This ensures that a sperm or egg donor is not mistakenly named the legal parent of the child.
- 3) *Opposite-Sex Marriage*. The "**husband presumption**" means that a child conceived by or born to a married woman is automatically considered the child of the husband. However, the **presumption may be rebutted** by clear and convincing evidence;<sup>267</sup> for example, by DNA testing. Same-sex marriage may potentially enjoy the same benefit, should the U.S. Supreme Court agree to hear *DeBoer v. Snyder*, a case with origins in Michigan's Eastern District federal court, or one of several other similar cases.<sup>268</sup>

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<sup>262</sup> MICH. COMP. LAWS § 400.1151 (2002).

<sup>263</sup> MICH. COMP. LAWS § 722.712(1) (2010).

<sup>264</sup> MICH. COMP. LAWS § 722.712(2)-(3) (2010).

<sup>265</sup> Mich. Dept. of Human Services, *Child Support Information for Hospitals*, [http://www.michigan.gov/dhs/0,1607,7-124-5453\\_5528-133813--,00.html](http://www.michigan.gov/dhs/0,1607,7-124-5453_5528-133813--,00.html) (last visited Aug. 23, 2010).

<sup>266</sup> MICH. COMP. LAWS § 333.2824(6) (1997).

<sup>267</sup> Quoted in *Rucinski v. Rucinski*, 431 N.W.2d 241, 242 (Mich. App. 1988) (citing *Shepherd v. Shepherd*, 265 N.W.2d 374, 377 (Mich. App. 1978)).

<sup>268</sup> SCOTUSBlog, *DeBoer v. Snyder: Pending petition*, <http://www.scotusblog.com/case-files/cases/deboer-v-snyder/> (last visited Jan. 4, 2015).

## Adoption and Parentage Determinations

- 4) *Order of Filiation.* The court may issue an order of filiation, naming a man not married to the mother of the child as the legal father under any of the following three circumstances:
- a. *Acknowledgement of paternity.* If a child is born to an unmarried woman, a man who voluntarily joins with her in signing an **Affidavit of Parentage (AOP)** form is from that time forward considered to be the father of the child.<sup>269</sup> The AOP can be signed at any time during the lifetime of the child. The mother receives initial custody of the child until the court can determine custody arrangements.<sup>270</sup> A hospital is required by law to provide the AOP form to any unmarried patient who gives birth to a living child.<sup>271</sup> **Alternately**, the father may claim paternity *before* the child is born by registering with a court his verified notice of intent to claim paternity. This creates a rebuttable presumption of paternity.<sup>272</sup>
  - b. *Granted paternity claim.* If the putative father declines to sign an AOP or is not in contact with the mother, she may file a paternity claim. The court will hold a hearing to determine whether the man is the biological father of the child.<sup>273</sup> It is a misdemeanor offense to make a false complaint identifying a father.<sup>274</sup>
  - c. *Default judgment.* If putative father does not respond to a summons issued for a paternity hearing, the court may issue a default judgment: the case is decided in the mother's favor without a hearing because of the father's lack of response.<sup>275</sup>

**Note:** For a child receiving Michigan **public assistance**, including Medicaid or MiChild, **the state can pursue a paternity determination** without the mother's participation or consent, for the purpose of commanding child support from the putative father, *if that person is known*. Although allowances are made for preventing such a determination when the putative father might present a threat to the child, no such allowance exists for his presenting a possible threat to the mother.<sup>276</sup>

- 5) *Adoption.* When a child is adopted, the parental rights of his or her original parents are terminated by the court. Upon placement with the adoptive family, the court issues an order of adoption, which gives the child and his or her new parents all the rights and responsibilities towards each other of biological families. ([See Adoption](#)) In a **stepparent** adoption, the parental rights of the non-custodial parent are terminated, and the spouse of the child's custodial parent adopts the child.

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<sup>269</sup> MICH. COMP. LAWS § 722.1003(1) (1997).

<sup>270</sup> MICH. COMP. LAWS § 722.1006 (2006).

<sup>271</sup> MICH. COMP. LAWS § 333.21532 (1997).

<sup>272</sup> MICH. COMP. LAWS § 710.33 (1975).

<sup>273</sup> MICH. COMP. LAWS § 722.714(5-6) (1998).

<sup>274</sup> MICH. COMP. LAWS § 722.722 (1973).

<sup>275</sup> *Id.*

<sup>276</sup> MICH. COMP. LAWS § 722.1441(4) (2012).

RESOURCES FOR HOSPITALS TO ASSIST PARENTAGE DETERMINATIONS

DHS produces a pamphlet, the *Hospital Paternity Acknowledgment Guide*,<sup>277</sup> to help hospitals carry out their legal duty to assist patients in acknowledging paternity. A particularly helpful table from the guide is included

Essential Questions Regarding Completion of an AOP			
Questions to ask the Mother	Yes No		When to Complete or NOT to Complete an AOP
	Is the mother married to the biological father of the child?	Yes	
Is the mother married to someone other than the biological father?	Yes		Do <b>NOT</b> complete the <a href="#">AOP</a> . The mother's husband is the legal father of any child born during the marriage. The mother must obtain a final court order stating the husband is not the father of the child before the mother and the biological father should complete the <a href="#">AOP</a> .
		No	If the mother is <b>unmarried</b> , the parents should complete the <a href="#">AOP</a> .
Is the mother divorced?	Yes		If the mother was divorced more than 10 months before the child's birth, then the child is <b>NOT</b> considered a child of the marriage. If the mother is <b>currently unmarried</b> , the parents should complete the <a href="#">AOP</a> .
		No	If the mother is <b>married</b> , the mother's husband is the legal father of any child born during the marriage. Prior to the biological parents completing the <a href="#">AOP</a> , the mother must obtain a final court order stating her husband is not the father of the child.
Has the mother been divorced within the last 10 months?	Yes		If the mother was divorced <b>within</b> 10 months prior to the child's birth, the child is considered a child of that marriage. The mother's ex-husband is the legal father until the couple obtains a final court order stating the ex-husband is not the father of the child. The parents should <b>NOT</b> complete the <a href="#">AOP</a> .
		No	If the mother is <b>married</b> , the mother's husband is the legal father of any child born during their marriage. Prior to the biological parents completing the <a href="#">AOP</a> , the mother must obtain a final court order stating the husband is not the father of the child.
Has the mother been divorced for more than 10 months?	Yes		If the mother is <b>unmarried</b> and was divorced more than 10 months prior to the child's birth, then the child is <b>NOT</b> considered a child of her previous marriage. The parents should complete the <a href="#">AOP</a> .

here.<sup>278</sup>

CAN PARENTAGE LATER BE REVOKED?

**Yes, but with limits.** Michigan's 2012 Revocation of Paternity Act allows the **mother**, the **person who signed the AOP**, the **person claiming to be the father**, or a **prosecuting attorney** to request that the AOP be revoked. The action must be filed within 3 years of the child's birth or 1 year of the AOP. *Most significantly*, it is now possible for a **person claiming to be the father** of the child to **challenge the "husband presumption"** that by default names the husband of the married mother as the father of the child.<sup>279</sup> Previously, only the husband or wife could challenge paternity, and then only in the context of divorce proceedings.

<sup>277</sup> Mich. Dept. of Human Services, *Hospital Paternity Acknowledgment Guide*, June 2012, available at [www.michigan.gov/documents/dhs/PAT\\_ACK\\_Guide\\_June\\_2011\\_356774\\_7.pdf](http://www.michigan.gov/documents/dhs/PAT_ACK_Guide_June_2011_356774_7.pdf).

<sup>278</sup> *Id* at 5.

<sup>279</sup> MICH. COMP. LAWS §§ 722.1438, 722.1443 (2012).



# MINORS AND THE LAW

## Health Care Rights of Minors

### Introduction

#### WHO IS A MINOR?

A minor is a person **under 18** years of age who is not emancipated.<sup>280</sup> Emancipation is a legal term; in order to be emancipated, a minor must fit under the legal definition.

#### WHEN IS A MINOR EMANCIPATED?

An emancipated minor has been **granted the status of adulthood** by a court and **therefore has the legal ability to make healthcare and other decisions and enter into contracts.**<sup>281</sup> Alternately, emancipation occurs when the minor is **validly married** or, temporarily, when **on active duty with the U.S. armed forces.**<sup>282</sup> A runaway minor is NOT emancipated solely by virtue of running away; emancipation is a formally granted legal status. **Pregnancy in an unmarried mother does NOT cause emancipation but does allow the mother to consent to care for her fetus.**

Rights of an emancipated minor include the following:<sup>283</sup>

- The **right to authorize her own preventive health care** and medical care without the knowledge of her parents. The parents in such a case are *not* responsible for payment.
- The **right to apply for public medical assistance**, general welfare assistance, and Aid to Families with Dependent Children.
- The **right to make decisions** and give authority in caring **for her own minor child.**

#### WHAT RIGHTS REGARDING MEDICAL CARE DOES A MINOR TYPICALLY HOLD?

**Very few.** Generally, the minor's parents or guardian, or a person acting *in loco parentis*<sup>284</sup> are responsible for making decisions regarding the minor's health and health care and

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<sup>280</sup> MICH. COMP. LAWS § 333.1105(5) (1978).

<sup>281</sup> MICH. COMP. LAWS § 722.4 (1968). Certain statutory limitations still apply, such as voting age and drinking age.

<sup>282</sup> MICH. COMP. LAWS § 722.4(2)(c) (1968).

<sup>283</sup> MICH. COMP. LAWS § 722.4e (1989).

<sup>284</sup> A person assumes (temporary) parental responsibility for a minor “when a person [or legal entity] undertakes the care and control of another [person of legal incapacity] in the absence of such supervision by the latter’s natural parents and in the absence of formal legal approval.” 787

have full access to the minor's medical record. **Because this status may cause minors not to seek urgently-needed treatment, the legislature has granted minors specified health care rights in certain circumstances.**

## Special Health Care Rights of Minors

### ABORTION

Michigan requires **parental consent** for abortions performed on unemancipated minors but also provides a **judicial alternative** to parental consent. ([See Abortion Laws in Michigan—Minors](#))

### ADOPTION

**Consent from the minor's parents is required** for any unemancipated minor who wishes to surrender a child for adoption.<sup>285</sup>

### CONTRACEPTION

Minors in Michigan **may purchase contraceptives** to the same extent that adults may.<sup>286</sup> Both **Medicaid**<sup>287</sup> and Title X of the Public Health Service Act<sup>288</sup> require that teens be provided confidential contraceptive services. Physicians prescribing contraceptives to a minor have **no legal duty to notify the minor's parents.**<sup>289</sup>

### EMERGENCY CONTRACEPTION

**Plan B** (levonorgestrel), the "Morning After Pill," is classified as emergency contraception (EC). It is not an abortifacient because it does not interrupt an established pregnancy or harm a developing embryo.<sup>290</sup> Laws regarding abortion do not apply to Plan B/EC.

Plan B has been **available without a prescription or age restriction** since June 2013.<sup>291</sup> A newer EC, **ella**, is **effective** when taken **up to five days after unprotected sex.**<sup>292</sup> It has been available in the United States since late 2010.<sup>293</sup> Like Plan B, ella is not an abortifacient.

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(6th Ed. 1990) (quoting *Griego v. Hogan*, 377 P.2d 953, 955-56 (N.M. 1963)). *In loco parentis* responsibility can be held by a child's school or childcare provider.

<sup>285</sup> MICH. COMP. LAWS §§ 710.43(4) (1998), 710.23b(3) (1995).

<sup>286</sup> *Carey v. Population Servs. Int'l*, 431 U.S. 678, 715 (1977).

<sup>287</sup> 42 U.S.C. § 1396d(a)(4)(C) (1970).

<sup>288</sup> 42 U.S.C. § 300 (2010).

<sup>289</sup> *Doe v. Irwin*, 615 F.2d 1162 (6th Cir. 1980).

<sup>290</sup> World Health Organization, *Fact sheet on the safety of levonorgestrel-alone emergency contraceptive pills (LNG ECPs)*,

[http://whqlibdoc.who.int/hq/2010/WHO\\_RHR\\_HRP\\_10.06\\_eng.pdf](http://whqlibdoc.who.int/hq/2010/WHO_RHR_HRP_10.06_eng.pdf), 2010.

<sup>291</sup> Memorandum of June 12, 2013, *Tummino v. Hamburg*, 936 F.Supp.2d 162 (2013) .

**RU-486** (mifepristone), in contrast, *is* an abortifacient and is therefore subject to the restrictions outlined in [Abortion Laws in Michigan—Minors](#).

## PARENTING

Minors **may consent to medical care** for their children.<sup>294</sup> **HOWEVER**, parents still retain the general right to consent to medical care for their unemancipated minor child.

## PREGNANCY

Any minor who is pregnant or believes herself to be pregnant is able to **consent to prenatal care for her fetus** as if she were an adult. Consent by parents, guardian, spouse, or father of the expected child is not required. The minor may also consent to care and treatment for her child once it is born, but she cannot consent to care for herself.<sup>295</sup>

Before any care is provided, the treating **physician must inform the minor that her parents** or guardian or the father of the expected child **may be notified**. The treating physician *may* choose to inform the minor's parents of the treatment but is not obliged to do so. Both informing and not informing the parents are actions not subject to the minor's consent.<sup>296</sup>

At the initial visit, the treating **physician must ask the minor for permission to contact her parents or guardian** for the purpose of obtaining **additional medical information** helpful or necessary for prenatal care.

## HIV/OTHER STD

Any minor who is infected or believes herself to be infected with HIV or a sexually transmitted disease is able to **consent to treatment** as if she were an adult. Consent by parents, guardian or spouse is *not* required.<sup>297</sup>

The treating **physician may choose to inform the minor's parents** of the treatment, but is not obliged to do so. Both informing and not informing the parents are actions not subject to

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<sup>292</sup> U.S. Food & Drug Administration, *FDA approves ella™ tablets for prescription emergency contraception*, <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm222428.htm>, Aug. 13, 2010.

<sup>293</sup> Watson Pharmaceuticals, *Watson Launches ella(R) (ulipristal acetate) Emergency Contraceptive*, <http://phx.corporate-ir.net/phoenix.zhtml?c=65778&p=irol-newsArticle&ID=1501974>, Dec. 1, 2010.

<sup>294</sup> MICH. COMP. LAWS § 333.9132 (1984).

<sup>295</sup> MICH. COMP. LAWS § 333.9132(1) (1984).

<sup>296</sup> MICH. COMP. LAWS § 333.9132(2-4) (1984).

<sup>297</sup> MICH. COMP. LAWS § 333.5127(1) (1989).

## Health Care Rights of Minors

the minor's consent.<sup>298</sup> Whether or not parents are notified, they are not financially liable for treatment costs.<sup>299</sup>

### HPV VACCINE

The HPV vaccine (Gardasil) is not considered a contraceptive, and so **requires parental consent** for administration.<sup>300</sup>

### PRIVACY OF HEALTH INFORMATION

If a minor **lawfully receives treatment without the consent or notification of her parents**, guardian or person acting *in loco parentis* (as in [Pregnancy](#) or [HIV/Other STD](#), above), **those persons should have no access to the minor's medical records** resulting from the treatment.<sup>301</sup>

### REPRODUCTIVE CANCERS

In the treatment of reproductive cancers, parents consent to treatment for their minor children. The minor has no legal right to object to the proposed treatment, but in practice it is often inadvisable to proceed over the minor's objections. ([See Right to Refuse Treatment](#) below)

If cancer treatment is expected to diminish the minor's fertility, parents may wish to consent to **preservation of the minor's oocytes**. Again, the minor alone cannot legally consent to this treatment. ([See Right to Refuse Treatment](#) below)

Problems can arise when a minor refuses care consented to by parents. *Example:* A parent requests an examination of the minor to see if she has been sexually active and the minor refuses. In these cases, it is important to consult with the Legal Office. In general, a non-medically necessary exam should not be conducted without the minor's assent.

### REPRODUCTIVE GENETIC SCREENING

An **intensive informed consent process** is dictated by Michigan law before any genetic tests may be performed.<sup>302</sup> The law does not address the particular case of genetic testing on a minor beyond specifying that the minor's parents must give consent. However, when considering **predictive tests for adult-onset genetic diseases** (such as Huntington's Disease), medical ethics suggest that parents alone should *not* be allowed to consent to such tests on the minor's behalf. Since minors, "far more than their parents, will be living with the repercussions, [minors] should

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<sup>298</sup> MICH. COMP. LAWS § 333.5127(2) (1989).

<sup>299</sup> MICH. COMP. LAWS § 333.5127(3) (1989).

<sup>300</sup> PHYSICIANS' DESK REFERENCE 2154-2162, (64<sup>th</sup> ed. 2010).

<sup>301</sup> MICH. COMP. LAWS § 333.20175a (2006).

<sup>302</sup> MICH. COMP. LAWS §§ 333.17020, 333.17520 (2000).

be able to decide about participation in such a genetic test."<sup>303</sup> In contrast, parents *should* be able to consent to genetic tests for conditions that are likely to manifest in childhood, to enable the parents to better prepare to care for the child.

Similarly, if a patient is diagnosed with an inheritable genetic disease, a physician may wonder whether **other family members who may be at risk** for the disease should be notified. In such cases, the minimal law on point suggests that the **physician's duty is to inform the patient** that the disease could also affect siblings and children, and that **the patient ought to tell these relatives**, so that they can be screened.<sup>304</sup>

### RIGHT TO REFUSE TREATMENT

*Example:* A mother asks a physician to perform a pelvic examination on her minor daughter to determine whether the daughter is sexually active.

While a competent adult patient has the legal right to refuse any treatment, traditionally a minor's right to refuse treatment was subsumed by her parents' right to consent on her behalf. This remains the letter of the law, but because **no physician is required to perform a certain examination or treatment on a minor at her parents' request**, the physician retains the scope to refuse on the minor's behalf. A statement by the American Academy of Pediatrics Committee on Bioethics indicates that the ethically desirable practice is to solicit **informed permission** from the minor's parents on her behalf and the **assent** of the minor herself whenever appropriate.<sup>305</sup>

In addition, logistics dictate that a physician often cannot perform such an examination or provide treatment for a non-consenting patient without the use of force. A minor's **privacy rights**, as well as her **basic right of bodily integrity** should exempt the physician from carrying out the exam or treatment.

### RESEARCH ON MINOR SUBJECTS

Medical researchers **may carry out research using minors as subjects**, but with significant limitations. Federal regulations (45 C.F.R. § 46, the so-called "Common Rule") generally permit research on children **only if the level of risk posed to the subject is minimal** and requires the consent of the minor's parents as well as the assent of the minor herself.<sup>306</sup> Research posing a **minor increase over minimal risk** is permissible under the following circumstances:

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<sup>303</sup> Pascal Borry, Tom Goffin, Herman Nys, & Kris Dierickx, *Predictive Genetic Testing in Minors for Adult-Onset Genetic Diseases*, 75 MOUNT SINAI J MED. 287, 294 (2008).

<sup>304</sup> *Pate v. Threlkel*, 661 So. 2d 278 (Fla. 1995).

<sup>305</sup> American Academy of Pediatrics Committee on Bioethics, *Informed Consent, Parental Permission, and Assent in Pediatric Practice*, 95 PEDIATRICS 314 (1995).

<sup>306</sup> 42 C.F.R. § 46.404 (2001).

- When there is a prospect of **direct benefit** to the individual subjects.<sup>307</sup>
- When the research is likely to yield **generalizable knowledge** about the subject's disorder or condition.<sup>308</sup>
- If no direct benefit then only when a **national panel of experts** in pertinent disciplines **has approved the study**.<sup>309</sup>

#### SEXUAL ABUSE; INTIMATE PARTNER VIOLENCE; STATUTORY RAPE

**Physicians must report any suspected abuse** of a minor perpetrated by a parent, legal guardian, or any other adult responsible for the minor's health or welfare, or by teachers or clergy. ([See Child Abuse and Neglect Reporting Requirements](#) and Child Protection Team at <http://www.med.umich.edu/mott/cpt/>).

Physicians have *no* duty to report **intimate partner violence** nor a duty to report a **minor's sexual relationship**. However, the law holds that an unemancipated minor is **not able to consent to sex**, and that sex with such a minor is legally classified as **statutory rape**. Differing degrees of criminal sexual conduct carry differing penalties, with those for sexual relationships with minors under the age of 13 particularly severe. **Physicians who engage in sexual relationships with their minor patients are committing not only a violation of professional ethics, but a violation of Michigan criminal law**. For more details, see [Rape Laws in Michigan](#).

#### SEXUAL ORIENTATION/TRANSGENDER ISSUES/GENITAL SURGERY

Michigan provides very few protections against **discrimination based on sexual orientation** against minors or adults in the areas of housing or employment, but does provide for **non-discrimination in health care facilities**.<sup>310</sup>

Minors wishing to consider **sexual reassignment treatment** or **intersex treatment** fall under the general rule of required parental consent for health care.

#### MAY A MINOR PATIENT BE DISCHARGED FROM THE FACILITY AGAINST MEDICAL ADVICE?

**This legal question has not been definitively decided under Michigan law**. The minor patient's parent(s)/guardian(s) and attending physician may agree to discharge a minor patient

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<sup>307</sup> 42 C.F.R. § 46.405 (2001).

<sup>308</sup> 42 C.F.R. § 46.406 (1983).

<sup>309</sup> 42 C.F.R. § 46.407 (2001).

<sup>310</sup> MICH. COMP. LAWS §§ 331.1306 (1998), 333.20201 (2006), 333.21761 (1998). *See also* Gov. Jennifer Granholm, *Executive Directive No. 2003-24, Equal Opportunity in State Employment*, Dec. 23, 2003, available at [http://www.michigan.gov/gov/0,1607,7-168-36898\\_36901-83560--,00.html](http://www.michigan.gov/gov/0,1607,7-168-36898_36901-83560--,00.html).

under circumstances that are less than ideal for the patient, but **if the attending physician does not agree that discharge of the patient is a reasonable option for the patient, the attending physician should consult CPT (<http://www.med.umich.edu/mott/cpt/>) at pager 2750.**

## Rape Laws in Michigan

### OVERVIEW

Under Michigan law, criminal sexual conduct is divided into four categories or degrees that cover a range of sexual contact and varying levels of force or coercion.<sup>311</sup> In rape cases, results from medical examinations are often used to provide corroborative evidence.

### WHAT IS RAPE?

**Rape is the sexual penetration of a person against the will and without the consent of that person.** Penetration can be vaginal, anal, oral, or involve placing a body part or object into another person's anal or vaginal opening.

### WHAT IS SEXUAL CONTACT?

Sexual contact is the intentional touching of intimate parts or clothing covering intimate parts for the purpose of sexual arousal or gratification.

### WHAT IS STATUTORY RAPE?

Since a child under 16 year of age is considered to be incapable of consenting to sexual intercourse, **sexual penetration of a child under 16 will be deemed rape** as a matter of statutory law—regardless of whether or not the child engages in the act willingly.

### FIRST DEGREE CRIMINAL SEXUAL CONDUCT

First degree criminal sexual conduct carries a penalty of up to imprisonment for life. A person commits this offense if there is **sexual penetration** under one (or more) of the following circumstances:<sup>312</sup>

- 1) Force, coercion, and personal injury
- 2) Personal injury and victim incapacity
- 3) Victim incapacity and EITHER a) relation by blood or marriage OR b) assailant in position of authority over victim
- 4) Assailant is aided by another person AND EITHER a) victim is mentally incapable, incapacitated, or physically helpless OR b) assailant used force or coercion OR c) a weapon was involved
- 5) Victim is under 13

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<sup>311</sup> MICH. COMP. LAWS § 750.520(a)-750.520(e) (2008).

<sup>312</sup> MICH. COMP. LAWS § 750.520(b) (2008).



## Rape Laws in Michigan

- 6) Victim is under 14 AND EITHER a) member of the same household OR b) related by blood or affinity OR c) assailant is in a position of authority over victim
- 7) Occurs during the commission of another felony

### SECOND DEGREE CRIMINAL SEXUAL CONDUCT

Second degree criminal sexual conduct carries a penalty of up to 15 years of imprisonment. A person commits this offense if there is **sexual contact (but no penetration)** under one (or more) of the following circumstances:<sup>313</sup>

- 1) Force, coercion, and personal injury
- 2) Personal injury and victim incapacity
- 3) Victim incapacity and EITHER a) relation by blood or marriage OR b) assailant in position of authority over victim
- 4) Assailant is aided by another person AND EITHER a) victim is mentally incapable, incapacitated, or physically helpless OR b) assailant used force or coercion OR c) a weapon was involved
- 5) Victim is under 13
- 6) Victim is under 14 AND EITHER a) member of the same household OR b) related by blood or affinity OR c) assailant is in a position of authority over victim
- 7) Occurs during the commission of another felony

### THIRD DEGREE CRIMINAL SEXUAL CONDUCT

Third degree criminal sexual conduct carries a penalty of up to 15 years of imprisonment. A person commits this offense if there is **sexual penetration** under one (or more) of the following circumstances:<sup>314</sup>

- 1) Force or coercion
- 2) Victim incapacity
- 3) Victim is 13, 14, or 15

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<sup>313</sup> MICH. COMP. LAWS § 750.520(c) (2008).

<sup>314</sup> MICH. COMP. LAWS § 750.520(d) (2008).

#### FOURTH DEGREE CRIMINAL SEXUAL CONDUCT

Fourth degree criminal sexual conduct carries a penalty of up to two years of imprisonment and/or a fine of \$500. A person commits this offense if there is **sexual contact (but no penetration)** under one (or more) of the following circumstances:<sup>315</sup>

- 1) Force or coercion
- 2) Victim incapacity
- 3) Victim is 13, 14, or 15 and assailant is 5 or more years older than the victim.

As discussed below in the [Child Abuse and Neglect Reporting Requirements](#) section, reporting is not required for all cases of rape but is mandated for cases that meet the definition of abuse or neglect.

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<sup>315</sup> MICH. COMP. LAWS § 750.520(e) (2008).

## Child Abuse and Neglect Reporting Requirements

### OVERVIEW

In the interest of protecting children, physicians (and some others) are required to report instances in which they have a reasonable cause to suspect that a child is a victim of abuse or neglect.<sup>316</sup>

### WHAT QUALIFIES AS CHILD ABUSE?

Child abuse is defined as:<sup>317</sup>

- 1) **harm or threatened harm** to a child's health or welfare
- 2) that occurs through **non-accidental physical or mental injury, sexual abuse, sexual exploitation, or maltreatment**
- 3) by a **parent, a legal guardian**, or any other person **responsible for the child's health or welfare**, or by a **teacher**, or a member of the **clergy**

### WHAT QUALIFIES AS CHILD NEGLECT?

Child neglect is defined as:<sup>318</sup>

- 1) **harm or threatened harm** to a child's health or welfare
- 2) by a **parent, a legal guardian**, or any other person **responsible for the child's health or welfare** that occurs through either of the following:
  - Negligent treatment, including the **failure to provide** adequate food, clothing, shelter, or **medical care**
  - Placing a child at an **unreasonable risk** to the child's health or welfare by **failure to intervene** to eliminate that risk when that person is able to do so and has, or should have, knowledge of the risk.

### WHO MUST REPORT CHILD ABUSE OR NEGLECT SUSPICION?

**Mandated reporters include physicians**, dentists, physician's assistants, registered dental hygienists, medical examiners, nurses, persons licenses to provide emergency medical care, audiologists, psychologists, marriage and family therapists, social workers, teachers,

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<sup>316</sup> MICH. COMP. LAWS § 722.623 (2009).

<sup>317</sup> MICH. COMP. LAWS § 722.622(f) (2005).

<sup>318</sup> MICH. COMP. LAWS § 722.622(j) (2005).

## Child Abuse and Neglect Reporting Requirements

counselors, school administrators, law enforcement officers, clergy members, regulated child care providers, and relevant employees of the Family Independence Agency.<sup>319</sup>

### WHERE SHOULD A PHYSICIAN REPORT?

Physicians must make an **immediate oral report** of suspected abuse or neglect to the Family Independence Agency.<sup>320</sup> **A written report must also be filed within 72 hours.**<sup>321</sup> At UMHS, all reports should be made to the Child Protection Team (<http://www.med.umich.edu/mott/cpt/>). The team will make any required report to the State.

### DOES PREGNANCY IN A CHILD UNDER 12 YEARS OF AGE TRIGGER A REPORTING REQUIREMENT?

**Yes.** The **pregnancy of a child less than 12** years of age is reasonable cause to suspect that child abuse and neglect have occurred.<sup>322</sup>

### DOES VENEREAL DISEASE IN A CHILD OVER ONE MONTH OF AGE BUT UNDER 12 YEARS OF AGE TRIGGER A REPORTING REQUIREMENT?

**Yes.** The presence of **veneral disease in a child who is over one month of age but less than 12** years of age is reasonable cause to suspect child abuse and neglect have occurred.<sup>323</sup>

### IS STATUTORY RAPE (OR SEX WITH A MINOR UNDER 16) CONSIDERED TO BE CHILD ABUSE THAT MUST BE REPORTED?

This situation is very fact dependent. **Whether the intercourse that occurred can be considered abuse or violence depends on consent.**<sup>324</sup> For children under age 13, the law is clear that sexual intercourse is both rape and abuse. For older children, it may not always be clear whether a minor consented to sexual intercourse or not.

Physicians should consider the maturity of the minor, whether the minor has the capacity to consent, the relationship between the minor and her sexual partner, and whether the couple's sexual relations are truly consensual.<sup>325</sup> Instances of power imbalance (teacher-student, large age differential, etc.) may indicate a problem.

Cases in which two 15-year olds have had consensual intercourse are typically not considered to be examples of abuse. On the other hand, cases in which the adult is significantly

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<sup>319</sup> MICH. COMP. LAWS § 722.623 (2009).

<sup>320</sup> MICH. COMP. LAWS § 722.623 (2009).

<sup>321</sup> MICH. COMP. LAWS § 722.623 (2009).

<sup>322</sup> MICH. COMP. LAWS § 722.623 (2009).

<sup>323</sup> MICH. COMP. LAWS § 722.623 (2009).

<sup>324</sup> Tunzi, Marc. *Isn't This Statutory Rape?* Am. Fam. Physician. (May 1, 2002).

<sup>325</sup> *Id.*

## Child Abuse and Neglect Reporting Requirements

older (such as a 25-yr old and a 15-yr old) may suggest that there is a power imbalance that needs to be examined when determining whether there truly was consent.

If you have questions, review the UM child abuse information at:

<http://health.med.umich.edu/healthcontent.cfm?xyzpdqabc=0&id=6&action=detail&AEProductID=HW%5FKnowledgebase&AEArticleID=tm4865&AEArticleType=HealthConditions> or contact the UM Child Abuse team. The team can be reached Monday through Friday by calling 763-0215. After hours, call the paging operator at 936-6267 and ask for the Child Protection Team member on-call.

### DOES THE PRESENCE OF DRUGS TRIGGER A REPORTING REQUIREMENT?

**Yes**, but only in the case of **methamphetamine**. A report is required if an individual responsible for a child's health or welfare allows a child to be **exposed to** or to have **contact with methamphetamine production**.<sup>326</sup> Reporting is **not** necessary if a pregnant woman has had contact with a methamphetamine production facility.

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<sup>326</sup> MICH. COMP. LAWS § 722.623(6) (2009).

# PHYSICIAN-PATIENT RELATIONSHIP: MALPRACTICE, DUTY TO TREAT, AND PATIENT DECISION-MAKING

## Ob-Gyn Medical Malpractice in Michigan

### Introduction

#### WHAT IS MEDICAL MALPRACTICE?

*Malpractice* means *bad practice*. A patient can sue a physician for bad practice, defined as practice below the standard of care set for the physician's specialty. If the physician is found to have been *negligent*, the patient can receive a financial award from the physician in compensation for the patient's injury. A patient can also report a physician to the state licensing board, but this action does not result in a financial award to the patient.

#### *What are the elements of malpractice?*

Negligence suits are brought in civil courts. The required elements of a malpractice suit are *relationship, duty, breach, causation, and damages*.

- **Relationship and duty.** The physician-patient *relationship* creates the physician's *duty* to provide services at or above an average standard of practice or care.<sup>327</sup> A physician in private practice may decide whether or not to add a new patient to the practice, although this decision may not be made on constitutionally impermissible grounds (age, race, sex, color, creed, or national origin).
- **Breach.** Practicing below the standard of care (*breach*)<sup>328</sup> is generally determined by competing expert witnesses.
- **Injury.** The patient must be shown to have suffered an *injury* (or *damages*).
- **Causation.** The injury must have been *caused* by the physician's substandard practice;<sup>329</sup> the legal test for causation is that *but for* the physician's breach, the injury would not have occurred.<sup>330</sup> *Example:* If a physician fails to swab a patient's skin with alcohol before giving an injection, the physician has breached the standard of care. But the physician cannot be found negligent unless the patient subsequently develops an infection or other injury as the result of the physician's failure to swab the skin.

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<sup>327</sup> *Cox v. Bd. of Hosp. Managers*, 651 N.W.2d 356, 358 (Mich. 2002)

<sup>328</sup> *Rogers v. Horvath*, 237 N.W.2d 595, 596-7 (Mich. App. 1975).

<sup>329</sup> MICH. COMP. LAWS § 600.2912a (1994). *See also Dykes v. William Beaumont Hosp.*, 633 N.W.2d 440, 443 (Mich. App. 2001), *appeal denied*, 639 N.W.2d 807 (Mich. 2002).

<sup>330</sup> *Weymers v. Khera*, 563 N.W.2d 647, 652-3 (Mich. 1997) (emphasis added).

***When may a patient file a malpractice suit?***

Michigan's **statute of limitations** allows a **competent adult** to file a malpractice suit up to two years after the injury occurs<sup>331</sup> or up to six months after the discovery of the injury<sup>332</sup> but not more than 6 years from the date of injury.<sup>333</sup> The patient is required to provide six months' prior notice of the suit (See below, What Should a Physician Do on Receiving Notice of a Suit?).

**The limitations period is extended for minors:**

- If a person **under the age of thirteen** suffers **injury to the reproductive organs**, the statute of limitations does not run (expire) until the person turns **fifteen**.<sup>334</sup> *Example:* A three-year-old girl undergoes surgery for a blocked vagina, during which the surgeon accidentally lacerates the cervix. The girl may bring suit any time until she turns fifteen.
- If a person **under the age of eight** suffers an **injury of any kind**, the statute of limitations does not run (expire) until the person turns **ten**.<sup>335</sup> *Example:* A baby suffers damage to the brachial plexus nerves because of the obstetrician's negligence in managing shoulder dystocia. The child may bring suit at any time until she turns ten. Any negligent injury sustained during birth that does not affect the baby's reproductive organs, such as asphyxia or shoulder dystocia falls under this category.

For **incompetent adults** the statute of limitations is not specified; there is an argument that the right to sue never expires.

***What are some typical malpractice claims?***

The most common claims from 2006 to 2008 were as follows:<sup>336</sup>

<b>Obstetric claims:</b>	<b>Gynecologic claims:</b>
Neurologically impaired infant 31.5%	Delay in or failure to diagnose 31.0%
Stillbirth/neonatal death 22.2%	Patient injury major 18.6%
Other infant injury – major 10.5%	Patient injury minor 18.6%
Delay in or failure to diagnose 9.3%	Other (not specified) 12.4%

<sup>331</sup> MICH. COMP. LAWS § 600.5805(6) (2003).

<sup>332</sup> MICH. COMP. LAWS § 600.5838(2) (1986).

<sup>333</sup> MICH. COMP. LAWS § 500.5838a(2) (1994).

<sup>334</sup> MICH. COMP. LAWS § 600.5851(8) (1994).

<sup>335</sup> M.C.L. § 600.5851 (7) (1994).

<sup>336</sup> District V includes Indiana, Kentucky, Michigan and Ohio. ACOG, *District V Liability Lowdown: Overview of the 2009 ACOG Survey on Professional Liability*, <http://www.acog.org/departments/professionalLiability/2009PLSurveyDistrictV.pdf> (last visited June 16, 2010).

## General Medical Malpractice Negligence

### WHAT ARE EXAMPLES OF CLAIMS PATIENTS FILE AGAINST OB-GYNS?

Patients can bring various causes of action in medical malpractice negligence suits. The list below contains examples relevant to the practice of obstetrics and gynecology.

#### *Failure to diagnose and delay in diagnosing*

*Example:* In a case of failure to diagnose or delay in diagnosing an **ectopic pregnancy**, a patient might allege that the delay caused unnecessary procedures before the correct diagnosis was reached, and also caused a burst fallopian tube which subsequently needed to be surgically removed, negatively impacting the patient's fertility.<sup>337</sup>

*Example:* In an injury resulting in a patient's death, such as a failure or delay in diagnosing **breast cancer**, Michigan law allows the dead patient's estate to recover for loss of opportunity to survive if the initial opportunity to survive was more than 50%, as established by expert witness.<sup>338</sup> A living patient may not recover for loss of opportunity to survive.<sup>339</sup>

#### *Failure to provide appropriate treatment*

*Example:* Medication error is a frequent cause of malpractice suits throughout the medical profession, and extends from physicians to other personnel, such as pharmacists.<sup>340</sup> **Pitocin** prescribed or administered incorrectly or excessively is a potential medication error, due to its widespread use.<sup>341</sup>

*Example:* Both performing and failing to perform a **Cesarean section** provide opportunity for liability. Patients have brought actions for performing a C-section in an earlier pregnancy when there is uterine rupture in a subsequent pregnancy.<sup>342</sup> Patients have brought actions for breach of contract when physicians have failed to deliver babies by C-section as planned;<sup>343</sup> an action in contract allows the physician to be charged with breach without any showing of fault. In negligence actions, a showing of fault is required, and numerous cases have been brought alleging fault in not performing a c-section.<sup>344</sup> In the case of Vaginal Birth After Cesarean (VBAC), which can generate either of these causes of action, liability avoidance is

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<sup>337</sup> *Roberts v. Mecosta County Hosp.*, 684 N.W.2d 711, 713 (Mich. 2004). The suit was ultimately dismissed for failure in plaintiff's filings to adequately detail malpractice elements.

<sup>338</sup> MICH. COMP. LAWS § 600.2912a(2) (1994). *See also Wickens v. Oakwood Healthcare Sys.*, 631 N.W.2d 686, 692 (Mich. 2001).

<sup>339</sup> 631 N.W.2d. at 687.

<sup>340</sup> *Becker v. Meyer Rexall Drug Co.*, 367 N.W.2d 424, 424 (Mich. App. 1985).

<sup>341</sup> *Craig ex rel. Craig v. Oakwood Hosp.*, 684 N.W.2d 296 (Mich. 2004). Judgment was eventually granted to defendant because of plaintiff's failure to prove causation.

<sup>342</sup> *Martin v. St. John Hosp. & Med. Ctr. Corp.*, 517 N.W.2d 787 (Mich. App. 1994).

<sup>343</sup> *Steward v. Rudner*, 84 N.W.2d 816 (Mich. 1957).

<sup>344</sup> *Wargelin v. Sisters of Mercy Health Corp.*, 385 N.W.2d 732 (Mich. App. 1986).



perhaps best managed as suggested in a recent *Obstetrics & Gynecology* editorial: "... the patient should be allowed to make that choice [to attempt or not attempt a VBAC] after she has been informed of the facts and has been counseled by her physician thoroughly."<sup>345</sup> The physician counsels by explaining the risks and benefits based on the best medical evidence.

This category encompasses many of the typical "birth injury" claims: failure to respond appropriately to bleeding, failure to observe or respond to umbilical cord entrapment, failure to respond to fetal distress, and misuse of forceps or a vacuum extractor.

### ***Failure to obtain informed consent***

It is a physician's duty to ensure that patients have sufficient **knowledge of specific risks and benefits** in order to make a decision about whether to undergo a proposed treatment.<sup>346</sup> In Michigan, the standard of care for risks and benefits required to be disclosed is based on expert testimony. Competent patients have the right to refuse any treatment. (Physicians' right to discontinue the patient-physician relationship can be found under **Abandonment**, below.) In general, a physician's failure to obtain informed consent allows a patient to sue for negligence. A patient can sue for battery if a physician treats or operates on the patient without consent.<sup>347</sup>

Expert witnesses are not required in informed consent cases, unlike other malpractice actions, where experts are required to explain the breach of standard of care to the fact finder (judge or jury).

### ***Abandonment***

A physician is free to discontinue a relationship with any patient, provided that the physician does not abandon the patient by failing to provide emergency care or by failing to provide for care from another physician.<sup>348</sup> Typically, the patient is given time to transfer her care to another provider and is provided a written letter saying when care will stop. The letter should not state a reason for ending the relationship, since this only allows grounds for a patient to claim discrimination or slander.

### ***Breach of patient-physician confidentiality***

Until 1993, a Michigan statute privileged communication between patients and physicians, stating that a physician should not "disclose any information that the person has

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<sup>345</sup> James R. Scott, "Solving the Vaginal Birth After Cesarean Dilemma," *115 Obstetrics & Gynecology* 1112, 1112-3 (June 2010).

<sup>346</sup> *Wlosinski v. Cohn*, 713 N.W.2d 16, 19-20 (Mich. App. 2005); *Lincoln v. Gupta*, 370 NW2d 312, 317 (Mich. App. 1985).

<sup>347</sup> *Werth v. Taylor*, 475 N.W.2d 426, 428-9 (Mich. App. 1991) (internal citations omitted). Note that battery in tort is unrelated to battery in the criminal code.

<sup>348</sup> *Tierney v. Univ. of Michigan Regents*, 669 N.W.2d 575, 578-9 (Mich. App. 2003).

acquired in attending a patient in a professional character...<sup>349</sup> The privilege was waived if the patient brought legal action against the physician.<sup>350</sup> Since the passage of the **HIPAA** (Health Insurance Portability and Accountability Act) **Privacy Rule**, however, state law is superseded by federal law, which states that protected health information can be disclosed only with the express authorization of the patient.<sup>351</sup> Unauthorized disclosure is permitted in response to court orders, subpoenas and discovery requests if they are accompanied by assurances that the patient whose records are being requested has been notified and given sufficient time to raise an objection with the court.<sup>352</sup> (See below, WHAT SHOULD A PHYSICIAN DO ON RECEIVING NOTICE OF A LAWSUIT?) HIPAA imposes a civil penalty and the possibility of criminal prosecution for violation of the disclosure rules<sup>353</sup> but does not allow the patient to sue the physician.<sup>354</sup>

### *Loss of consortium*

When a parent is negligently injured, his or her child may sue for *loss of consortium*; that is, for the resulting "loss of society and companionship" of that parent.<sup>355</sup> However, in Michigan, a parent may not sue for loss of consortium of a negligently injured child.<sup>356</sup>

### WHAT ARE PRE-CONCEPTION TORTS?

Michigan law allows a negligence action for prenatal injury if the fetus is subsequently born alive or was viable at the time of the injury.<sup>357</sup> A **viable** fetus is described in the [Born Alive Infant Protection Act](#) as one that after its expulsion from its mother displays at least one of the following signs of life: breathing, heartbeat, umbilical cord pulsation, or definite movement of voluntary muscles.<sup>358</sup>

In addition, the law allows certain specific **pre-conception** torts, with the caveat that recovery is limited to damages suffered during the perinatal period; recovery for the costs of raising a healthy child is prohibited as a matter of public policy, since "those costs are outweighed by the benefits of that child's life."<sup>359</sup>

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<sup>349</sup> MICH. COMP. LAWS § 600.2157 (1995).

<sup>350</sup> *Id.*

<sup>351</sup> 45 C.F.R. § 164.502 (2002).

<sup>352</sup> 45 C.F.R. § 164.512(e) (2002).

<sup>353</sup> 42 U.S.C. § 1320d-5-6 (2009).

<sup>354</sup> Gina Marie Stevens, *CRS Report for Congress: A Brief Summary of the Medical Privacy Rule*, <http://mchenry.house.gov/UploadedFiles/HEALTH%20-%20A%20Brief%20Summary%20of%20the%20Medical%20Privacy%20Rule.pdf> (Feb. 14, 2003), CRS-4.

<sup>355</sup> *Berger v. Weber*, N.W.2d 424, 425 (Mich. 1981).

<sup>356</sup> *Sizemore v. Smock*, 422 N.W.2d 666, 674 (Mich. 1988).

<sup>357</sup> *Martin v. St. John Hosp. & Med. Ctr. Corp.*, 517 N.W.2d 787, 788 (Mich. App. 1994).

<sup>358</sup> MICH. COMP. LAWS § 333.1071(2)(b) (2003).

<sup>359</sup> *Rinard v. Biczak*, 441 N.W.2d 441, 442 (Mich. App. 1989).

### ***Wrongful conception/failure to diagnose pregnancy***

Should a physician negligently fail to carry out a desired **sterilization** or **abortion** procedure, and the patient respectively becomes pregnant or unknowingly continues the unwanted pregnancy, she may bring an action for wrongful conception and recover damages for medical costs, lost wages, mental distress, and pain and suffering.<sup>360</sup>

### ***Wrongful birth/wrongful life***

**Wrongful birth** torts usually involve "an allegation of a negligent failure relatively early in the pregnancy to inform the parents of the risk of birth defects."<sup>361</sup> *Example:* A physician fails to diagnose anencephaly in prenatal tests; the parents are thereby deprived of the opportunity to consider terminating the pregnancy.<sup>362</sup> **Wrongful life** claims are brought "by or on behalf of the child who alleges that she was born because of the doctor's negligent failure to properly advise her parents and, as a result, has to suffer the condition."<sup>363</sup> *Example:* A physician fails to warn a mother that rubella infection during pregnancy can cause birth defects, and the child is born with serious congenital deformities; the child files a wrongful life claim for the "severe pain and suffering, emotional distress and pain, embarrassment and humiliation" she suffers as a result of the physician's failure. **Claims for wrongful birth or wrongful life are forbidden by Michigan statute** since 2001, with the **exception** of "damages for an intentional or **grossly negligent** act or omission, including, but not limited to, an act or omission that **violates the Michigan penal code**..."<sup>364</sup> Grossly negligent conduct is conduct so reckless or mistaken as to be obvious to a layperson without medical training, such as an HIV-positive obstetrician, who engages in a consensual sexual relationship with his pregnant patient without telling her of his HIV status, putting her and her fetus at risk of HIV infection.

### ***Wrongful death***

A patient can sue for wrongful death of her fetus only if the fetus was born viable. The Michigan Court of Appeals has found that **a non-viable fetus is not a "person"** within the meaning of the Wrongful Death Act.<sup>365</sup>

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<sup>360</sup> *Rouse v. Wesley*, 494 N.W.2d 7, 8 (Mich. App. 1992).

<sup>361</sup> *Taylor v. Kurapati*, 600 N.W.2d 670, 674-5 (Mich. App. 1999).

<sup>362</sup> *Proffitt v. Bartolo*, 412 N.W.2d 232, 234 (Mich. App. 1987).

<sup>363</sup> 600 N.W.2d at 682.

<sup>364</sup> MICH. COMP. LAWS § 600.2971 (2001).

<sup>365</sup> *Estate of McDowell v. Stubbs*, 564 N.W.2d 463, 463 (Mich. 1997).

## Other Malpractice Actions

### WHAT OTHER MALPRACTICE ACTIONS ARE FILED AGAINST PHYSICIANS?

Although tort cases make up the vast majority of lawsuits against physicians, practitioners may also be subject to actions for **breach of contract** or warranty, **administrative or state licensing inquiries**, and even **criminal charges**.

#### *Breach of contract*

A physician who promises a particular result with absolute certainty opens up the possibility of a breach of contract claim if the result does not follow, regardless of the presence or absence of negligence. In the famous "hairy hand" case,<sup>366</sup> a physician proposing a skin graft to repair a scar guaranteed a "one hundred percent good hand" but instead produced a weaker and hairy hand. Because he had promised to restore the hand to its original condition, he was held to have breached his contract with the patient.

To avoid a breach of contract claim, physicians should avoid using language that promises patients a perfect result, an absolute chance, or a total cure.

#### *Administrative/state licensing inquiries*

Anyone may initiate a complaint against a physician with the Michigan Department of Community Health. MDCH's Health Regulatory Division receives complaints and determines whether investigation is warranted.<sup>367</sup> MDCH may ultimately take action against the practitioner along a scale of probation or reprimand at its lowest end to suspension or revocation of medical license at its highest.<sup>368</sup> The instigator of the complaint is not necessarily involved after the complaint is filed, and does not receive compensation or damages.

#### *Criminal charges*

Most criminal charges against physicians involve controlled substances, Medicare fraud, or sexual offenses, such as soliciting intercourse under pretext of medical treatment.<sup>369</sup> Administrative disciplinary actions and civil suits in tort may accompany criminal suits.

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<sup>366</sup> *Hawkins v. McGee*, 146 A. 641 (N.H. 1929). The Michigan equivalent is *Guilmet v. Campbell*, 188 N.W.2d 601 (Mich. 1971).

<sup>367</sup> Mich. Dept. of Community Health, *Allegation Process-FAQ's*, [http://www.michigan.gov/mdch/0,1607,7-132-27417\\_27647-43590--,00.html](http://www.michigan.gov/mdch/0,1607,7-132-27417_27647-43590--,00.html) (last visited June 15, 2010).

<sup>368</sup> Mich. Dept. of Community Health, *What happens after an allegation is filed?*, [http://www.michigan.gov/mdch/0,1607,7-132-27417\\_27647-67383--,00.html](http://www.michigan.gov/mdch/0,1607,7-132-27417_27647-67383--,00.html) (last visited June 15, 2010).

<sup>369</sup> This felony is punishable by up to ten years in state prison. MICH. COMP. LAWS § 750.90. See *People v. Williams*, 175 N.W. 187 (Mich. 1919).

## The Course of a Lawsuit

### HOW ARE MALPRACTICE CASES RESOLVED?

In 2005, only 16% of malpractice cases filed were decided by trial verdict; the rest were settled, dismissed or resolved by other means.<sup>370</sup> Overall, the number of Michigan malpractice cases filed has been declining since 2000.<sup>371</sup> Nationally, the number of payments made on behalf of physicians as well as the cumulative value of payments have also declined.<sup>372</sup>

### WHAT SHOULD A PHYSICIAN DO ON RECEIVING NOTICE OF A LAWSUIT?

Since the 1993 Michigan tort reforms, claimants must provide 182 days' written notice of lawsuits.<sup>373</sup> A UMHS employee who receives such notice—or any other legal document, such as a complaint or licensing notice—should immediately contact the Health System Legal Office in the North Ingalls Building, at 764-2178. The Legal Office will work with Risk Management to investigate the complaint and respond appropriately. No release of patient records is required until 56 days after notice is given of the suit;<sup>374</sup> however, UMHS employees should not release any records, but instead refer the matter to the Legal Office.

### SHOULD A PHYSICIAN WORRY ABOUT BEING SUED?

No. The best defense against suit is doing what a physician already does: practicing within the standard of care for his or her specialty. It is worth noting that the popular conception of patients as a particularly litigious group seeking damage awards is not necessarily backed up by research. Insurance law scholar Tom Baker summarizes the results of three studies which suggest that fewer than 4% of patients injured by malpractice bring claims.<sup>375</sup> He writes:

The reality is most people do not sue. Juries do not favor plaintiffs in medical malpractice cases. Malpractice insurance companies fight weak claims, and strong claims, too. When the companies do pay to settle a questionable case, they pay much less than for a clear case. Finally, claimants and their lawyers usually make reasonable decisions based on what they can know at the time. [...] When patients get credible and conclusive evidence that there was no mistake, most drop their claims.<sup>376</sup>

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<sup>370</sup> Michigan Office of Finance and Insurance Services, *Analysis of Michigan Medical Professional Liability Insurance Claims, Exhibit 17*, Jan. 2007, [http://www.mi.gov/documents/cis/MMRFINAL\\_189175\\_7.pdf](http://www.mi.gov/documents/cis/MMRFINAL_189175_7.pdf).

<sup>371</sup> *Id.*

<sup>372</sup> Public Citizen, *Medical Malpractice Payments Fall Again in 2009*, March 3, 2010, <http://www.citizen.org/documents/NPDBFinal.pdf>.

<sup>373</sup> MICH. COMP. LAWS § 600.2912b(1) (1994).

<sup>374</sup> MICH. COMP. LAWS § 600.2912b(5) (1994).

<sup>375</sup> TOM BAKER, *THE MEDICAL MALPRACTICE MYTH* 69 (2005).

<sup>376</sup> *Id.* at 68.

### **Michigan's New Apology "I'm Sorry" Law**

In April 2011, the Michigan legislature passed a law that makes **expressions of sympathy or compassion** in relation to the pain, suffering, or death of an individual that are conveyed to the individual or her family **inadmissible as evidence of an admission of liability** in an action for medical malpractice.<sup>377</sup>

However, **statements of fault, negligence or culpable conduct** that are part of or made in addition to a statement, writing, or action expressing sympathy or compassion **CAN be admitted into evidence as an admission of liability** in an action for medical malpractice.<sup>378</sup>

What's the difference? "I am so sorry for your loss" is NOT an admission of liability and cannot be used in court, while "The reason you are sore is because I botched your stitches, and I am sorry for that" CAN be admitted into evidence in a medical malpractice case.

The law is consistent with UMHS' policy of full disclosure and compensation for medical errors.<sup>379</sup>

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<sup>377</sup> Public Act 21 of 2011. Amends MICH. COMP. LAWS §§ 600.101 to 600.9947 by adding section 2155.

<sup>378</sup> *Id.*

<sup>379</sup> See <http://www2.med.umich.edu/prmc/media/newsroom/details.cfm?ID=1684>.

## Duty to Treat

### OVERVIEW OF THE LAW

Physicians and hospitals are different legal obligations with respect to the duty to treat patients. **Doctors generally do not have a duty to treat a patient unless a physician-patient relationship is formed.** Even once such a relationship is formed, a physician has the right to terminate the physician-patient relationship by following certain procedures.

**Hospitals are seen as being affected with the public interest and, as such, are held to a higher standard under a federal law called EMTALA (The Emergency Medical Treatment and Active Labor Act).** Hospitals have a duty to provide a medical screening examination to patients seeking care at their emergency departments. If the patient is deemed to have an “emergency medical condition,” the patient must receive stabilizing treatment or receive an appropriate transfer.

### Physicians

#### NO DUTY BEFORE A PHYSICIAN-PATIENT RELATIONSHIP IS FORMED

A physician has no duty to treat a patient if a physician-patient relationship has not been established. There is no legal obligation for doctors to enter into a physician-patient relationship.

#### DUTY AFTER A PHYSICIAN-PATIENT RELATIONSHIP IS FORMED

Michigan law prohibits patient abandonment.<sup>380</sup> Once a physician-patient relationship is formed, the physician must provide adequate medical care until the relationship is terminated.

Physicians “on call” at a hospital covered by the federal EMTALA law have specific duties to patients seeking emergency care at a hospital. ([See EMTALA](#))

#### HOW DO YOU KNOW IF A PHYSICIAN-PATIENT RELATIONSHIP HAS BEEN FORMED?

There is no set of concrete criteria that govern the formation of a physician-patient relationship. In general, the relationship is considered as having formed when the physician begins to “act like a doctor.”

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<sup>380</sup> *Tierney v. Univ. of Michigan Regents*, 669 N.W.2d 575, 578-9 (Mich. App. 2003). *Fortner v. Koch*, 269 N.W. 762 (Mich. 1936).

## Duty to Treat

**The physician-patient relationship is most commonly formed in one or more of the three following ways:**

- 1) Accepting a person as a patient<sup>381</sup>
- 2) Undertaking to examine and/or treat a patient<sup>382</sup>
- 3) Agreement with a health care facility or organization to be “on call” or be available to render medical care<sup>383</sup> ([See EMTALA](#))

## WHAT TERMINATES A PHYSICIAN-PATIENT RELATIONSHIP?

**A physician-patient relationship is terminated when one or more of the following occurs:**<sup>384</sup>

- 1) The relationship is ended by the consent of both parties
- 2) The relationship is ended by the patient who dismisses the physician
- 3) The physician’s services are no longer needed
- 4) The physician withdraws from the relationship. **\*\*If the physician is unilaterally terminating the relationship, he must notify the patient and give the patient a reasonable opportunity to obtain alternative care.** ([See “Abandonment” in OB-Gyn Medical Malpractice in Michigan](#))

## Hospitals (EMTALA)

### WHAT IS EMTALA?

Under the common law, a hospital has no duty to treat a person unless there is an unmistakable emergency.<sup>385</sup> EMTALA, the federal **Emergency Medical Treatment and Active Labor Act, imposes a legal duty on hospitals to provide care in emergency situations.**<sup>386</sup>

EMTALA is part of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). The purpose of the law is to prevent “patient dumping”—the practice of transferring or discharging medically unstable patients for financial reasons.

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<sup>381</sup> *Zoterell v. Repp*, 153 N.W. 692, 695-6 (Mich. 1915).

<sup>382</sup> *Lince v. Monson*, 108 N.W.2d 845 (Mich. 1961).

<sup>383</sup> *Danner v. Holy Cross Hosp.*, 474 N.W.2d 124, 124 (Mich. 1991).

<sup>384</sup> *Tierney v. Univ. of Michigan Regents*, 669 N.W.2d 575, 579 (Mich. App. 2003). *Fortner v. Koch*, 269 N.W. 762 (Mich. 1936).

<sup>385</sup> *Ritter v. Wayne County Gen. Hosp.*, 436 N.W.2d 673 (Mich. App. 1988).

<sup>386</sup> 42 U.S.C. § 1395dd et. seq. (1986).



## IS UMHS COVERED BY EMTALA?

Yes, EMTALA applies to all hospitals that voluntarily participate in the federal Medicare program and receive Medicare funding (which includes almost all hospitals).<sup>387</sup>

## WHAT DOES EMTALA REQUIRE OF UMHS AND UMHS PHYSICIANS?

- 1) **Medical Screening**—Any patient who comes to the ER requesting examination or treatment for a medical condition must be provided with an appropriate medical screening examination to determine if the patient is suffering from an **“emergency medical condition.”**<sup>388</sup>
- 2) **Treat or Transfer**—If the patient has an **“emergency medical condition,”** the hospital must either a) provide stabilizing treatment or 2) transfer her to another hospital in accordance with EMTALA provisions.<sup>389</sup>
- 3) **Pregnant Woman in Active Labor**—A pregnant woman in active labor must be admitted to the hospital and treated until delivery UNLESS a transfer would be appropriate under EMTALA.
- 4) **Hospital Signage**—EMTALA requires that hospitals post conspicuous signs that notify patients and visitors of the right to be examined to receive treatment under the law.<sup>390</sup>
- 5) **Record Maintenance**—Maintain medical and other records related to individuals transferred to and from the hospital for a period of 5 years from the date of transfer.
- 6) **Central Log**—Maintain a central log of individuals who seek treatment in the emergency department that indicates whether they refused treatment, were denied treatment, were treated, admitted, stabilized, transferred, etc.
- 7) **Physician Call List**—Maintain a list of physicians who are on call to provide evaluation and necessary stabilizing treatment to a person with an “emergency medical condition.”
- 8) **No Delay Because of Availability of Insurance**—EMTALA allows the hospital to ask the patient if she has medical insurance, but it does not permit the inquiry to delay the medical screening examination and treatment.

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<sup>387</sup> EMTALA provisions apply to all patients "whether or not eligible for Medicare benefits". 42 U.S.C. § 1395dd(a) (1986).

<sup>388</sup> 42 § U.S.C. 1395dd(a) (1986).

<sup>389</sup> 42 § U.S.C. 1395dd (1986).

<sup>390</sup> 42 C.F.R. § 489.20(q)(1) (1986).

## Duty to Treat

### WHAT IF THE PATIENT DOES NOT HAVE AN “EMERGENCY MEDICAL CONDITION?”

If the patient does not have an “emergency medical condition, the hospital does not have an affirmative duty to treat the patient under EMTALA.

### WHAT IS AN “EMERGENCY MEDICAL CONDITION?”

The determination of what constitutes an “emergency medical condition” is a medical conclusion rather than a legal one. However, the law does provide some guidance to medical professionals:<sup>391</sup>

An “emergency medical condition” is a medical condition manifesting itself by **acute symptoms of sufficient severity** (including severe pain) such that lack of immediate medical attention could reasonably be expected to result in:

- 1) **jeopardy to the health of the individual** (or to the **unborn child**, with respect to a pregnant woman), or
- 2) **serious impairment to bodily functions**, or
- 3) **serious dysfunction of any bodily organ or part**, or
- 4) with respect to **pregnant woman** who is experiencing contractions, there is **inadequate time to safely transfer** her to another hospital before delivery.

### WHAT IS “ACTIVE LABOR?”

**A pregnant woman must be experiencing contractions to be in active labor.** Some patients present with false labor or are having contractions that are too far apart to be considered as being in active labor. While it may not ultimately be necessary to admit a patient who is not active labor, **EMTALA requires that the medical screening examination be done to determine the stage of labor and to assess whether or not the patient can be safely transferred.** If a pregnant woman is at a stage in which she may safely be transferred, the hospital may discharge her without violating EMTALA.

### HOW IS THE MEDICAL SCREENING EXAMINATION DIFFERENT FROM TRIAGE?

Individuals seeking care at an emergency room must be provided a medical screening exam beyond initial triaging. Triage is for determining the order in which individuals will be seen. A medical screening exam is a more detailed process by that is needed to determine whether or not a medical emergency exists.

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<sup>391</sup> 42 U.S.C. § 1395(e) (1986).

WHAT DOES IT MEAN TO “STABILIZE” UNDER EMTALA?<sup>392</sup>

- 1) Stabilizing an emergency medical condition means that no material deterioration of the patient’s condition is likely to result or occur during a transfer.
- 2) Stabilizing a patient in active labor means that both the infant and the placenta have been delivered.

WHAT ARE THE REQUIREMENTS FOR AN APPROPRIATE TRANSFER OF A PATIENT UNDER EMTALA?

**Transfers are permitted when:**

- 1) **Patient Requests a Transfer**—A transfer is allowed when the individual (or someone acting on his behalf) requests a transfer after being informed of the hospital’s EMTALA duties and any risks of transfer. This request must be in writing and should indicate the reasons for the transfer request and that the patient knows of the risks and benefits of transfer.

**AND/OR**

- 2) **Physician Certifies the Necessity for a Transfer**—A transfer is allowed when a physician has signed a written certification saying that, based on the information available at the time of the transfer, the medical benefits of the transfer to another facility outweigh the possible risks of being transferred. The certification should contain a summary of the risks and benefits assessed by the physician and the reasons for recommending a transfer.

**Transfers are appropriate if they meet ALL four of the following requirements:**<sup>393</sup>

- 1) The patient must first be **treated and stabilized** according to the hospital’s capacity and capabilities in order to sufficiently minimize the risks of transfer.
- 2) The **receiving facility must have available space and qualified medical professionals** who have agreed to accept the transfer and provide appropriate treatment to the individual.
- 3) The transferring hospital must **send to the receiving facility all available medical records (or copies) related to the patient’s emergency condition**. Other records that are not readily available should be sent as soon as possible after the transfer.
- 4) The transfer should be carried out by **qualified personnel with appropriate transportation equipment**, including any life support needed during the transfer.

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<sup>392</sup> 42 U.S.C. § 1395(e) (1986).

<sup>393</sup> 42 U.S.C. § 1395 (1986).

## Duty to Treat

### WHAT IF THE PATIENT DOES NOT WANT THE MEDICAL SCREENING EXAMINATION AND/OR TREATMENT?

If the patient does not want (or refuses) medical assistance, EMTALA is not violated as long as the hospital:

- 1) Offers the patient medical examination and treatment,
- 2) Informs the patient of the risks and benefits of the examination and treatment,
- 3) And the patient refuses to consent to the medical examination and treatment.

The refusal should be documented in the hospital's medical records. The patient should sign a document indicating that he has been informed of the risks and benefits of examination and treatment and the risks and benefits of refusing examination and treatment.

### WHAT DOES EMTALA REQUIRE OF RECEIVING HOSPITALS?

While most EMTALA provisions apply to the transferring hospital, there are some obligations imposed on the receiving hospital as well:

- 1) **Specialized Facilities**—Any participating hospital which has specialized capabilities or facilities (such as burn units, neonatal ICUs, etc.) may not refuse to accept a patient in transfer if it has the capacity to treat the patient.
- 2) **Regional Referral Center in a Rural Area**—Any regional referral center in a rural area may not refuse a transfer if it has the capacity to treat the patient.

### DO ANY EMTALA PROVISIONS IMPOSE OBLIGATIONS ON PHYSICIANS?

While most of EMTALA applies to hospitals, it also governs physicians:

- 1) If a physician is assigned as an on-call physician in a hospital's emergency department, he can face a penalty for failing to respond.
- 2) A physician who signs a certification supporting a transfer can be held liable under EMTALA if he knew or should have known that the certification was false.

## Informed Choice

### OVERVIEW

Lawsuits against physicians alleging a lack of informed consent have become increasingly common. Informed consent means that the **patient has a right to know** certain things before making a decision about medical care. **Documentation** of physician disclosure and patient response is advisable.

It is helpful to think of this legal concept as “**informed choice**” rather than “informed consent,” because patients (or legally authorized representatives) can **consent to or refuse** a treatment. Informed consent and informed refusal are essentially two sides of the same coin. In either case a patient must be **provided with relevant information, given a chance to understand the information, allowed to ask questions, and be given relevant answers. Only then can the patient make an informed, unforced choice.** Once determined, the choice should be **documented**. If the choice is a refusal, the information provided and the reason for the refusal should be noted.

This document begins with the treatment of **competent patients**. Competence means that the patient is 18 or older (or is an emancipated minor) who understands both the nature and consequences of her actions. The treatment of incompetent patients is discussed subsequently.

### WHAT ARE THE PHYSICIAN’S RESPONSIBILITIES?

The physician must:<sup>394</sup>

- 1) **Disclose, without coercion**, to the competent patient or the responsible decision maker for an incompetent patient,
- 2) **Prior** to any treatment or procedure,
- 3) **Sufficient information** about the procedure, its foreseeable risks, and potential benefits and alternatives, to enable the patient to make an informed decision.
- 4) **Obtain consent OR refusal** to the treatment.

### WHAT INFORMATION MUST THE PHYSICIAN DISCLOSE?<sup>395</sup>

- 1) **Diagnosis**
- 2) What and Why: The **nature and purpose** of the proposed treatment.

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<sup>394</sup> 1-19 MICHAEL G. MACDONALD & SCOTT BECKER, TREATISE ON HEALTH CARE LAW § 19.02 (2<sup>nd</sup> ed. 1998).

<sup>395</sup> *Id.*

## Informed Choice

- 3) **Risk and Consequences:** What might happen if we do this AND what can happen if we don't?
- 4) **Alternatives:** What else can we do?
- 5) If the patient is seeking an **ABORTION**, there is a specialized consent process prescribed by Michigan law. ([See Abortion Laws in Michigan—Informed Consent](#))

### WHAT INFORMATION DOES THE PHYSICIAN NOT HAVE A DUTY TO DISCLOSE?<sup>396</sup>

- 1) Any information beyond what a **qualified physician in a similar medical classification** would know.
- 2) **Detailed technical information** that the patient probably would not even understand.
- 3) Risks that the patient **already knows**.
- 4) **Extremely remote possibilities** that could falsely or detrimentally scare the patient.
- 5) Information in **emergencies** where the failure to provide treatment would be more harmful than the treatment itself.
- 6) Information in circumstances in which the patient does not have the **capacity to consent**.

### HOW MUCH MUST THE PHYSICIAN DISCLOSE?

Michigan generally applies the professional practice standard. The physician must disclose **whatever information a reasonable medical practitioner with the same level of training under similar circumstances** would disclose.

### WHAT ARE THE BEST WAYS TO ENSURE VALID CONSENT?

- 1) Whoever is going to actually perform the procedure should obtain consent.
- 2) The physician should have a **complete understanding** of the patient's **medical history**.
- 3) The healthcare provider should have thorough **consent forms** to give to patients.
- 4) The physician must make sure that the patient has the **legal and mental capacity** to give consent. ([See Competency to Make Medical Decisions](#))
- 5) The patient must **consent to a specific procedure**, and the health care provider should not proceed further than that procedure's scope.
- 6) Make sure the patient is **not being coerced**.
- 7) **Disclose sufficient information** to the patient to allow an informed decision.

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<sup>396</sup> *Id.*

- 8) Allow the patient **adequate opportunity to process the information and to ask follow-up questions**. It can be useful to quiz the patient briefly to make sure she has processed and understands the material presented. *Example:* The physician might ask: What is the procedure? What is it designed to do? What might happen to you? What other choices do you have?

#### WHAT IF THE PATIENT IS NOT COMPETENT?

If the patient is incompetent or lacks legal capacity, **substitute decision-makers must be sought**. ([See Medical Decision-Making Chain](#))

#### WHAT IF A PATIENT CONSENTS TO A TREATMENT BUT LATER WITHDRAWS THAT CONSENT?

If the patient withdraws consent, the physician **must again disclose** all the necessary information to the patient **and obtain consent again** before proceeding with the treatment.<sup>397</sup>

#### WHAT IF THE PATIENT DOESN'T WANT TO HEAR THE INFORMATION?

If the physician begins to deliver the required information and the patient asks him to stop, the physician is not obligated to continue.<sup>398</sup> **HOWEVER, the physician can rely on the patient's waiver of informed consent only if it is clear and explicit.** It is best to ask patients *why* they do not wish to receive the information and whether they would be willing to hear it if provided with some kind of reassurance or support.<sup>399</sup> In a few cases, patients have claimed after the fact that had they been told the risks, they would never have proceeded. For this reason, it is important that the physician provide a clear explanation of the procedure, its foreseeable risks, potential benefits and available alternatives, and then document the discussion.

#### WHEN DOES THE PHYSICIAN NOT NEED TO OBTAIN EXPRESS CONSENT?<sup>400</sup>

##### A) Consent is **IMPLIED**...

- 1) In an **emergency situation** in which **taking time** to obtain consent would result in **significant harm** to the patient *or*
- 2) If the patient is **unconscious or otherwise incapable of communicating consent, it is important to start an intervention AND** the patient's **family is not readily available**.
- 3) For routine, non-invasive or minimally invasive procedures.

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<sup>397</sup> *Id.*

<sup>398</sup> *Id.*

<sup>399</sup> *Id.*

<sup>400</sup> *Id.*

**HOWEVER, if the patient refuses treatment in an emergency, the physician cannot move forward with the treatment.** There may be a question as to the patient's mental competency or whether the patient has enough information to make an informed choice, but these questions must be resolved before treatment can proceed. ([See Competency to Make Medical Decisions](#) and [Refusal of Treatment by Competent Patients](#)) *Example:* An adult Jehovah's Witness with a ruptured spleen can refuse blood or blood products.

### B) Unanticipated Conditions During Surgery

- 1) When a physician is performing a procedure on a patient under **anesthesia**
- 2) **AND** discovers an **unanticipated condition** that requires attention,
- 3) the physician **may treat the condition** instead of making the patient undergo the risks and inconveniences of a second surgery.

**HOWEVER, a physician should NOT** rely on the unanticipated conditions exception if the procedure:

- 1) Involves **removal of an organ,**
- 2) **Affects reproductive capacity,**
- 3) **OR significantly increases the risks** of the surgery.

## Refusal of Treatment by Competent Patients

### OVERVIEW OF THE LAW

Informed consent means that the **patient has a right to know** certain things before making medical care decisions. It is helpful to think of this legal concept as "**informed choice,**" because patients (or legally authorized representatives) can **consent to or refuse** a treatment. Informed consent and informed refusal are essentially two sides of the same coin. ([See Informed Choice](#)). Documentation of the reason the patient has refused treatment is important.

In general, a competent patient has **autonomy** over her body and has the **right to refuse treatment**. The Supreme Court has found that a patient has a constitutionally protected liberty interest in refusing treatment.<sup>401</sup> However, there are **some exceptions** in which the **right to refuse treatment is not absolute** and is outweighed by certain state interests.

### SCOPE OF REFUSAL

**Competent patients can refuse any kinds of treatments...**

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<sup>401</sup> *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1990).



## Informed Choice

- 1) even those that have a number of benefits and relatively few side effects.
- 2) even if the refusal will lead to their deaths.
- 3) even if their family, physicians, or friends disagree with them.
- 4) even if the decision to refuse treatment is not religiously motivated.

## LIMITATIONS ON REFUSAL

The right to refuse treatment is not absolute. The law recognizes a couple of extremely narrow exceptions in which the physician may override a patient's refusal of treatment in order to protect a vulnerable third party.

- 1) **Communicable Diseases**—If a patient refuses a treatment for a contagious illness that can jeopardize public health, the right to refuse treatment is not absolute.<sup>402</sup> For example, local health departments are granted broad authority<sup>403</sup> to treat persons diagnosed with highly communicable diseases like tuberculosis and HIV/AIDS.
- 2) **Prisoners**—Several judicial opinions have affirmed the right of the state to override treatment refusals by prisoners in correctional facilities.<sup>404</sup>

## PREGNANT PATIENT'S RIGHT TO REFUSE TREATMENT

In the past, courts have ordered lifesaving treatment against the wishes of competent pregnant patients when a) the patient's refusal would result in her death, and therefore the death of the fetus, or b) the patient's refusal would result in the death of the fetus.<sup>405</sup> **BUT recent cases have supported the pregnant patient's right to refuse treatment that can save her life or the life of her fetus.**<sup>406</sup> ([See Maternal-Fetal Interests](#)) **The American Congress of Obstetrics and Gynecology has stated that doctors are almost never justified in compelling treatment for competent pregnant women.**<sup>407</sup>

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<sup>402</sup> *Jacobson v. Massachusetts*, 197 U.S. 11 (1905).

<sup>403</sup> MICH. COMP. LAWS § 333.5111 (2010).

<sup>404</sup> *Commissioner of Correction v. Myers*, 399 N.E.2d 452 (Mass. 1979). *Von Holden v. Chapman*, 450 N.Y.S.2d 623 (N.Y. App. Div. 1982); *State ex rel. White v. Narick*, 292 S.E.2d 54 (W. Va. 1982); *see also Washington v. Harper*, 494 U.S. 210 (1990).

<sup>405</sup> *Raleigh Fitkin-Paul Morgan Mem'l Hosp. v. Anderson*, A.2d 537 (N.J.), *cert. denied*, 377 U.S. 985 (1964).

<sup>406</sup> *In re A.C.*, 573 A.2d 1235 (D.C. 1990) (en banc).

<sup>407</sup> ACOG recognizes that "physicians are not obligated to provide futile care" and defines futile care as occurring in situations where "[e]vidence exists that the suggested therapy cannot achieve its physiologic goal" or the patient's or family's stated goals. ACOG Committee on Ethics, *Medical Futility*, No. 362 (2007). *See also* the U-M guidelines for termination of care at: [http://www.med.umich.edu/adultethics/Withholding\\_Life\\_Sustaining\\_Tx.pdf](http://www.med.umich.edu/adultethics/Withholding_Life_Sustaining_Tx.pdf).

# **Competency to Make Medical Decisions**

## **Introduction**

### OVERVIEW

Competency is a legal concept used to determine if a patient can legally make a decision about health care or other issues (writing a will, marriage, etc.). While competency is ultimately a legal concept determined by a court, medical professionals are often the ones who actually apply the standard and evaluate a patient's decisional ability by using mental status exams.

**Competency issues arise when the patient may or may not be capable of giving informed consent due to age or a mental or physical impairment.** ([See Informed Choice](#))

This section discusses the legal standard (the ability to understand the nature and consequences of one's actions), the medical approach, best practices, and what steps to take when a patient is found to be incompetent ([See Medical Decision-Making Chain](#))

### WHAT IS THE DIFFERENCE BETWEEN MEDICAL AND LEGAL COMPETENCY?

When physicians refer to "competence," they generally mean a clinical determination that focuses on the integrity of the patient's mental functions. In the legal context, competence (or capacity) is a person's ability to perform particular acts, such as making a contract or will, managing property and affairs, consenting to or refusing medical treatment, etc.<sup>408</sup>

**Patients are legally presumed to be competent, but that presumption can be rebutted by evidence of incompetence.** The two competing values in play are 1) the desire to promote autonomy and individual freedom and 2) the need to protect those who are incapacitated from suffering harm.<sup>409</sup>

### HOW SHOULD PHYSICIANS UNDERSTAND COMPETENCY?

**Consent obtained from an incompetent patient is INVALID.** Physicians who do not obtain a substituted decision can be sued for treating a patient without informed consent.

The medical world lacks a universally accepted definition of competency. But as a rule, the competency to make medical decisions is the ability of a person aged 18 or older:<sup>410</sup>

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<sup>408</sup> The Ethox Centre, *The Assessment of Competence*, <http://www.ethox.org.uk/education/undergraduate-course/no-consent/4-the-assessment-of-competence> (last visited June 17, 2010).

<sup>409</sup> Macdonald & Becker, *supra* note 172, at § 19.05.

<sup>410</sup> N.Y. PUB. HEALTH LAW § 2980(3) (2010).

## Competency to Make Medical Decisions

- 1) **to understand and appreciate the nature and consequences of the medical decisions,**
- 2) **including the benefits and risks of and alternatives to any proposed health care,**
- 3) **AND to reach an informed decision.**

### IS COMPETENCE FUNCTION-SPECIFIC?

**Yes, a person is not considered to be “globally” competent or incompetent.** A person may be deemed incompetent to make a will or may be civilly committed to a mental institution but can still have the competency to consent to or refuse medical treatment. **In some situations, a patient might be competent to consent to one treatment but not to another.**<sup>411</sup> The **appointment of a guardian or conservator** to manage the patient’s affairs **does not mean that the patient is not competent** to make medical decisions.

## Guidelines and Best Practices for Assessing Competency

### WHAT FACTORS MIGHT AFFECT A PATIENT’S COMPETENCY?<sup>412</sup>

- 1) Intellectual or cognitive ability
- 2) Memory impairment, which can vary at different times during the day
- 3) Psychiatric condition or mental disorder
- 4) Emotional maturity
- 5) Whether person is subject to coercion or threat
- 6) Whether person is in a relationship that might impact capacity to freely make a choice
- 7) Time to process information

### RELEVANT LEGAL CRITERIA FOR COMPETENCY TO MAKE MEDICAL DECISIONS<sup>413</sup>

#### 1) **Communicate a Choice**

##### a) Patient’s Task

- Clearly indicate a preferred treatment option.

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<sup>411</sup> “[T]he mental capacity required by the law in respect of any instrument is relative to the particular transaction which is being effected by means of the instrument, and may be described as the capacity to understand the nature of that transaction when it is explained.” *Gibbons v. Wright* 91 C.L.R. 423, 428 (1954).

<sup>412</sup> The Ethox Centre, *The Assessment of Competence*, <http://www.ethox.org.uk/education/undergraduate-course/no-consent/4-the-assessment-of-competence> (last visited June 17, 2010).

<sup>413</sup> *Adapted from* Paul S. Appelbaum, *Assessment of Patients’ Competence to Consent to Treatment*, 357 N. ENGL. J. MED. 1834, 1836 (Table 1) (Nov. 1, 2007).

## Competency to Make Medical Decisions

### b) Physician's Assessment Approach

- Ask patient to indicate a treatment choice.
- Inconsistency and frequent reversals of choice, especially due to psychiatric or neurologic conditions, may indicate lack of capacity.

### c) Questions for Clinical Assessment

- Have you decided whether to follow your doctor's [or my] recommendation for treatment?
- Can you tell me what that decision is?
- [If no decision] What is making it hard for you to decide?

## 2) Understand the Relevant Information

### a) Patient's Task

- Grasp the fundamental meaning of information communicated by the physician.

### b) Physician's Assessment Approach

- Encourage patient to paraphrase disclosed information regarding medical condition and treatment.
- Information to be understood includes :
  - Nature of the patient's condition
  - Nature and purpose of proposed treatment
  - Possible benefits and risks of that treatment, alternative treatment, and no treatment

### c) Questions for Clinical Assessment

- Please tell me in your own words what your doctor [or I] told you about:
  - The problem with your health now...
  - The recommended treatment...
  - The possible benefits and risks (or discomforts) of the treatment...
  - Any alternative treatments and their risks and benefits...
  - The risks and benefits of no treatment...

## 3) Appreciate the Situation and its Consequences

### a) Patient's Task

- Acknowledge medical condition and likely consequences of treatment options.

### b) Physician's Assessment Approach

- Ask patient to describe views of medical condition, proposed treatment, and likely outcomes.

## Competency to Make Medical Decisions

- Courts have recognized that patients who do not acknowledge their illnesses (often referred to as “lack of insight”) cannot make valid decisions about treatment.
- Delusions or pathologic levels of distortion or denial are the most common causes of impairment.

### c) Questions for Clinical Assessment

- What do you believe is wrong with your health now?
- Do you believe you need some kind of treatment?
- What is treatment likely to do for you?
- What makes you believe it will have that effect?
- What do you believe will happen if you are not treated?
- Why do you think your doctor [or I have] has recommended this treatment?

## 4) Reason About Treatment Options

### a) Patient’s Task

- Engage in a rational process of manipulating the relevant information.

### b) Physician’s Assessment Approach

- Ask patient to compare treatment options and consequences and to offer reasons for selection of option.
- This criterion focuses solely on the process by which a decision is reached, NOT the outcome of the patient’s choice, since patients have the right to make unreasonable or irrational choices.

### c) Questions for Clinical Assessment

- How did you decide to accept or reject the recommended treatment?
- What makes [chosen option] better than [alternative option]?

## Patient Incompetence

### WHEN IS A PATIENT CLEARLY INCOMPETENT?

A patient is clearly incompetent when she is an unemancipated **minor, unconscious, severely retarded, highly intoxicated**, or for any other reason **incapable of making any decision at all.**<sup>414</sup>

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<sup>414</sup> Macdonald & Becker, *supra* note 172, at § 19.05.

## Competency to Make Medical Decisions

### WHAT STEPS SHOULD BE TAKEN AFTER A PATIENT IS DEEMED TO BE INCOMPETENT?

If the patient is incompetent or lacks legal capacity, and it is not an emergency situation, **substitute decision-makers must be sought.** ([See Medical Decision-Making Chain](#))

### WHEN IS IT NOT SO CLEAR THAT A PATIENT IS INCOMPETENT?

It may be difficult to decide whether or not a patient is incompetent when the patient has some understanding of what is occurring around him, but his **judgment is clouded by factors such as fear or mental/physical illness.**

### CAN A PATIENT BE TEMPORARILY INCOMPETENT?

**Yes, the determination of whether a patient is competent can also be affected by whether the conditions affecting mental functions are temporary or permanent.** *Example:* If a patient is 1) incapacitated by alcohol or drugs or 2) suffering from a mental or physical condition that is expected to be transient, it may be possible to postpone the decision until the patient's mental capacity improves in non-emergency situations.<sup>415</sup>

### WHAT IF THE PATIENT MAKES A DECISION WHEN COMPETENT AND LATER BECOMES INCOMPETENT?

The decision made while the patient is competent is **still valid** even after the patient becomes incompetent.

### WHAT IF THE PATIENT'S DECISION IS UNREASONABLE?

A person is **not to be deemed incompetent** just because he makes **an imprudent decision** that does not align with the physician's recommendations or opts for a choice that a reasonable person would not make. A decision that is against the patient's best interests **might alert the doctor to the need to assess capacity, but cannot be the sole determinant in the evaluation of competency.**<sup>416</sup>

### SLIDING SCALE VIEW OF DECISION-MAKING CAPACITY

#### A) Risk of Harm

Where there is a **greater risk of harm** that can result from the patient's decision, there must be a **higher level of certainty as to the patient's competence** to make decisions. Determining whether or not a patient has competency to make medical decisions means **weighing the extent to which the patient can assess the objective risks and benefits of the proposed treatment.**

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<sup>415</sup> Macdonald & Becker, *supra* note 172, at § 19.05.

<sup>416</sup> Macdonald & Becker, *supra* note 172, at § 19.05.

## Competency to Make Medical Decisions

### B) Complexity of the Decision

Some decisions are more complex than others and may require a higher level of decision-making capacity. *Example:* A patient with moderate dementia may be able to make a decision about whether to take antibiotics for pneumonia but not about whether to undergo chemotherapy for metastatic lung cancer.<sup>417</sup>

### C) Likelihood of Adverse Results

**If a competency issue ends up in court, a court is more likely to conclude that a patient lacks capacity if his or her decision will have serious adverse results.**<sup>418</sup>

*Example:* Where the patient is refusing lifesaving treatment and has a good prognosis overall, a determination that the patient is incompetent is more likely than if the proposed treatment is disfiguring, painful, or affects the patient's mental or reproductive functions.

### D) Patient's Best Interests

Patients with minimal capacity are usually allowed to consent to treatment that is in their best interests, especially if no alternative treatment is available. However, the riskier or more controversial the treatment, the higher the level of certainty is needed to determine competency.

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<sup>417</sup> Ronald Arnold, *Decision Making Capacity*, MEDICAL COLLEGE OF WISCONSIN END OF LIFE/PALLIATIVE EDUCATION RESOURCE CENTER, Apr. 2009, [http://www.eperc.mcw.edu/fastFact/ff\\_55.htm](http://www.eperc.mcw.edu/fastFact/ff_55.htm).

<sup>418</sup> Macdonald & Becker, *supra* note 172, at § 19.05.

## Medical Decision-Making Chain

### OVERVIEW

Michigan laws recognize the authority of certain individuals to make medical decisions for the patient:

- 1) The **patient** who is making decisions about his or her own medical care will be given the most weight.
- 2) A **patient advocate** designated by an **advanced directive recognized under Michigan law** can make decisions if the patient is incompetent.<sup>419</sup>
- 3) A **legal guardian** may need to make medical decisions on behalf of the patient if the patient is a minor or is incompetent.<sup>420</sup> Legal guardians are appointed by a court.
- 4) **Spouses** can make decisions for each other in the event of incompetency.<sup>421</sup>
- 5) **Parents** can execute a limited power of attorney to allow a named individual to make health care decisions for a minor child for a time period not to exceed 6 months.<sup>422</sup>

When a patient is found to be **incompetent** ([See Competency to Make Medical Decisions](#)) or otherwise incapable of giving informed consent ([See Informed Choice](#)), medical professionals should look to **surrogate decision-makers** or third parties to obtain consent.

### WHAT IS COMPETENCY?

Competency decides whether a patient can legally make a decision about health care. While competency is ultimately a legal concept determined by a court, it is often medical professionals who apply the standard and evaluate a patient's decisional ability by using mental status exams. **Physicians should assess whether a patient has the ability to understand the nature and consequences of her actions.**<sup>423</sup> ([See Competency to Make Medical Decisions](#))

### WHAT IF A PATIENT IS INCOMPETENT BUT IS IN AN EMERGENCY SITUATION?

Consent is **IMPLIED** in an **emergency situation** in which taking time to obtain consent from a patient advocate or surrogate would result in **significant harm** to the patient. Typically, implied consent in emergencies is presumed when a patient who is incapable of providing express consent arrives at the emergency room without family members or a legal guardian.

Physicians should make sure that whatever care is provided adheres to recognized professional standards. Also, there should be no treatment beyond what is necessary to stabilize

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<sup>419</sup> MICH. COMP. LAWS § 700.5506 (1008).

<sup>420</sup> MICH. COMP. LAWS § 700.5314 (2000).

<sup>421</sup> MICH. COMP. LAWS § 400.66h (1957).

<sup>422</sup> MICH. COMP. LAWS § 700.5103(a) (2004).

<sup>423</sup> See *May v. Leneair*, 297 N.W.2d 882 (Mich. App. 1980).



## Medical Decision-Making Chain

the emergency at hand. Reasonable attempts should be made to contact family members or next of kin as soon as possible after rendering the necessary aid.

WHAT STEPS SHOULD MEDICAL PROFESSIONALS TAKE ONCE A PATIENT IS DETERMINED TO BE [INCOMPETENT](#)?

- 1) **Advanced Directive:** Physicians should first check if the patient has an advanced directive (also called a durable power of attorney) that names a patient advocate who can legally give consent. If an advanced directive exists, the terms of that document control.
- 2) **IF Advocate in Advanced Directive Refuses OR is Clearly Acting Irresponsibly:** If the patient advocate named in the advance directive a) refuses to participate in the medical decision-making OR b) is clearly acting irresponsibly in making medical decisions on the patient's behalf, a court hearing might be needed to remove the advocate.
- 3) **IF NO Advanced Directive, Try to Get Surrogate Consent:** If a patient does not have an advanced directive, health care professionals should try to contact the patient's immediate family members, next of kin, or legal guardians to obtain surrogate consent that is in the patient's best interests. A legal guardian will have precedence over family members and next of kin.
- 4) **IF NO Patient Surrogates Available, Contact Close Friends:** If a patient has no advanced directive and no family members or next of kin who can provide surrogate consent, health care professionals should try to contact the patient's close friends and ask if any would be willing to be appointed as the patient's guardian by a court.
- 5) **Court Guardianship:** If a patient has no advanced directive, no surrogates, and no close friends who are willing to be appointed guardians, the court will appoint a guardian.

MAY A PREGNANT PATIENT'S LIFE SUPPORT BE DISCONNECTED BY ORDER OF THE ADVANCE DIRECTIVE?

**NO.** Michigan law specifically exempts pregnant people from consenting to this decision through an advanced directive: "This patient advocate designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant that would result in the pregnant patient's death."<sup>424</sup>

WHAT IS AN ADVANCED DIRECTIVE OR A DURABLE POWER OF ATTORNEY?

An advanced directive, also known as a durable power of attorney, is a document in which a person **appoints another individual to make medical decisions** in the event that the person loses the ability to consent to medical treatment.

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<sup>424</sup> MICH. COMP. LAWS § 700.5507 (2008).

## Medical Decision-Making Chain

### WHAT IS A PATIENT ADVOCATE?

A patient advocate is a person designated by a patient to make decisions about the patient's care, custody, and/or medical treatment in the event that the patient cannot supply consent.<sup>425</sup> A patient advocate must be over 18 years of age.

### WHAT IS A SURROGATE DECISION-MAKER?

A surrogate decision-maker is:<sup>426</sup>

- 1) A parent or legal guardian of a patient who is under 18 years of age OR
- 2) A member of the immediate family, the next of kin, or the legal guardian of a patient who is incompetent (or incapable of giving informed consent to medical treatment) WHO
- 3) Will act on behalf of and in the "best interests" of an incompetent patient.

### MICHIGAN LAW AND RELIANCE ON CONSENT BY SURROGATE DECISION-MAKER

**Under Michigan law, physicians may rely on consent by family members, next of kin, or legal guardians if the patient is incapable of consenting to treatment.**<sup>427</sup> Generally speaking, the legal risks of relying on consent of family members are significantly lower if:<sup>428</sup>

- 1) The treatment is medically indicated and in the patient's best interests.
- 2) The treatment does not involve the patient's reproductive capacity.
- 3) Other family members are not objecting.
- 4) The patient is not objecting.

### MICHIGAN LAW AND SURROGATE DECISION-MAKER REFUSAL

In an emergency situation in which the patient is incompetent, consent by surrogates to proceed with treatment will generally be adequate as long as the informational duties of informed consent are met by the physician. ([See Informed Choice](#))

**However, when a patient advocate REFUSES treatment on the patient's behalf in an emergency situation without an advanced directive, the standard for obtaining consent may be higher.** The Michigan Supreme Court held that life-sustaining treatment could not be removed from a patient who had formerly been competent and lacked an advanced directive UNLESS it could be shown by "clear and convincing evidence" (i.e. in the 80% likely realm) that the patient would not want the treatment under the circumstances.<sup>429</sup>

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<sup>425</sup> MICH. COMP. LAWS § 700.1106 (2009).

<sup>426</sup> MICH. COMP. LAWS § 333.5653 (2004).

<sup>427</sup> MICH. COMP. LAWS §§ 333.5653-5657 (2004).

<sup>428</sup> Macdonald & Becker, *supra* note 172, at § 17.05, Treatment Without Express Consent.

<sup>429</sup> *In re Martin*, 538 N.W.2d 399 (Mich. 1995).

# OBLIGATIONS BROADER THAN THE PROVIDER-PATIENT RELATIONSHIP: PROVIDER REPORTING ISSUES, STATE BREAST CANCER LAW, STATE HIV LAW, DOCTOR'S NOTES

## Reporting Requirements for Michigan Ob-Gyns

### Introduction

Physicians are under legal obligation to report various patient conditions and procedures. The reporting requirements originate from both state and federal legal bodies.

#### WHY IS THERE AN OBLIGATION TO REPORT?

Federal and state governments impose reporting obligations for the purpose of **tracking public health needs** and trends so that resources can be allocated to safeguard the population.<sup>430</sup> **Michigan's Public Health Code** establishes requirements for "reporting and other surveillance methods for measuring the occurrence of diseases, infections, and disabilities and the potential for epidemics."<sup>431</sup> The Code empowers the **Michigan Department of Community Health** (MDCH) to create additional reporting requirements by formulating rules,<sup>432</sup> which have the equivalent force of law.

The U.S. **Centers for Disease Control and Prevention** (CDC) likewise requires that certain diseases, conditions, and events be reported.<sup>433</sup> In most instances, however, the reporting is the **responsibility of local and state health departments**. This section will note the few cases when individual physicians do have a legal duty to report.

#### WHO MUST REPORT?

Obligations exist for various state medical license holders; this document covers the reporting requirements of **physicians**, specifically **obstetricians** and **gynecologists**.

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<sup>430</sup> Public Health Code, 1978 Mich. Pub. Acts 368 (codified at MICH. COMP. LAWS §§ 333.1101-25211).

<sup>431</sup> MICH. COMP. LAWS § 333.5111(b) (1994).

<sup>432</sup> Mich. Dept. of Community Health, *Michigan Reportable Diseases and Conditions*, <http://www.mdch.state.mi.us/pha/epi/cded/cd/cd.htm> (last visited July 8, 2010).

<sup>433</sup> Council of State & Territorial Epidemiologists, *CSTE List of Nationally Notifiable Conditions*, <http://www.cste.org/dnn/LinkClick.aspx?fileticket=KV0%2fcS9UR5Q%3d&tabid=36&mid=1496> (June 2010).

## WHERE SHOULD PHYSICIANS REPORT?

**Child abuse or neglect**, including pregnancy or sexually transmitted diseases in minors, should be reported to the UMHS Child Protection Team, who will then review and, as required, report to the relevant state child protection office. (For more details, see [Child Abuse and Neglect Reporting Requirements](#).)

Other incidents should be reported as follows:

- Crimes on campus .....Hospital Security  
(<http://www.med.umich.edu/security/index.htm>)
- Contagious diseases .....Department of Pathology  
(<http://www.pathology.med.umich.edu/>)
- Birth and death notices.....Birth Certificates and Vital Statistics Office  
(<http://www.med.umich.edu/i/him/About/bc.html>)
- Provision of abortion – statistical data.....Michigan Dept. of Community Health.<sup>434</sup>  
([http://www.michigan.gov/mdch/0,4612,7-132-2945\\_5221-14276--,00.html?ref=driverlayer.com/web](http://www.michigan.gov/mdch/0,4612,7-132-2945_5221-14276--,00.html?ref=driverlayer.com/web))

## Communicable or Infectious Diseases

Communicable diseases are tracked by the government so that its public health mechanism can assist in preventing their spread. Diseases included here are either specific to the practice of obstetrics or gynecology, or included because they are of particular concern to the health of the pregnant woman, fetus, or newborn.

### UNUSUAL DISEASES

The Michigan Department of Community Health (MDCH) mandates that any **unusual occurrence, outbreak or epidemic of any disease, condition, and/or nosocomial infection** be reported **immediately**.

### SEXUALLY TRANSMITTED DISEASES

All incidences of sexually transmitted diseases are required to be reported to MDCH. (See below for timetable.)

- **HIV.** The health care provider is required to submit the patient's name and contact information, the **test result**, and the probable method of HIV transmission. The local health department may not maintain a roster of patient names, but it does maintain individual case files, encoding them to protect test subjects' identities. Regardless of

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<sup>434</sup> MICH. COMP. LAWS § 333.2835(2) (2013).

## Reporting Requirements for Michigan Ob-Gyns

this provision, a patient may request that her physician report test results *without* her name and contact information attached.<sup>435</sup>

- If the physician determines that an HIV-positive patient needs assistance with **notification of a sexual or needle-sharing partner**, she must refer the patient to the local health department for that purpose. The patient has a legal obligation to inform any sexual partner of her HIV-positive status before engaging in a sexual relationship; failure to do so may result in criminal charges.<sup>436</sup> This obligation also holds true for any HIV-positive health care provider in a sexual relationship with a patient.
- **HIV testing.** A **pregnant woman** is required by statute to be **tested for HIV**. She may refuse to be tested; this or any other reason for not carrying out the test should be noted in her record.<sup>437</sup>
- **Test results for sexually transmitted diseases, HIV or antibody to HIV, and hepatitis B** carried out on a **pregnant** or newly **postpartum** patient must be retained by the physician and made available if requested to the local health department and/or a physician who treats the patient or her children.<sup>438</sup>
- **All sexually transmitted diseases.** Occurrences of the following diseases should be reported to the local health department within the time frame noted:<sup>439</sup>
  - **Within 24 hours: AIDS, chancroid, gonorrhea, granuloma inguinale, lymphogranuloma venereum, syphilis.**
  - **Within three working days: Chlamydia.**
  - **Within one week: HIV.**

### SELECTED OTHER COMMUNICABLE OR INFECTIOUS DISEASES

The following diseases are some of those mandated for reporting by MDCH, selected for their relevance to gynecology and obstetrics. For a complete list, see [http://www.michigan.gov/documents/Reportable\\_Diseases\\_Chart\\_136393\\_7.pdf](http://www.michigan.gov/documents/Reportable_Diseases_Chart_136393_7.pdf).

- **Within 24 hours:** *H. influenzae* (meningitis or epiglottitis), hepatitis B in a pregnant women, meningococcal disease (meningitis or meningococemia), pertussis, rubella.
- **Within 3 days:** listeriosis, bacterial or viral meningitis, staphylococcal disease (first 28 days post-partum, mother or child), toxic shock syndrome.

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<sup>435</sup> MICH. COMP. LAWS § 333.5114 (2005).

<sup>436</sup> MICH. COMP. LAWS § 333.5114a (2005).

<sup>437</sup> MICH. COMP. LAWS § 333.5123 (1994).

<sup>438</sup> MICH. COMP. LAWS § 333.5123 (1994).

<sup>439</sup> Mich. Dept. of Community Health, *Physician – Disease Reporting*, Dec. 1999, <http://www.mdch.state.mi.us/pha/epi/cded/physicianlistweb.pdf> (referencing Communicable Disease Rules, MICH. ADMIN. CODE r 325.171-3 (2009)).

- **Within 1 week:** chicken pox (numbers of cases only).

## Other Mandated Reporting

### LIFE AND DEATH

- **Live birth.** A child born **at or en route to an institution** must be registered as being born at that institution within five days of the birth. This responsibility does not fall to the attending physician; however, that physician must "provide the medical information required by the certificate of birth and certify to the facts of birth not later than 72 hours after the birth."<sup>440</sup> The birth of a child born elsewhere must be registered by any physician in attendance at or immediately after the live birth, but no time frame for registration is specified.<sup>441</sup> The UMHS Birth Certificate and Vital Statistics office, located in F7790 Mott, manages all reporting of vital statistics. See <http://www.med.umich.edu/i/him/About/bc.html>.
- **Birth defects.** All diagnosed incidences of birth defects, including **congenital or structural malformations**, or **biochemical or genetic diseases**, must be reported to MDCH.<sup>442</sup> Specific defects to be reported are referenced on the Michigan Birth Defects Registry (MBDR) website (<http://www.mdch.state.mi.us/pha/osr/BirthDefects/BXDefectCodeGroups.asp>).<sup>443</sup> All personal information submitted in the physician's report is kept confidential; it is used only as statistical or summary data.<sup>444</sup>
- **Fetal death.** The death of a fetus that has **completed at least 20 weeks of gestation or weighs at least 400 grams**<sup>445</sup> must be reported to the state registrar within five days after delivery of the fetus.<sup>446</sup> "Delivery" means that the fetus has separated from the mother; if the fetus dies *in utero* before 20 weeks of gestation and before reaching 400 grams, the death need not be reported. If the dead fetus is delivered in an

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<sup>440</sup> MICH. COMP. LAWS § 333.2822(1)(a) (2003).

<sup>441</sup> MICH. COMP. LAWS § 333.2822(1)(b)(i) (2003). If a birth occurs inside a moving vehicle in another state, but the child is first removed from the vehicle in Michigan, the birth is registered in Michigan. MICH. COMP. LAWS § 333.2823(1) (1978). If the birth occurs in a moving vehicle in a foreign country, but the child is first removed from the vehicle in Michigan, the birth is registered in Michigan, but the birth certificate lists the actual place of birth. MICH. COMP. LAWS § 333.2823(2) (1978).

<sup>442</sup> MICH. COMP. LAWS § 333.5721(1) (1988).

<sup>443</sup> Detailed reporting instructions are available from MBDR. Mich. Dept. of Community Health, *Michigan Birth Defects Registry Reporting Manual*, [http://www.michigan.gov/documents/Bxdefect\\_10554\\_7.PDF](http://www.michigan.gov/documents/Bxdefect_10554_7.PDF) (2008).

<sup>444</sup> MICH. COMP. LAWS § 333.5721(2) (1988), 333.2631 (1978).

<sup>445</sup> MICH. COMP. LAWS § 333.2803(2) (2002).

<sup>446</sup> MICH. COMP. LAWS § 333.2834(1) (2002).

institution, the individual in charge of the institution is responsible for filing the report; if the dead fetus is **delivered outside an institution, the physician in attendance must file the report.**<sup>447</sup>

- **Abortion.** A physician who performs an abortion must report the procedure to MDCH within seven days. The report does NOT contain the patient's name, contact information, or identifying information.<sup>448</sup>
- **Death.** A physician or registered nurse may pronounce death; a health facility may determine which of its personnel is responsible for pronouncing and certifying death.<sup>449</sup> The UMHS Birth Certificate and Vital Statistics office manages all reporting of vital statistics. See <http://www.med.umich.edu/i/him/About/bc.html>.

#### ABUSE/DRUGS/VIOLENCE

- **Child abuse.** Physicians are required to report instances in which they have reasonable cause to suspect that a child is a victim of neglect or abuse. ([See Child Abuse and Neglect Reporting Requirements](#))
- **Controlled substances.** A physician who knows or suspects from a **newborn's symptoms** that the child has "any amount of alcohol, a controlled substance, or a metabolite of a controlled substance" in his or her body must report the circumstance to MDCH, unless the substance is present as a direct result of medical treatment given to the newborn or the mother.<sup>450</sup> The mother may subsequently be charged with child abuse or neglect. However, the presence of any controlled substance in the **pregnant woman alone** does *not* warrant any reporting or legal action.<sup>451</sup>
- **Wounds caused by violence.** A physician has the duty to report immediately to the local chief of police any **wound or other injury inflicted "by means of a knife, gun, pistol, or other deadly weapon, or by other means of violence."**<sup>452</sup> Although this duty is chiefly imposed on directors of hospitals or emergency rooms, the law specifically includes any physician treating such a patient. This law can be interpreted to cover **domestic violence**, even when no weapon other than a fist has been used; however, a physician has **no specified duty to report suspected domestic violence** when the suspected victim is a competent adult.
- **Abuse of vulnerable adults.** A vulnerable adult is defined as one who is **unable to protect herself** from abuse, neglect, or exploitation because of a **mental or physical**

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<sup>447</sup> MICH. COMP. LAWS § 333.2834(3-4) (2002).

<sup>448</sup> MICH. COMP. LAWS § 333.2835(2-3) (2002).

<sup>449</sup> MICH. COMP. LAWS § 333.1033(3) (1992).

<sup>450</sup> MICH. COMP. LAWS § 722.623a (1997).

<sup>451</sup> *People v. Hardy*, 469 N.W.2d 50, 53 (Mich. App. 1991).

<sup>452</sup> MICH. COMP. LAWS § 750.411 (2001).

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**impairment** or because of **advanced age**.<sup>453</sup> If such an adult is the suspected victim of abuse, her physician is obligated to immediately report the abuse to the county department of social services in the county where the abuse occurred; alternately, the physician may report to MDCH.<sup>454</sup>

- **Patient/Staff Safety**—If a situation arises in which violence is threatened, refer to UMHS Security Services at <http://www.med.umich.edu/security/index.htm>.

### ENVIRONMENTAL CONDITIONS

- **Lead and heavy metal poisoning.** Laboratories bear the responsibility of reporting lead poisoning to the state, but **physicians assist** in that venture by including with their analysis request the patient's identifying information, containing the name of the patient's employer.<sup>455</sup> The same holds true for heavy metal poisoning by **mercury**.<sup>456</sup> CDC funds state surveillance programs with its **Adult Blood Lead Epidemiology and Surveillance** program.<sup>457</sup>
- **Occupational diseases.** If a physician suspects that the heavy metal poisoning—or any other condition—is the result of workplace exposure, the physician must report the condition to MDCH within ten days of discovery.<sup>458</sup> Occupational disease reporting forms are available at Michigan State University's Occupation and Environmental Medicine website, at <http://www.oem.msu.edu/ReportForm.aspx>.

### OTHER

- **Cancer.** MDCH requires that all new cases of cancer "and other specified tumorous and precancerous diseases" be reported to the state or a cancer reporting registry that meets state standards.<sup>459</sup> Michigan's Statewide Cancer Registry gathers data for the Michigan Cancer Surveillance Program ([http://www.michigan.gov/mdch/0,1607,7-132-2944\\_5323---,00.html](http://www.michigan.gov/mdch/0,1607,7-132-2944_5323---,00.html)). The federal government also tracks data at the CDC; see <http://apps.nccd.cdc.gov/cancercontacts/npcr/contact.asp?contactId=204>.
- Specific conditions to be reported include "all diagnoses with a behavior code of 2 (carcinoma in situ) or 3 (malignant primary site) as listed in the publication entitled "International Classification of Diseases for Oncology," 1976, excluding basal, epithelial, papillary, and squamous cell carcinomas of the skin, but including

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<sup>453</sup> MICH. COMP. LAWS § 400.11 (1990).

<sup>454</sup> MICH. COMP. LAWS §§ 400.11a (1990), 333.21771 (1979).

<sup>455</sup> MICH. ADMIN. CODE. r. 325.9083 (2010).

<sup>456</sup> MICH. ADMIN. CODE. r. 62 (2005).

<sup>457</sup> CDC National Institute for Occupational Safety and Health, Adult Blood Lead Epidemiology and Surveillance (ABLES), <http://www.cdc.gov/niosh/topics/ABLES/ables.html> (last visited July 10, 2010).

<sup>458</sup> MICH. COMP. LAWS § 333.5611 (1978).

<sup>459</sup> MICH. COMP. LAWS § 333.2619(1)-(2) (1984).



**carcinomas of skin of the vagina, prepuce, clitoris, vulva, labia, penis, and scrotum.**<sup>460</sup> See the *Michigan Cancer Surveillance Program Cancer Reporting Manual* for details.<sup>461</sup> The Michigan program is funded by CDC's National Program of Cancer Registries (NPCR).<sup>462</sup>

- **Vaccines.** Although MCDH requires reporting only of childhood immunizations, it encourages providers also to report **adult immunizations** to the Michigan Care Improvement Registry.<sup>463</sup> In case of an **adverse reaction** to a vaccine, the physician should report the reaction to the **Vaccine Adverse Event Reporting System (VAERS)**, a program of the CDC and the FDA.<sup>464</sup> **Specific reportable adverse reactions** are listed in the **Vaccine Injury Table**,<sup>465</sup> but physicians are asked to report *any* adverse reaction, even if they are not sure the vaccine caused the adverse event.<sup>466</sup>

### Assisted Reproductive Technologies

**ART Clinic Success Rate.** The federal government requires all assisted reproductive technology programs to report to the CDC their success rates for each technology used.<sup>467</sup> The success rate is defined as live births per number of ovarian stimulation procedures and per successful oocyte retrieval procedure.<sup>468</sup> The results of the reporting are compiled annually and made available on the CDC website.<sup>469</sup> Data is reported to the Society for Assisted Reproductive Technologies (SART) at <http://www.sart.org/>.

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<sup>460</sup> MICH. ADMIN. CODE. r. 325.9051 (2004).

<sup>461</sup> Mich. Dept. of Community Health, *Michigan Cancer Surveillance Program Cancer Reporting Manual*, [http://www.michigan.gov/documents/mdch/MCSPManual2007\\_223356\\_7.pdf](http://www.michigan.gov/documents/mdch/MCSPManual2007_223356_7.pdf), (Jan. 1, 2007).

<sup>462</sup> Centers for Disease Control and Prevention, *National Program of Cancer Registries (NPCR)*, <http://www.cdc.gov/cancer/npcr/> (May 21, 2010).

<sup>463</sup> Mich. Care Improvement Registry, *Provider Information*, <http://www.mcir.org/providercontent.html> (last visited July 8, 2010). MCIR was formerly known as the *Michigan Childhood Immunization Registry*.

<sup>464</sup> Vaccine Adverse Event Reporting System, *Report an Adverse Event*, <http://vaers.hhs.gov/esub/index>, (last visited July 10, 2010). See also 42 U.S.C. § 300aa-25(b) (2009)

<sup>465</sup> VAERS *Table of Reportable Events Following Vaccination*, [http://vaers.hhs.gov/resources/VAERS\\_RET.pdf](http://vaers.hhs.gov/resources/VAERS_RET.pdf) (last visited July 10, 2010). See also 42 U.S.C. § 300aa-14 (1993).

<sup>466</sup> Vaccine Adverse Event Reporting System, *Report an Adverse Event*, <http://vaers.hhs.gov/esub/index>, (last visited July 10, 2010).

<sup>467</sup> 42 U.S.C. § 263a-1(a) (2009).

<sup>468</sup> 42 U.S.C. § 263a-1(b)(2) (2009).

<sup>469</sup> Centers for Disease Control and Prevention, *Assisted Reproductive Technology (ART): Annual ART Success Rates Reports*, <http://www.cdc.gov/art/ARTReports.htm> (Feb. 18, 2010).

## Privacy

### HOW IS PATIENT PRIVACY REGULATED?

The Privacy Regulation passed pursuant to **HIPAA** (Health Insurance Portability and Accountability Act) mandates privacy of patient medical, billing, and demographic data but **allows reporting** to appropriate authorities for the purpose of preventing or controlling disease, injury, or disability.<sup>470</sup> In addition, many state laws which mandate reporting for epidemiological purposes also contain provisions for anonymizing the data.

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<sup>470</sup> 45 C.F.R. § 164.512(b) (2002).

## **Breast Cancer Law in Michigan**

### OVERVIEW OF THE LAW

At both the federal and state levels, laws have been passed regarding access to screening and treatment, insurance coverage mandates, Medicaid and Medicare coverage, genetic testing, and education and research initiatives. Physicians are required to inform patients of all available treatments and provide special informed consent before genetic testing and prior to any decision about treatment. This law was a result of lobbying by women's groups after studies found lumpectomy to be as effective as radical mastectomy in treating breast cancer. The groups were concerned that health care professionals were not providing full information to patients.

### **Breast Cancer Screening and Treatment Coverage**

Both federal and state legislation has been put in place to assure access to diagnosis and treatment for low-income patients and to mandate inclusion of those services in health insurance and disability policies.

### INSURANCE COVERAGE MANDATES

**Michigan law requires that any health insurance plan operating in the state must include coverage for breast cancer diagnostic services, outpatient treatment services and rehabilitative services.**<sup>471</sup>

- 1) *Diagnostic services* include but are not limited to "mammography, surgical breast biopsy, and pathologic examination and interpretation"<sup>472</sup> and must be covered for women once between ages 35 and 39, and once every calendar year for women 40 and older.<sup>473</sup>
- 2) *Outpatient treatment* includes but is not limited to "surgery, radiation therapy, chemotherapy, hormonal therapy, and related medical follow-up services."<sup>474</sup>
- 3) *Rehabilitative services* include but are not limited to "reconstructive plastic surgery, physical therapy, and psychological and social support services."<sup>475</sup> Prosthetic devices following a mastectomy are specifically mandated for inclusion in insurance

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<sup>471</sup> MICH. COMP. LAWS § 550.1416(1) (1989).

<sup>472</sup> MICH. COMP. LAWS § 550.1416(3)(a) (1989). Mammography facilities are certified by federal statute. 42 U.S.C. § 263b (2010).

<sup>473</sup> MICH. COMP. LAWS § 550.1416(2) (1989).

<sup>474</sup> MICH. COMP. LAWS § 550.1416(3)(d) (1989).

<sup>475</sup> MICH. COMP. LAWS § 550.1416(3)(b) (1989).

## Breast Cancer Law in Michigan

policies.<sup>476</sup> Michigan statutes include corresponding provisions for disability insurance plans.<sup>477</sup>

### BREAST AND CERVICAL CANCER CONTROL PROGRAM

In 1991, the Michigan Department of Community Health implemented the Breast and Cervical Cancer Control Program (BCCCP), which is designed to provide access to breast cancer screening and treatment for low-income women.<sup>478</sup> It is funded by Amanda's Fund for Breast Cancer Prevention and Treatment Act, passed in 2007, which receives ongoing grants from the federal Centers for Disease Control and Prevention as well as Michigan tax revenue and donations.<sup>479</sup>

**Patients may be referred to a local BCCCP agency at 1-800-922-MAMM.**

### MEDICAID

Federal law mandates that every state's Medicaid plan include treatment for breast cancer.<sup>480</sup> Michigan screens Medicaid breast cancer patients through the BCCCP (see above).<sup>481</sup>

### MEDICARE

Mammograms are available yearly to all Medicare patients age 40 and older; younger women can obtain one baseline mammogram between the ages of 35 and 39.<sup>482</sup> Medicare also covers doctor's services, chemotherapy, radiation therapy, inpatient hospital care (albeit with significant coinsurance costs), outpatient hospital services, breast prostheses (both external or surgically implanted), injectable cancer drugs, and some oral cancer drugs and anti-nausea drugs.<sup>483</sup>

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<sup>476</sup> MICH. COMP. LAWS § 550.1415(2) (1981).

<sup>477</sup> MICH. COMP. LAWS §§ 500.3406a (1983), 500.3406d (1989), 500.3613 (1983), 500.3616 (1989).

<sup>478</sup> Mich. Dept. of Community Health, *Breast and Cervical Cancer Control Program*, [http://www.michigan.gov/mdch/0,1607,7-132-2940\\_2955-13487--,00.html](http://www.michigan.gov/mdch/0,1607,7-132-2940_2955-13487--,00.html) (last visited June 25, 2010).

<sup>479</sup> 42 U.S.C. § 300k-n, MICH. COMP. LAWS §§ 206.435(1)(d) (2009), 333.26231-7 (2007).

<sup>480</sup> 42 U.S.C. § 1396a(10)(a)(i)(XVIII), 42 C.F.R. § 410.34.

<sup>481</sup> National Women's Law Center, *Women and Medicaid in Michigan* (Feb. 2010), <http://nwlc.org/pdf/medicaid/Michigan.Medicaid.pdf>.

<sup>482</sup> Medicare.gov, *Breast Cancer Screening (Mammograms)*, <http://www.medicare.gov/navigation/manage-your-health/preventive-services/breast-cancer-screening.aspx> (last visited June 28, 2010).

<sup>483</sup> Centers for Medicare & Medicaid Services, *Your Medicare Benefits*, (Dec. 2009), <http://www.medicare.gov/Publications/Pubs/pdf/10116.pdf>.

## MICHIGAN CANCER DRUG REPOSITORY PROGRAM

To ensure that costly cancer medications are available to patients who need them, the Michigan Department of Community Health is charged with the operation of the Michigan Cancer Drug Repository Program, in which any licensed pharmacy or health care facility may participate.<sup>484</sup> Full details are available at [http://www.michigan.gov/documents/mdch/mdch\\_pharmacy\\_cancer\\_drug\\_repository\\_pkt\\_2388\\_87\\_7.pdf](http://www.michigan.gov/documents/mdch/mdch_pharmacy_cancer_drug_repository_pkt_2388_87_7.pdf).

## GENETIC TESTING

The federal Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers or health insurance carriers from discriminating on the basis of genetic information, such as the results of BRCA tests.<sup>485</sup> ([See Genetic Information Nondiscrimination Act](#)) It does NOT similarly restrict carriers of life insurance, disability insurance, or long-term care insurance.<sup>486</sup> In addition, the employment restrictions do not apply to employers with fewer than fifteen employees.<sup>487</sup>

Although tests for BRCA1 and BRCA2 have been quite costly up to this point, the 2010 New York federal court decision that invalidated the patents on those genes may cause competitors of the former patent holder to develop more economical tests.<sup>488</sup>

Michigan's Insurance Code states that a for-profit or non-profit insurance carrier cannot require genetic testing or disclosure of test results as a condition of issuing or continuing a policy or certificate.<sup>489</sup> In addition, state law requires a physician to administer a special informed consent process before carrying out any genetic testing on a patient. The patient must be informed of the test's nature, purpose, effectiveness, limitations and implications, as well as the future uses of the sample taken, the meaning of the test results, and who will have access to the sample and the results.<sup>490</sup>

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<sup>484</sup> MICH. COMP. LAWS § 333.17780 (2006).

<sup>485</sup> Genetic Information Nondiscrimination Act of 2008, Pub.L. 110-233, 122 Stat. 881, (May 21, 2008). For more information, see Department of Health and Human Services, *The Genetic Information Nondiscrimination Act of 2008: Information for Researchers and Health Care Professionals*, <http://www.genome.gov/Pages/PolicyEthics/GeneticDiscrimination/GINAInfoDoc.pdf> (April 6, 2009).

<sup>486</sup> Dept. of Health & Human Services, Office of Human Research Protections, *Guidance on the Genetic Information Nondiscrimination Act* (March 24, 2009).

<sup>487</sup> *Id.*

<sup>488</sup> *Ass'n for Molecular Pathology v. U.S. Patent & Trademark Office*, 702 F.Supp.2d 181, (S.D.N.Y. 2010).

<sup>489</sup> MICH. COMP. LAWS §§ 500.3407b (2000), 550.1401 (1991).

<sup>490</sup> MICH. COMP. LAWS § 333.17020 (2000).

## Physicians Must Inform Patients of All Available Treatments

### WHAT IS THE LAW?

The Michigan Breast Cancer Informed Consent Law of 1978 requires a physician who is administering the primary treatment for breast cancer to **inform the patient about all available methods** of treatment, including surgery, radiation or chemotherapy and to include the advantages, disadvantages and risks of each method.<sup>491</sup>

### WHAT MUST A PHYSICIAN DO?

Physicians can fulfill the legal requirement by **presenting a brochure** from the Michigan Department of Community Health, *What You Need to Know Before Treatment About: Breast Cancer*.<sup>492</sup> Once a form indicating receipt of the brochure and signed by the patient has been placed in the patient's medical record, the patient is barred from bringing suit against the physician for lack of informed consent in regard to information about all available forms of breast cancer treatment, and the advantages, disadvantages and risk of each method.<sup>493</sup> See a model consent form at [http://www.michigan.gov/documents/InformedConsent\\_69182\\_7.pdf](http://www.michigan.gov/documents/InformedConsent_69182_7.pdf).<sup>494</sup>

## Education and Research

### NATIONAL PROGRAM OF CANCER REGISTRIES

The Centers for Disease Control and Prevention oversees the National Program of Cancer Registries, which provides support for states and territories to maintain registries that provide high-quality data to allow public health professionals to understand and address the cancer burden more effectively.<sup>495</sup> The Program includes a statutory provision to study certain states in which breast cancer mortality rates are elevated in comparison with other states; Michigan does not fall in the elevated category.<sup>496</sup>

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<sup>491</sup> MICH. COMP. LAWS § 333.17013(1) (1989).

<sup>492</sup> Mich. Dept. of Community Health, Cancer Prevention and Control Section, *What You Need to Know Before Treatment About: Breast Cancer*, (Sept. 2008), available at <http://www.michigancancer.org/PDFs/MDCHPublications/WhatYouShouldKnowBeforeTreatment-Sept2008.pdf>.

<sup>493</sup> MICH. COMP. LAWS § 333.17013(7) (1989).

<sup>494</sup> Mich. Dept. of Community Health, *Informed Consent for Genetic Testing*, (May 2006), [http://www.michigan.gov/documents/InformedConsent\\_69182\\_7.pdf](http://www.michigan.gov/documents/InformedConsent_69182_7.pdf).

<sup>495</sup> Centers for Disease Control & Prevention, *National Program of Cancer Registries (NPCR)* (May 24, 2010), <http://www.cdc.gov/cancer/npcr/>. The Registries were established under 42 U.S.C. § 280e-3 (2010).

<sup>496</sup> 42 U.S.C. § 280e-3(a)-(b) (2010).

BREAST CANCER MORTALITY REDUCTION PROGRAM

In 1989 the Michigan Legislature enacted the Breast Cancer Mortality Reduction Program, which provides for education of the general public on breast cancer screening and treatment, education for medical professionals on acquiring diagnosis and treatment skills, and provisions for research on breast cancer mortality and methods to assure access to diagnosis and treatment to high-mortality populations.<sup>497</sup> Its effectiveness is tracked by biennial reports to the Legislature.<sup>498</sup>

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<sup>497</sup> MICH. COMP. LAWS § 333.9501 (1989).

<sup>498</sup> MICH. COMP. LAWS § 333.9503 (1989).

# HIV Laws in Michigan

## Informed Consent for HIV Testing

Informed Consent Requirement	<p><b>All HIV tests must be preceded by written or verbal informed consent</b>, and the physician must document that consent was obtained.</p> <p>*NOTE: Prior to an amendment to Michigan state law in 2010, the informed consent requirement for HIV testing could only be satisfied by written consent. The recent change allows the requirement to be met by verbal consent with a written chart note as well.</p>	M.C.L. § 333.5133
Mandatory Counseling	<p>A health care provider who orders or performs an HIV test must provide <b>counseling to the patient both BEFORE and AFTER the test is administered</b>. Counseling must include:</p> <ul style="list-style-type: none"><li>• An explanation of the test, including, but not limited to, the purpose of the test, the potential uses and limitations of the test, and the meaning of test results.</li><li>• An explanation of the patient’s rights including, but not limited to, the right to withdraw consent to the test prior to its administration, the right to confidentiality of test results, and the right to be tested on an anonymous basis.</li><li>• Designation of person(s) to whom the test results may be disclosed.</li></ul>	M.C.L. § 333.5133
Informed Consent for Minors	<p>Any minor who is infected or believes herself to be infected with HIV or a sexually transmitted disease is able to <b>consent to treatment as if she were an adult</b>. Consent by parents, guardian or spouse is <i>not</i> required. However, the physician can provide information to a parent/guardian if it is felt to be in the best interests of the child.</p>	M.C.L. § 333.5127  <a href="#">See Health Care Rights of Minors</a>



Documentation When Patient Requests Anonymity	Patients can request that HIV testing be done on an anonymous basis. If HIV testing is done on an anonymous basis, informed consent should be documented using a coded system rather than the signature of the patient.	M.C.L. § 333.5133
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### Exceptions to Informed Consent (HIV)

Patient Inability to Give Consent	If the patient is <b>unable to give consent</b> or to understand the information conveyed AND a <b>legal guardian</b> or other person authorized to make medical decisions on behalf of the patient is <b>not readily available</b> , consent is not required before testing.	M.C.L. § 333.5133
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Double-blind Research	If the HIV test is performed for <b>double-blind research</b> —i.e. the researcher does not know the identity of the test subject, and the test results are not revealed to the test subject—consent is not required before testing.	M.C.L. § 333.5133
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Exposure of First Responders and Health Professionals	If the HIV test is performed after a health care professional, police officer, firefighter, medical first responder, EMT, or licensed paramedic sustains a percutaneous, mucous membrane, or open wound <b>exposure to the blood or other body fluids</b> of the patient, while treating the patient <b>before transport to a health facility or transporting the patient to a health facility</b> , consent is not required before testing.	M.C.L. § 333.5133
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### Confidentiality of HIV-Related Information

Confidentiality	<b>HIV-related information</b> —i.e. all reports, records, and data pertaining to testing, care, treatment, counseling, and research—is <b>confidential</b> and cannot be released unless the <b>patient authorizes disclosure</b> or certain confidentiality <b>exceptions</b> apply.	M.C.L. § 333.5131
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Patient- Authorized Disclosure	Patients may authorize disclosure of HIV-related information and/or medical records. This authorization must be in writing and must contain a specific statement if the disclosure covers HIV-related information in the records.	M.C.L. § 333.5131
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**Exceptions to Confidentiality (HIV)**

Release to a Local Health Department or a Health Care Provider	HIV-related information can be released without patient consent if it is released to a local health department or a health care provider for the <b>purpose of protecting the health of an individual, contact tracing to prevent further transmission of HIV, and/or diagnosing and caring for a patient.</b>	M.C.L. § 333.5131
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Response to Subpoena or Court Order	If HIV-related information is requested through a court order or a subpoena, the court must determine that <b>other ways of getting this information are not available or feasible</b> and that the <b>public interest</b> and need for the disclosure outweighs the patient’s confidentiality interest.	M.C.L. § 333.5131
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Disclosure to Known Contacts	Physicians or local health officers can release HIV-related information if the information is released to a <b>known contact of the infected individual</b> AND if the disclosure is <b>necessary to prevent a reasonably foreseeable risk of HIV transmission.</b> (Also known as <b>Contact Tracing</b> )	M.C.L. § 333.5131
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Disclosure to Individual’s School District	Health departments may disclose HIV-related information to a school district for the <b>purpose of preventing a reasonably foreseeable risk of HIV transmission.</b>	M.C.L. § 333.5131
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Disclosure Under Child Protection Law	HIV-related information may be released if the information is <b>part of a report required under Michigan’s child protection law.</b>	M.C.L. § 333.5131  M.C.L. §§ 722.621 to 722.636
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Disclosure to Foster Parents	Disclosure of a foster child’s HIV serostatus is allowed <b>if the foster parent is the legal guardian</b> . However, only the Family Independence Agency, the State Department of Mental Health (part of the Department of Community Health), the Probate Court, or a child placing agency may make such a disclosure to the foster parent.	M.C.L. § 333.5131
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### **HIV Notification Laws**

Michigan law allows individuals with HIV to receive **assistance in notifying their sexual partners or those who have shared needles with them** of their potential exposure to HIV. Infected individuals may be counseled to notify their partner(s), to seek assistance from their physician, and/or to seek assistance from a local health department.

Partner Counseling and Referral Services (PCRS)	In response to a referral, the health department must interview or attempt to interview the patient within 14 days. The health department must also inform the patient of her <b>legal obligation to inform partners about positive HIV status prior to engaging in sexual relations</b> and that she may be subject to criminal sanctions (up to a felony) for failure to do so.	M.C.L. § 333.5114a
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Within 35 days of the interview, the department is required to **confidentially and discreetly contact each sexual or needle-sharing partner regarding their possible exposure to HIV**. Patient identity should not be disclosed unless the patient expressly consented prior to notification.

HIV Laws in Michigan

Physician's Duty to Warn (component of PCRS)	<p>Physicians and local health officers have an affirmative duty to notify known sexual or needle-sharing partners of HIV-infected patients about their potential exposure to HIV. <b>HOWEVER</b>, health professionals can discharge this duty to <b>PCRS staff at local health departments</b>.</p> <p>When a health professional makes a referral, the name of the known sexual or needle-sharing partner(s) and his/her address(es) and phone number(s)—if known—should be given to the local health department.</p> <p>See <a href="#">PCRS Form</a> available at MDCH Website.</p>	M.C.L. § 333.5131
Child Abuse Reporting Requirement	<p>Presence of HIV in a child over one month but under 12 years of age will trigger a child abuse reporting requirement. At UMHS, all reports should be made to the <a href="#">Child Protection Team</a>. The team will make any required report to the State.</p>	<a href="#">See Child Abuse and Neglect Reporting Requirements</a>
Reporting Requirements	<p>Health care providers must report <b>diagnostic HIV test results</b> to state or local health departments <b>within 7 days</b> of receiving test results.</p> <p>Health care providers must report <b>NON-diagnostic HIV test results</b> to state or local health departments <b>within 30 days</b> of receiving test results.</p> <p>Providers must complete either an <a href="#">Adult HIV Case Report</a> or a <a href="#">Pediatric HIV Case Report</a>.</p>	M.C.L. § 333.5114
Notification of Funeral Director	<p>If, at the time of death, a physician who is required to complete the medical certification has <b>actual knowledge of the presence of infectious agents (including HIV) in the deceased individual</b>, the physician must notify the funeral director (or an authorized agent of the funeral director) of the appropriate infection control precautions that should be taken. The funeral director may not refuse to handle the patient's body upon notification.</p>	M.C.L. § 333.2843b

**First responders**—police, fire fighters, EMTs, paramedics, or any individual assisting an emergency patient—are entitled to notification **if the patient they have assisted has tested positive for an infectious agent** AND if the potential exposure occurred **prior to transport** to a health facility OR **during transport** to a health facility.

Notification to Potentially Exposed First Responders

Within 2 days after test results are obtained, the health facility should inform the first responder of the **potential exposure to an infectious agent**, the **approximate date** of the potential exposure, and the **appropriate infection control precautions** to take.

M.C.L. § 333.20191

\*NOTE: The first responder should be encouraged to be tested for HIV, hepatitis B, and other infectious agents. Even if the test results indicate that the patient is HIV positive, **the health facility must not reveal that the infectious agent is HIV UNLESS the health facility has received a written request from the first responder.**

If the first responder’s identity is not known, the person’s **employer** should be notified instead.

Under Michigan law, it is a **felony** for an HIV-infected individual, who know he/she is infected, **to engage in sexual penetration without first informing the other person of the HIV infection.**

Criminal Felony—“Health Threat to Others”

An individual who is a **“health threat to others”** may be arrested and placed in custody in order to prevent transmission of HIV or any other serious communicable disease when the individual 1) is infected or reasonably believed to be infected and 2) is displaying an unwillingness or inability to conduct himself/herself in a way that does not place others at risk of transmission.

M.C.L. §§ 333.5201, 333.5203, 333.5205, 333.5207, 333.5210

If an individual is deemed to be a “health threat to others,” a report should be made to the local health department.

## Mandatory HIV Testing

**Any blood, tissue, organ, or other specimens collected for the purpose of transfusion, transplantation, or use in a human body must be tested for HIV prior to use.**

Generally, if the specimen tests positive, it cannot be used.

HOWEVER, if **HIV positive blood** was donated for **autologous transfusion**, the blood may be used if the donor and the recipient have **both consented in writing** to the use of the blood.

Testing of  
Donated  
Blood, Breast  
Milk, Sperm,  
and Organs

If a test result is **positive for HIV**, the health professional who ordered the test **must inform the donor of the test result**. If the donation is a **self-replicating body fluid** (such as breast milk or sperm), and the person is a **regular donor**, then HIV testing must be done **at least every 3 months**.

M.C.L. §  
333.9123

In an **emergency situation**, the donated specimen may be used if the person recipient provides **written consent acknowledging insufficient time for testing**. If the recipient is unable to provide written consent, a family member, guardian, or other representative with authority to make medical decisions may provide substitute consent.

Physicians must test **pregnant women** for HIV, hepatitis B, and sexually transmitted disease, **UNLESS** the woman **refuses to consent** to testing OR the physician determines the tests are **medically inadvisable**.

Prenatal  
Testing  
Requirement

HIV tests must also be performed for women who present for care in the **immediate postpartum period** (24 hours), having recently **delivered outside a health care facility**, and there is **no documentation of HIV test results**.

M.C. L. §  
333.5123

**Test results and the date of testing must be documented in the medical records.** Refusal of the test must be recorded. If the test is not ordered, an explanation of why the test was not ordered must be included in the records.

Exposure of First Responders	<p>If a <b>first responder</b> assists an emergency patient BEFORE transport to a health facility OR DURING the actual transport to a health facility, AND sustains a <b>percutaneous, mucous membrane, or open wound exposure to the blood or body fluids of the emergency patient</b>, the first responder may request that the emergency patient be tested for HIV and/or hepatitis B.</p> <p>The health facility must <b>NOT identify the emergency patient</b> by name, and the <b>request</b> for testing must be received by the facility <b>before the patient is discharged</b>.</p> <p>See <a href="#">First Responder HIV Request Form</a>.</p>	M.C. L. § 333.20191
Testing in State Correctional Facilities	<p>Michigan law requires that <b>all persons admitted to state correctional facilities</b> be tested for HIV, UNLESS the person has undergone an HIV test within the last 3 months.</p> <p><b>Testing</b> for HIV, hepatitis B, and sexually transmitted disease MAY be ordered by the court when a person is arrested and charged with prostitution or for solicitation of prostitution.</p>	M.C.L. § 791.267
Court-ordered Testing for Sex-related Crimes	<p><b>Counseling recommendation and written material</b> on information about HIV, hepatitis B, and sexually transmitted disease MUST be provided by a judge or magistrate when a person is arrested and charged for IV drug use, prostitution, solicitation of prostitution, or gross indecency.</p> <p>If a person is <b>awaiting trial for a crime or is convicted of a crime involving sexual penetration or exposure to defendant's bodily fluids</b>, the court MUST order that the defendant be <b>tested</b> AND receive <b>counseling</b> for HIV, hepatitis B, and sexually transmitted disease.</p> <p>Upon conviction, test results must be sent to the Department of Corrections and may be sent to the victim of the crime.</p>	M.C.L. § 333.5129

Exposure to  
Arrestees,  
Inmates,  
Parolees, or  
Probationers

If a **police officer, fire fighter, correctional officer, county employee, or other person making a lawful arrest** is exposed to the **blood or body fluids** of an arrestee, inmate, parolee, or probationer, the exposed individual may request that the person be tested for HIV, hepatitis B, and/or hepatitis C.

M.C.L. §§  
333.5204-5207

### **Antidiscrimination Laws**

Several federal and state statutes prohibit discrimination against those who are HIV-infected or are believed to be HIV-infected. These include Section 504 of the Federal Rehabilitation Act of 1973, the Fair Housing Amendments Act of 1988, the Americans with Disabilities Act of 1990 (ADA), and the Michigan Persons with Disabilities Civil Rights Act. The case of *Bragdon v. Abbott*, 524 U.S. 624 (1998) held that an HIV positive person had an impaired reproductive status and that reproduction qualifies as a major life activity under the [Americans with Disabilities Act \(ADA\)](#).

Physicians and other health care workers cannot refuse to treat an HIV-infected person merely based on the patient's HIV status or because HIV may be perceived to increase health risks to the physician or health care worker. A physician, however, may refer an HIV-infected person to a specialist or physician experienced in treating such patients if such medical care and treatment are needed by the patient.

Adapted from *Michigan HIV Laws*, published by the Michigan Department of Community Health, Division of Health, Wellness and Disease Control.



## **Doctor's Notes**

### WHO CAN REQUEST A DOCTOR'S NOTE AND FOR WHAT CONDITIONS?

Doctor's notes, also called "doctor's excuses" or "fit notes" are **requested by patients on behalf of** a third party, usually the patient's **employer**, to either **clarify work limitations** based on a medical condition, or to recommend the **lifting** of those limitations.

### WHAT SHOULD PROVIDERS CONSIDER WHEN WRITING NOTES?

Because **notes can be used** in legal forums **to determine legal rights**, physicians should give careful thought to what and how they write. For example, a note that recommends a pregnant woman refrain from lifting might cause her to lose her employment.<sup>499</sup> The provider should discuss with the patient why she requested the note, how it will be used, and any possible ramifications. In case of uncertainty, providers can consult with the Health System Legal Office.

### DO INDEPENDENT MEDICAL EXAMINERS AND INDUSTRY-EMPLOYED PHYSICIANS BEAR ANY ADDITIONAL RESPONSIBILITIES?

**Yes.** The American Medical Association imposes additional ethical responsibilities<sup>500</sup> on Independent Medical Examiners (IMEs) and Industry Employed Physicians (IEPs). Physicians in both these groups are employed by business or industry to perform medical examinations. Such physicians experience a limited patient-physician relationship and must therefore objectively evaluate the patient's health or disability, maintain patient confidentiality, and **disclose fully any potential or perceived conflicts of interest**. Physicians should clarify their role to their patients:

IEPs and IMEs are responsible for administering an objective medical evaluation but not for monitoring patients' health over time, treating patients, or fulfilling many other duties traditionally held by physicians. Consequently, a limited patient-physician relationship should be considered to exist during isolated assessments of an individual's health or disability for an employer, business, or insurer.

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<sup>499</sup> *Young v. United Parcel Service, Inc.* (4th Cir. 2013), *cert. granted, argued* (U.S. Dec. 3, 2014) (No. 12-1226).

<sup>500</sup> American Medical Association, Opinion 10.03 - Patient-Physician Relationship in the Context of Work-Related and Independent Medical Examinations, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion1003.page?> (visited Feb. 13, 2015).

## MISCELLANEOUS ISSUES

### Laws Concerning Prisoners and Medical Treatment

#### Prisoners Receiving Care at Health Care Institutions

##### HEALTH CARE NEEDS OF PRISONERS

An inmate at a federal or state prison or jail generally receives health care at the facility at which she is incarcerated. However, if the prisoner's health care needs cannot be met at that facility, the prison is required to obtain appropriate care for her at a health care institution.<sup>501</sup>

##### THE PRISON OR JAIL IS RESPONSIBLE FOR PAYING FOR INMATES' HEALTH CARE

**Jails may not release prisoners solely to make them responsible for their own health care expenses. City or county jails** are permitted by law to seek co-payment or reimbursement from prisoners for incurred health care expenses as well as to bill insurance companies or Medicaid for prisoner care, where applicable.<sup>502</sup> Likewise, **federal prisons** may charge prisoners a co-payment for medical care, although prenatal care is exempted from co-payment.<sup>503</sup>

##### MAY NON-PRISONER PATIENT DISCHARGE INFORMATION BE REVEALED?

**No.** If a prisoner has been completely released in order to receive medical treatment at an external health care institution, the privacy regulations passed pursuant to the Health Insurance Portability and Accountability Act (HIPAA) do not permit the institution to reveal information about the former prisoner.<sup>504</sup> The institution may *not* notify the jail that the former prisoner is about to be discharged in order to allow the facility to take that patient into custody once more.

#### Shackling of Pregnant Prisoners During Labor and Delivery

##### WHAT IS THE LAW REGARDING PRISONERS IN MICHIGAN JAILS AND PRISONS?

Prisoners are frequently placed in restraints for transport from jails or prisons to external health care facilities. Because most women prisoners are serving time for non-violent offenses,<sup>505</sup> security concerns during medical treatment are less than for male prisoners.

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<sup>501</sup> MICHIGAN DEPT. OF CORRECTIONS, POLICY DIRECTIVE: HEALTH SERVICES 03.04.100 (2005)

<sup>502</sup> MICH. COMP. LAWS §§ 801.5a, 801.301 (1982), 801.4 (2006) and MICHIGAN DEPT. OF CORRECTIONS, POLICY DIRECTIVE: SERVICES 03.04.101 (2009).

<sup>503</sup> U.S. DEPT. OF JUSTICE, FED. BUREAU OF PRISONS, PROGRAM STATEMENT: INMATE COPAYMENT PROGRAM, P6031.02 (2005).

<sup>504</sup> 45 C.F.R. § 164.502 (2002).

<sup>505</sup> "Nearly 71 percent of all arrests of women are for non-violent larceny and theft or drug-related offenses." *Improve Conditions of Confinement*, THE REBECCA PROJECT FOR HUMAN

Although no Michigan law or Department of Corrections policy mandates that shackles be removed when women are in labor, a criminal justice journalism website reports that Michigan jails and prisons do not use restraints during labor and birth, although they may use restraints on women in their third trimester of pregnancy.<sup>506</sup>

Many correctional facilities follow a practice of removing restraints when women begin labor; however, some guards may mistakenly equate labor with pushing or birth itself and therefore may not remove restraints until birth is imminent.<sup>507</sup> Often, guards are expected to remove restraints when asked to do so by medical personnel; therefore, physicians may wish to identify the beginning of labor for guards and request the removal of restraints.

#### WHAT IS THE LAW REGARDING FEDERAL PRISONERS?

The Federal Bureau of Prisons and the U.S. Marshals Service issued a policy statement in October 2008 forbidding the use of restraints on laboring, delivering, or post-partum prisoners except in limited cases: where a prisoner presents a clear danger to herself or others, or presents an immediate risk of escape.<sup>508</sup> Should restraints be necessary in such cases, they must be of the least intrusive types.<sup>509</sup>

### **Prisoners and Medical Research**

#### MAY PRISONERS ACT AS SUBJECTS IN BIOMEDICAL RESEARCH?

**Yes, with strict limitations.** Because incarceration could affect prisoners' "ability to make a truly voluntary and un-coerced decision" to participate in research,<sup>510</sup> federal regulations (the so-called "Common Rule") restrict research using prisoner subjects to the following areas:<sup>511</sup>

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#### RIGHTS,

[http://www.rebeccaproject.org/index.php?option=com\\_content&task=view&id=69&Itemid=151](http://www.rebeccaproject.org/index.php?option=com_content&task=view&id=69&Itemid=151)  
(last visited July 26, 2010).

<sup>506</sup> Caution: this assertion is without attribution. *Movement Builds to Stop Shackling Pregnant Prisoners*, THE CRIME REPORT, (Aug. 31, 2009),

<http://thecrimereport.org/2009/08/31/movement-builds-to-stop-shackling-pregnant-prisoners/>.

<sup>507</sup> Colleen Mastony, *Childbirth in Chains*, CHICAGO TRIBUNE, July 18, 2010.

<sup>508</sup> U.S. DEPT. OF JUSTICE, FED. BUREAU OF PRISONS, PROGRAM STATEMENT: ESCORTED TRIPS (2008). *See also Shackling Pregnant Prisoners*, 12 AELE MO. L. J. 301 (2009). This change in policy may have been in response to the then ongoing Eight Circuit case in which the court ultimately found that the plaintiff "should not have been restrained by shackles while on the verge of giving birth and that she was in no condition to flee while her whole body was engaged in moving her baby to birth." *Nelson v. Corr. Med. Servs.*, 583 F.3d 522 (8th Cir. 2009).

<sup>509</sup> *Id.*

<sup>510</sup> 45 C.F.R. § 46.302 (1978).

<sup>511</sup> 45 C.F.R. § 46.306 (1978).

- 1) Studies on **causes, effects and processes of incarceration and criminal behavior**, provided that the research presents no more than minimal risk and no more than inconvenience to the subjects.
- 2) Studies of **prisons as institutional structures** or of **prisoners as incarcerated persons**, provided that the research presents no more than minimal risk and no more than inconvenience to the subjects.
- 3) Research on **conditions particularly affecting prisoners as a class**, such as hepatitis or substance abuse.
- 4) Research on **practices which have the intent and reasonable probability of improving the health or well-being of the prisoner subjects**.

In addition, federal regulations place restrictions on research methodology:<sup>512</sup>

- 1) **IRB membership requirements.** The Institutional Review Board for the proposed study must include at least one prisoner or prisoner representative, and the majority of the Board must have no association with the prison involved.<sup>513</sup>
- 2) **Risk/benefit perception.** Advantages to prisoners from participating in research must not be of such magnitude as to impair their ability to weigh the risks against the benefits. The risks must be commensurate with risks that would be accepted by research subjects who are not prisoners.
- 3) **Fairness in selection and parole status.** Research subjects must be selected fairly from the prison population, with no arbitrary intervention by prison authorities or prisoners. Researchers must be certain that parole boards will not take into account prisoner participation in research as a basis for parole decisions.
- 4) **Follow-up care.** Adequate provision must be made for any necessary follow-up examinations or care after prisoner participation in research is ended, with attention given to length of prisoner sentences.

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<sup>512</sup> 45 C.F.R. § 46.305 (1978).

<sup>513</sup> 45 C.F.R. § 46.304 (1981).

## **Involuntary Civil Commitment**

### OVERVIEW OF THE LAW

Involuntary civil commitment is the admission of individuals against their will into a psychiatric ward or hospital for the purpose of providing necessary treatment. The legal process for involuntary commitment in Michigan is governed by the Michigan Mental Health Code.

### WHAT IS THE LEGAL STANDARD THAT MUST BE MET TO COMMIT SOMEONE INVOLUNTARILY?

To commit someone involuntarily, you must show that:<sup>514</sup>

- 1) The person is mentally ill AND,
- 2) Unable to care for herself OR is dangerous to herself or others AND,
- 3) Is in need of treatment,
- 4) Which must be provided in-patient.

### HOW LONG CAN A PATIENT BE HELD AGAINST HER WILL WHILE PETITIONING THE COURT FOR COMMITMENT?

UMHS can hold a patient for up to 72 hours while petitioning the Probate Court for commitment. Psychiatry will manage the process with you. Contact the Psych Consult or Psychiatry Emergency Service at <http://www.psych.med.umich.edu/HospitalandCommunity/services.asp> for assistance.

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<sup>514</sup> MICH. COMP. LAWS § 333.1401-03 (1974).

# EMPLOYMENT ISSUES

## Research Issues

- **Research conducted with federal funding or research involving the jurisdiction of the FDA** (new drugs and devices) must be conducted in accordance with the **rules protecting human subjects** (45 C.F.R. § 46 the so-called “Common Rule” since it is common to 16 federal agencies).
  - **Subsection B of the regulations covers fetuses, pregnant women and *in vitro* fertilization.** The subsection seeks to protect fetuses by limiting the research that can occur in pregnant women.
  - U-M follows the provisions of the regulations for all research regardless of funding source. **Research can occur only if it will meet the health needs of the mother and fetus and not put the fetus at risk.** For details see: <http://www.med.umich.edu/irbmed/>
  - Interpretation of the regulations is that women of reproductive potential must use **effective means of contraception when involved in research that could be harmful to a fetus.**
  - The research rules for children are discussed in the [Minors](#) section.
  - Under the **Dickey-Wicker Amendment**, the federal government will **not fund** any research that could **damage or destroy an embryo.** (Section 128 of P.L. 104-99)
  - **Michigan law allows research that could damage or destroy an embryo.** (Article I § 27 of the State Constitution of Michigan)
  - **Michigan law allows use of dried blood spots from newborn screening to be used for IRB-approved research.** (M.C.L.A. 333.5431)
- Pregnant Women**
- Women of Reproductive Age**
- Minors**
- Embryonic Stem Cell Research and Federal Funding**
- Research Using Dried Blood Spots from Newborn Screening**

## Employment Discrimination

### WHAT IS DISCRIMINATION?

Employment discrimination generally covers three different kinds of behavior or practices for which employers can be sued:

- 1) **Disparate Treatment**—Treating someone less favorably because of her race, color, religion, sex, or national origin.<sup>515</sup> Discriminatory motive is an element of these cases.
- 2) **Disparate Impact**—Using a selection criteria, tests, rules, etc. that look neutral on the surface, but have an adverse impact on members of a protected group.<sup>516</sup> The intent to discriminate is not necessary for an employer to be liable in these cases
- 3) **Refusal to Accommodate**—This category applies only to discrimination based on religion in Title VII and disability in the ADA ([See Americans with Disabilities Act](#)). The employer must find some way to accommodate an employee’s religious practices unless it would cause undue hardship to the employer’s business.

### Summary of Employment Discrimination Laws

Covered Category	Law	NOT Covered by Law Sexual Orientation Marriage Equality Gender Identity
<a href="#">Race</a>	<a href="#">Title VII</a>	
<a href="#">Sex</a>	<a href="#">Title VII, PDA, Title IX</a>	
<a href="#">Religion</a>	<a href="#">Title VII</a>	
<a href="#">National Origin</a>	<a href="#">Title VII</a>	
<a href="#">Disability</a>	<a href="#">ADA, PWDCRA</a>	
<a href="#">Pregnancy</a>	<a href="#">PDA, ADA</a>	
<a href="#">Genetics</a>	<a href="#">GINA</a>	
<a href="#">Age</a>	<a href="#">ADEA</a>	
<a href="#">Religion, Race, Color, Nat'l Origin, Age, Height, Weight, Marital/Familial Status</a>	Michigan Elliott-Larsen Civil Rights Act	

### EQUAL OPPORTUNITY VS. EQUAL STATUS

Employment discrimination laws do not mandate that employers produce a workforce that is completely proportionate to the population. Rather, laws are in place to guarantee **equal opportunity** and to ensure the removal of discriminatory barriers.

<sup>515</sup> *Teamsters v. United States*, 431 U.S. 324, 335 (1977).

<sup>516</sup> 42 U.S.C. § 2000e-2(k)(1)(A)(i) (1978).

# Title VII

## Introduction

### OVERVIEW OF THE LAW

Title VII of the Civil Rights Act of 1964<sup>517</sup> prohibits employers from discriminating on the basis of:

- 1) [Race or color](#)
- 2) [Sex](#)
- 3) [Religion](#)
- 4) [National origin](#)

in the process of:<sup>518</sup>

- 1) Hiring
- 2) Firing
- 3) Setting compensation, terms, conditions, and privileges of employment
- 4) Limiting, segregating, or classifying employees or applicants

Some **exceptions** permit distinctions made on a person's religion, sex, or national origin (but NOT race/color). **The most common exception is in cases where a person's religion, sex, or national origin is a "bona fide occupational qualification" that is reasonably necessary for the job.**<sup>519</sup>

The law also **prohibits an employer from retaliating** against employees for filing complaints alleging Title VII violations with the Equal Employment Opportunity Commission (EEOC).<sup>520</sup>

### WHO DOES TITLE VII PROTECT?

Title VII prohibits discrimination against **all job applicants and employees**, including temporary, part-time, and probationary employees.

### WHAT IS DISCRIMINATION?

Employment discrimination generally covers 3 different kinds of behavior or practices for which employers can be sued:

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<sup>517</sup> 42 U.S.C. § 2000e et seq (1978).

<sup>518</sup> 42 U.S.C. § 2000e-2(a) (1978).

<sup>519</sup> 42 U.S.C. § 2000e-2(e) (1978).

<sup>520</sup> 42 U.S.C. § 2000e-3(a) (1978).



## Title VII

- 4) **Disparate Treatment**—Treating someone less favorably because of the person’s race, color, religion, sex, or national origin.<sup>521</sup> Discriminatory motive is an element of these cases.
- 5) **Disparate Impact**—Using a selection criteria, tests, rules, etc. that look neutral on the surface, but have an adverse impact on members of a protected group.<sup>522</sup> The intent to discriminate is not necessary for an employer to be liable in these cases
- 6) **Refusal to Accommodate**—This category only applies to discrimination based on religion in Title VII and disability in the ADA ([See Americans with Disabilities Act](#)). The employer has to find some way to accommodate an employee’s religious practices unless it would cause undue hardship to the employer’s business.

### EQUAL OPPORTUNITY VS. EQUAL STATUS

Employment discrimination laws do not mandate that employers produce a workforce that is completely proportionate to the population. Rather, laws are in place to guarantee **equal opportunity** and ensure the removal of discriminatory barriers.

### Race

#### TWO IMPORTANT MATTERS FOR EMPLOYERS ABOUT TITLE VII AND RACE:

- 1) **There is NO “bona fide occupational qualification” exception for race.** This means that an employer cannot say that being (or not being) a particular race is necessary to qualify for a job.
- 2) **There is positive duty on an employer to maintain a work environment that is free from racial harassment.** This means that an employer has to actively investigate and put an end to the use of racial slurs and stereotypes, insulting remarks or ethnic jokes, adverse treatment of the basis of race, etc. in the workplace.<sup>523</sup>

#### WHAT IF THE EMPLOYER HAS RULES ABOUT DRESS AND APPEARANCE THAT HAVE RACIAL IMPLICATIONS?

An employer’s rules of conduct might disallow certain hairstyles, facial hair, manner of dress, etc. Requirements that employees **look professional, wear uniforms, or adhere to other conditions of employment that have a business necessity** are generally permissible.

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<sup>521</sup> *Teamsters v. United States*, 431 U.S. 324, 335 n.15 (1977) .

<sup>522</sup> 42 U.S.C. § 2000e-2(k)(1)(A)(i) (1978).

<sup>523</sup> EEOC Dec. No. 72-1561, 4 Fair. Empl. Prac. Case (BNA) 852 (1972) .

## Title VII

However, in some cases, hairstyles (such as the Afro) have been found to be “**an appropriate expression of heritage, culture, and racial pride**”—making an employer’s ban on Afros a potential violation of Title VII.<sup>524</sup>

Rules prohibiting beards may or may not be found to be discriminatory. **In most cases, a no-beard policy that is equally applied to all races will be permissible.** However, no-beard policies have been **struck down** in the following limited circumstances:

- 1) **Disparate Impact**—*Example*: African-American men are more susceptible than men of other races to a skin disorder that prevents them from shaving.<sup>525</sup>
- 2) **Safety Reasons**—*Example*: Firefighters cannot have beards facial hair can interfere with the effectiveness of the seal on a respirator.<sup>526</sup>
- 3) **Business Necessity**—*Example*: Grocery store employees cannot have beards because customers need to be impressed with the stores cleanliness.<sup>527</sup>

### ARE WHITE PEOPLE PROTECTED BY TITLE VII?

**Yes, members of all races (including white) are covered by Title VII.** White people can assert rights to Title VII protection from reverse racial discrimination.<sup>528</sup>

## Sex

### WHEN DOES UNLAWFUL SEX DISCRIMINATION OCCUR?

Sex discrimination occurs when:

- 1) An employer takes an **employment action** against a person on the **basis of his or her gender.**
- 2) An employer **treats a member of one sex with a certain characteristic or circumstance differently** than members of the other sex who have that same characteristic or circumstance. (*Example*: Married female employees are treated differently than married male employees.)
- 3) An employer **treats men and women differently on the basis of a trait** that is either only or mostly **associated with one sex.** (*Example*: A woman is fired for being pregnant).

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<sup>524</sup> EEOC Dec. No. 72-0979, 4 Fair. Empl. Prac. Case (BNA) 840 (1972).

<sup>525</sup> *EEOC v. Trailways, Inc.*, 530 F. Supp. 54 (D. Colo. 1981).

<sup>526</sup> *Fitzpatrick v. City of Atlanta*, 2 F.3d 1112 (11<sup>th</sup> Cir. 1993) .

<sup>527</sup> *Woods v. Safeway Stores*, 420 F. Supp. 35 (E.D. Va. 1976) , *aff'd*, 579 F.2d 43 (4<sup>th</sup> Cir. 1978).

<sup>528</sup> *McDonald v. Santa Fe Trail Transportation Co.*, 513 F.2d 90 (5<sup>th</sup> Cir. 1976).

## Title VII

- 4) An employer has a **rule, policy, or requirement** that seems to be neutral on the surface, but ends up having a **disproportionate effect on one sex** AND there is **no valid business justification**.
- 5) An employer places **appearance or grooming standards** on its employees, **which affect one sex more than the other**.
- 6) An employer:<sup>529</sup>
  - a) Who **sexually harasses** employees of one gender more than the other OR,
  - b) Whose workplace is a hostile work environment for members of one sex due to unwelcome **sexual harassment**.
- 7) An employer discriminates **on the basis of pregnancy, childbirth, or related medical conditions**. ([See Pregnancy Discrimination Act](#))

\*Disability related to pregnancy must be treated like any other temporary disability. ([See Americans with Disabilities Act](#))

### WHEN CAN EMPLOYERS TREAT MEN AND WOMEN DIFFERENTLY?

Employers can treat male and female employees differently if the gender of the employee is a **bona fide occupational qualification** that is **reasonably necessary to the normal operations of the business**.

*Example:* It is permissible for an employer to ask that only women apply to jobs as wet nurses, attendants in female restrooms, etc. Asking that only men apply to jobs that require heavy lifting is NOT permissible because a woman may be capable of lifting the weight and should have an equal opportunity to be considered for the position.

### WHAT IS A BONA FIDE OCCUPATIONAL QUALIFICATION?

Title VII contains a very narrow bona fide occupational qualification (or BFOQ) exception.<sup>530</sup> **Employers can differentiate between employees WHILE HIRING AND EMPLOYING on the basis of religion, sex, or national origin (BUT NOT RACE)** in those certain circumstances where religion, sex, or national origin is a **job qualification that is reasonably necessary to the normal operation of that business**.<sup>531</sup>

\*\*Note that this exception is just for hiring and employing members of Title VII protected classes and NOT for firing, depriving of employment opportunities, setting the terms and conditions of employment, etc.

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<sup>529</sup> *Meritor Sav. Bank, FSB v. Vinson*, 477 U.S. 57 (1986); 29 C.F.R. § 1604.11 (1979).

<sup>530</sup> *Dothard v. Rawlinson*, 433 U.S. 321 (1977) .

<sup>531</sup> 42 U.S.C. § 2000e-2(e) (1978).

## Title VII

### WHEN IS SEX A BONA FIDE OCCUPATIONAL QUALIFICATION (BFOQ)?

Sex is a BFOQ in the following instances:

- 1) Physical sex features are required for the job (Ex. Wet nurse)
- 2) Sex authenticity is required (Ex. Model, actress, etc.<sup>532</sup>)
- 3) Conventional decency or privacy should be maintained (Ex. Restroom attendant,<sup>533</sup> hospital orderly/nurse in the labor and delivery area<sup>534</sup>)
- 4) The job increases vulnerability to sexual assault (Ex. Prison guard<sup>535</sup>)

### CAN AN EMPLOYER, IN ORDER TO PROTECT A FETUS, REFUSE TO HIRE WOMEN FOR POSITIONS THAT EXPOSE THEM TO TOXIC SUBSTANCES OR RADIATION?

**No, the employer cannot refuse to hire women for this reason because gender-based fetal protection policies violate Title VII sex discrimination provisions.**

Because exposure to some substances involve a risk a reproductive harm, some employers made a policy decision to not hire women for jobs that require employees to work near such substances.<sup>536</sup> However, some hiring practices designed to maintain occupational health and safety did not square with equal employment opportunity.

In the 1991 “*Johnson Controls*” decision<sup>537</sup>, the Supreme Court struck down a company policy that denied jobs involving lead exposure to fertile female applicants. After the “*Johnson Controls*” decision, the EEOC issued an official statement on fetal protection policies. **The EEOC stated that employer policies that exclude members of one sex from a workplace in order to protect fetuses cannot be justified under Title VII.**<sup>538</sup>

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<sup>532</sup> *Rosenfeld v. Southern Pac. Co.*, 444 F.2d 1224 (9<sup>th</sup> Cir. 1971).

<sup>533</sup> *EEOC v. Spokane Concrete Prods.*, 534 F. Supp. 518 (E.D. Wash. 1982).

<sup>534</sup> *EEOC v. Mercy Health Ctr.*, 1982 U.S. Dist. LEXIS 12256 (W.D. Okla. 1982). A male applicant for the position of staff nurse in the labor and delivery department was not hired because of his sex. The court found that the patients’ preference for female nurses involved personal privacy interests that can be protected by the employer. *See also Fesel v. Masonic Home of Delaware, Inc.* 447 F. Supp. 1346 (D. Del. 1978) , *aff’d*, 591 F.2d 1334 (3<sup>rd</sup> Cir. 1979).

<sup>535</sup> *Dothard v. Rawlinson*, 433 U.S. 321 (1977) . The main case that resulted in the opposite outcome from *Dothard* is *Gunther v. Iowa State Men's Reformatory* 612 F.2d 1079 (8<sup>th</sup> Cir. 1980) , overruled on other grounds by *Kremer v. Chem. Constr. Corp.*, 456 U.S. 461 (1982).

<sup>536</sup> Introduction to Proposed Guidelines on Employment Discrimination and Reproductive Hazards, 45 Fed. Reg. 7514 (1980).

<sup>537</sup> *Int'l Union, UAW v. Johnson Controls, Inc.*, 499 U.S. 187 (1991).

<sup>538</sup> EEOC Policy Guide on *United Auto Workers v. Johnson Controls* (June 28, 1991), reprinted in FEP Manual (BNA) 405: 6941.

## Title VII

### CAN AN EMPLOYER SAY THAT A WOMAN MUST NOT BE PREGNANT TO QUALIFY FOR A JOB?

No, in almost all cases, an employer cannot claim that a woman's non-pregnancy is a bona fide occupational qualification. ([See Pregnancy Discrimination Act](#))

In the past, airlines hiring flight attendants,<sup>539</sup> industries hiring for positions that involve risks to fetuses,<sup>540</sup> and schools or youth groups hiring teachers and counselors<sup>541</sup> have all attempted to establish non-pregnancy as a BFOQ. **Some jurisdictions have permitted it, but on the whole, Title VII has not been found to support the argument that non-pregnancy is a BFOQ.**

\*Disability related to pregnancy has to be treated like any other temporary disability. ([See Americans with Disabilities Act](#))

## Religion

### WHAT DOES "RELIGION" INCLUDE UNDER TITLE VII?

Religion includes all aspects of **religious observance, practice, and belief** UNLESS an employer shows that the employer cannot reasonably accommodate the observance, practice, or belief without causing undue hardship to the employer's business.<sup>542</sup>

\*\*The religious belief must be **sincere** to get Title VII protection.<sup>543</sup>

\*\***Political beliefs and personal preferences do not count as religion.**<sup>544</sup>

### DOES ATHEISM COUNT AS A RELIGION?

Technically, atheism is not considered to be a religion by the EEOC Guidelines because religion contains theistic concepts. However, **atheists can still get protection under Title VII** because applicants and employees cannot be discriminated against on the basis of religious belief—including the lack of religious belief.<sup>545</sup>

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<sup>539</sup> *Burwell v. Eastern Air Lines*, 633 F.2d 361 (4th Cir. 1980). *Harriss v. Pan Am. World Airways*, 649 F.2d 670 (9th Cir. 1980) (policy upheld); *In re Pan Am. World Airways*, 905 F.2d 1457 (11th Cir. 1990) (policy struck down).

<sup>540</sup> *Int'l Union, UAW v. Johnson Controls, Inc.*, 499 U.S. 187 (1991) (policy struck down).

<sup>541</sup> *Chambers v. Omaha Girls Club, Inc.*, 834 F.2d 697 (1987).

<sup>542</sup> 42 U.S.C. § 2000e(j) (1988). *See generally* 29 C.F.R. § 1605 (1992).

<sup>543</sup> *Hansard v. Johns-Manville Products Corp.*, 1973 U.S. Dist. LEXIS 14889 (E.D. Tex. 1973).

<sup>544</sup> *Bellamy v. Mason's Stores, Inc.*, 368 F. Supp. 1025 (E.D. Va. 1973), *aff'd*, 508 F.2d 504 (4th Cir. 1974).

<sup>545</sup> *Young v. Southwestern Savings & Loan Ass'n*, 509 F.2d 140 (5th Cir. 1975).

## Title VII

### WHEN DOES UNLAWFUL RELIGIOUS DISCRIMINATION OCCUR?

Religious discrimination occurs when:

- 1) An employer takes an **adverse employment action** against an applicant or employee **on the basis of the religious beliefs or practices** of the applicant or employee.<sup>546</sup>
- 2) An employer's work environment contains **religious harassment** that rises to a certain degree of offensiveness.<sup>547</sup>
- 3) An employer **fails to make a reasonable accommodation** for an employee's religious observance, practices, or beliefs AND the accommodation would not cause undue hardship to the employer's business.

### WHAT MUST UMHS DO?

- 1) **UMHS must not discriminate on the basis of religion** when hiring, firing, setting the terms and conditions of employment, etc.
- 2) **UMHS must make efforts** to satisfy the employee's request for **religious accommodation**.

### WHAT MUST THE EMPLOYEE DO?

Once the hospital makes sufficient effort to accommodate the employee, the employee then has to try to meet his religious needs through the options offered by the employer.<sup>548</sup>

### WHEN NEED AN EMPLOYER NOT MAKE AN ACCOMMODATION FOR AN EMPLOYEE'S RELIGION?

- 1) When an accommodation would cause **undue hardship to the employer's business**.<sup>549</sup>  
Reasonable accommodations might include flexible scheduling, voluntary shift exchanges, etc. Anything that would disrupt work, involve excessive cost, conflict with a collective bargaining agreement, etc. would result in an undue hardship.
- 2) When religion is a **bona fide occupational qualification (BFOQ)** for the position.<sup>550</sup>
- 3) When the employer is a **religious corporation, association, or educational institution**.<sup>551</sup>

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<sup>546</sup> *Shapolia v. Los Alamos Nat'l Lab.*, 992 F.2d 1033 (10<sup>th</sup> Cir. 1993).

<sup>547</sup> *See Abramson v. William Paterson Coll.*, 260 F.3d 265 (3<sup>rd</sup> Cir. 2001) , *Powell v. Yellow Book USA, Inc.*, 445 F.3d 1074 (8<sup>th</sup> Cir. 2006).

<sup>548</sup> *Brener v. Diagnostic Ctr. Hosp.*, 671 F.2d 141 (5<sup>th</sup> Cir. 1982).

<sup>549</sup> 42 U.S.C. § 2000e(j) (1988). *See generally* 29 C.F.R. Part 1605 (1992).

<sup>550</sup> 42 U.S.C. § 2000e-2(e)(1) (1978).

## Title VII

- 4) The hospital does not have to provide a solution that is on the employee's terms only. Once the hospital makes **sufficient efforts** to accommodate the employee, the employee then has to try to meet his religious needs through the options offered by the employer.<sup>552</sup>  
**The hospital will not face liability under Title VII if it has made a good faith attempt to provide reasonable accommodation.**

### WHAT IS A BONA FIDE OCCUPATIONAL QUALIFICATION?

Title VII contains a very narrow bona fide occupational qualification (or BFOQ) exception.<sup>553</sup> Employers can differentiate between employees WHILE HIRING AND EMPLOYING on the basis of **religion, sex, or national origin (BUT NOT RACE)** in those certain circumstances where **religion, sex, or national origin is a job qualification that is reasonably necessary to the normal operation of that business.**<sup>554</sup>

This **exception is only for hiring and employing** members of Title VII protected classes and NOT for firing, depriving of employment opportunities, setting the terms and conditions of employment, etc.

### WHAT IF A HEALTH PROFESSIONAL HAS A RELIGIOUS BELIEF REGARDING ABORTION?

Michigan has a **conscience clause law** that protects health professionals with moral/religious objections to abortions from discrimination. ([See Conscience Laws](#)) Title VII cases regarding abortion-related religious beliefs must be examined on their own individual facts. The employer must have made a good faith effort to accommodate the sincere religious beliefs of the employee unless undue hardship results from attempts to accommodate.<sup>555</sup>

## National Origin

### WHAT IS "NATIONAL ORIGIN"?

National origin is the place from which a person or his or her forebears comes.

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<sup>551</sup> 42 U.S.C. § 2000e-1(a) (1978). Note that religious institutions cannot discriminate on the basis of race, sex, or national origin.

<sup>552</sup> *Brener v. Diagnostic Ctr. Hosp.*, 671 F.2d 141 (5<sup>th</sup> Cir. 1982).

<sup>553</sup> *Dothard v. Rawlinson*, 433 U.S. 321 (1977).

<sup>554</sup> 42 U.S.C. § 2000e-2(e) (1978).

<sup>555</sup> *Kenny v. Ambulatory Ctr. of Miami, Florida, Inc.* 400 So. 2d 1267 (Fla. Dist. Ct. App. 1981).

## Title VII

### DOES TITLE VII PROTECT REGIONALISM WITHIN THE UNITED STATES?

No, national origin does not protect people who are discriminated against for being from a part of the country. *Example:* A person who is not hired because he has a Southern accent will not be protected under Title VII because “Southernness” is not a protected trait.<sup>556</sup>

### DOES TITLE VII PROTECT ONLY MINORITY NATIONALITIES?

No, Title VII protects all nationalities from employment discrimination, even members of majority nationalities.<sup>557</sup>

### WHAT MUST UMHS DO?

- 1) **UMHS must not discriminate on the basis of national origin** when hiring, firing, setting the terms and conditions of employment, etc.
- 2) **UMHS must maintain a work environment that is free from national origin harassment.** This means that an employer has to actively investigate and put an end to the use of national origin slurs and stereotypes, insulting remarks or ethnic jokes, adverse treatment of the basis of national origin, etc. in the workplace.<sup>558</sup>

### WHEN DOES UNLAWFUL NATIONAL ORIGIN DISCRIMINATION OCCUR?

National origin discrimination occurs when:

- 1) An employer takes an adverse employment action against an applicant or employee on the basis of the national origin of the applicant or employee.<sup>559</sup>
- 2) An employer’s work environment contains religious harassment that rises to a certain degree of offensiveness.<sup>560</sup>
- 3) An employer uses selection criteria that appear neutral but result in a negative impact on people of a certain national origin. (Ex. Height and weight requirements, testing procedures, linguistic and fluency requirements, etc.)<sup>561</sup>

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<sup>556</sup> *Williams v. Frank*, 757 F. Supp. 112 (D. Mass. 1991), *aff’d without op.*, 959 F.2d 230 (1<sup>st</sup> Cir. 1992).

<sup>557</sup> *EEOC v. Consol. Servs. Sys.*, 777 F. Supp. 599 (N.D. Ill. 1991), *aff’d*, 989 F.2d 233 (7<sup>th</sup> Cir. 1993).

<sup>558</sup> 42 U.S.C. § 2000e-2(a)(1) (1978), 29 C.F.R. § 1606.8(a) (1999).

<sup>559</sup> 42 U.S.C. § 2000e-2(a)(1) (1978).

<sup>560</sup> 29 C.F.R. § 1606.8(a) (1999).

<sup>561</sup> 29 C.F.R. § 1606.2 (1999).



## Title VII

### WHEN CAN AN EMPLOYER DISCRIMINATE ON THE BASIS OF NATIONAL ORIGIN?

Unlike Title VII sex discrimination cases, which often bring up the bona fide occupational qualification exception, there are very few national origin cases that invoke the BFOQ argument. While national origin can technically be a BFOQ, the Supreme Court has indicated that it is an extremely narrow exception in such cases.<sup>562</sup>

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<sup>562</sup> *Dothard v. Rawlinson*, 433 U.S. 321, 323 (1977).

## **State Civil Rights Law: Michigan's Elliott-Larsen Act**

### INTRODUCTION

Michigan's Elliott-Larsen Civil Rights Act (ELCRA), enacted in 1976, acts in complement to the federal civil rights protections outlined above. It provides for protections against discrimination in employment, public accommodations and educational institutions. ELCRA may be preempted if a lawsuit interprets provisions covered by a federal law, such as collective bargaining agreements.<sup>563</sup> However, ELCRA protections are broader in some ways than federal protections.

### WHAT ADDITIONAL PROTECTIONS DOES THE ELLIOTT-LARSEN ACT PROVIDE?

In addition to protections against discrimination on the basis of race, color, national origin, age, and sex, ELCRA provides protections against discrimination on the basis of **height, weight, familial status, and marital status**.<sup>564</sup> The category of "sex" includes pregnancy, childbirth, or a medical condition related to pregnancy, but does not include nontherapeutic abortion not intended to save the life of the mother.<sup>565</sup> It also includes sexual harassment; indeed, most sexual harassment cases in Michigan are brought under ELCRA.<sup>566</sup>

### WHAT STATE EMPLOYMENT LAW PROTECTION EXISTS BEYOND ELCRA?

A recent Michigan federal district court decision struck down the 2011 law<sup>567</sup> that prohibited local units of government from furnishing health care and other fringe benefits to the domestic partners of their employees. The Act effectively denied **benefits to same-sex partners of public employees**, due to Michigan's prohibition on same-sex marriage. [See Parentage Determinations](#). The Act imposed similar prohibitions against opposite-sex unmarried partners of public employees. The 2014 decision struck down the 2011 Act, permitting the reinstatement of such benefits.<sup>568</sup> The state failed to appeal the decision; therefore, no further action is expected.

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<sup>563</sup> *Donajkowski v. Alpena Power Co.*, 596 N.W.2d 574 (Mich. App. 1996).

<sup>564</sup> Elliott-Larsen Civil Rights Act, 1976 Mich. Pub. Acts 453, § 37.2102(1).

<sup>565</sup> *Id.* at § 37.2201(d).

<sup>566</sup> Leonard Niehoff & Andrea Roumell Dickson, *Title VII and the "Hostile Work Environment,"* 73 MICH. BAR J. 76, 77 (1994).

<sup>567</sup> Public Employee Domestic Partner Benefit Restriction Act, Pub. Act 197 of 2011.

<sup>568</sup> *Bassett v. Snyder*, No. 12-10038 (E.D. Mich. Nov. 12 2014).

## **Americans with Disabilities Act (ADA)**

### OVERVIEW OF THE LAW

The Americans with Disabilities Act (ADA) is a civil rights law that prohibits employers, state and local governments, and places of public accommodation from discriminating against qualified individuals with disabilities.<sup>569</sup> **UMHS, as both an employer<sup>570</sup> and a place of public accommodation,<sup>571</sup> cannot discriminate against people with disabilities.**

Discrimination on the basis of disability is also prohibited under Michigan state law ([See Persons with Disabilities Civil Rights Act](#)).

### WHAT IS REQUIRED OF UMHS AS A PLACE OF PUBLIC ACCOMMODATION UNDER THE ADA?

UMHS must allow disabled individuals to have **full and equal enjoyment** of the goods, services, facilities, privileges, advantages, or accommodations of the hospital system.<sup>572</sup>

### WHAT IS REQUIRED OF UMHS AS AN EMPLOYER UNDER THE ADA?

Employers covered by the ADA **must not discriminate against a qualified individual with a disability** in the terms and conditions of employment.

Discrimination can include traditional forms of adverse action (such as refusal to hire disabled job-seekers) or more subtle omissions (such as failure to make a reasonable accommodation).

The employer must determine:

- 1) Whether the individual is **disabled**
- 2) Whether the individual is **qualified** for the job
- 3) Whether the individual can perform the **essential functions** of the job
- 4) Whether the individual could perform the essential functions with **reasonable accommodation**

### WHAT IS PROHIBITED DISCRIMINATION UNDER THE ADA?

An employer cannot discriminate on the basis of disability against a qualified individual with a disability in regard to any term, condition, or privilege of employment, including:<sup>573</sup>

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<sup>569</sup> 42 U.S.C. § 12101 et seq. (1990).

<sup>570</sup> 42 U.S.C. § 12111 (1990).

<sup>571</sup> 42 U.S.C. § 12181 (1990).

<sup>572</sup> 42 U.S.C. § 12181 (1990).

<sup>573</sup>

## Americans with Disabilities Act (ADA)

- 1) Job application process, recruitment, advertising
- 2) Hiring and rehiring
- 3) Upgrading, promotion, award of tenure
- 4) Demotion, transfer, layoff, termination
- 5) Compensation, changes in compensation
- 6) Job assignments and classifications, organizational structure, position descriptions, seniority.
- 7) Leaves of absence, sick leave, or other leave
- 8) Fringe benefits that are part of the employment relationship
- 9) Social and recreational activities sponsored by an employer
- 10) Selection and financial support for training (apprenticeships, professional meetings, conferences, and other related activities).

### **The following types of actions are considered to be discriminatory:**<sup>574</sup>

- 1) Limiting, segregating, or classifying a job applicant or employee with a disability in a manner that adversely affects his opportunities or status
- 2) Participating in a contractual or other agreement that results in discrimination
- 3) Utilizing qualification standards, criteria, or other methods of administration that:
  - a. are not job-related
  - b. are not consistent with business necessity
  - c. and have the effect of discriminating or perpetuating discrimination
- 4) Failure to make a reasonable accommodation, unless the accommodation would impose an undue hardship
- 5) Retaliating, coercing, or interfering with an individual's lawful actions or exercise of rights under the ADA
- 6) Engaging in prohibited medical examinations or inquiries

### WHO IS A "QUALIFIED INDIVIDUAL WITH A DISABILITY?"

A "qualified individual with a disability" is a disabled individual who:<sup>575</sup>

- 1) Satisfies the requisite **skill, experience, education, and other job-related requirements** of the employment position
- 2) AND who, with or without **reasonable accommodation**,
- 3) Can perform the **essential functions** of the position.

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<sup>574</sup> 42 U.S.C. § 12112 (1990).

<sup>575</sup> 29 C.F.R. § 1630.2 (1991).

## Americans with Disabilities Act (ADA)

### WHAT IS A DISABILITY?

The ADA defines “disability” as:

- 1) A physical or mental **impairment** that **substantially limits** one or more of the person’s **major life activities**; AND
- 2) EITHER **record** of such an impairment OR being **regarded** as having such an impairment.

### WHAT COUNTS AS A PHYSICAL OR MENTAL IMPAIRMENT?

The ADA does not have a specific list of conditions that are considered to be physical or mental impairments. The Act’s definition of disability is intentionally broad and allows for a case-by-case analysis.

However, the U.S. Equal Employment Opportunity Commission (EEOC) has provided some guidance:<sup>576</sup>

- 1) A **physical impairment** is any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of these body systems:
  - a) Neurological
  - b) Musculoskeletal
  - c) Special sense organs
  - d) Respiratory, including speech organs
  - e) Cardiovascular
  - f) Reproduction
  - g) Digestive
  - h) Genito-urinary
  - i) Hemic and lymphatic
  - j) Skin
  - k) Endocrine
- 2) A **mental impairment** is any mental or psychological disorder, including:
  - a) Mental retardation
  - b) Organic brain syndromes
  - c) Emotional or mental illness
  - d) Specific learning disabilities

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<sup>576</sup> 29 C.F.R. § 1630.2 (1991).

WHAT CHARACTERISTICS DO NOT COUNT AS IMPAIRMENTS?<sup>577</sup>

- 1) Eye color/hair color
- 2) Left-handedness
- 3) Weight/Muscular tone (but obesity due to glandular conditions might be a disability)
- 4) Common personality traits (stress, irritability, poor judgment, etc.)
- 5) Simple myopia, corrected vision, or crossed eyes
- 6) Sensitivity to tobacco smoke
- 7) Tendinitis/Bursitis (temporary and minor conditions do NOT count as disabilities)
- 8) Environmental, cultural, or economic disadvantages
- 9) Menopause
- 10) Advanced age (although medical conditions that are frequently associated with old age might be considered disabilities)
- 11) Pregnancy (although medical complications arising from a pregnancy or a physical impairment aggravated by a pregnancy might be considered disabilities)
- 12) Sexual orientation and sexual behavior
- 13) Psychological disorders that can lead to illegal conduct (kleptomania, pyromania, compulsive gambling)
- 14) Psychoactive substance use disorder resulting from illegal use of drugs

WHAT ARE “MAJOR LIFE ACTIVITIES?”

To be considered a disability, an impairment must **substantially limit a major life activity**, which may include the **operation of a major bodily function**. The U.S. Supreme Court has determined that **loss of reproductive ability is a “major life activity.”**<sup>578</sup> In the ADA Amendments Act of 2008 (ADAAA), Congress provided a list of major life activities that include, but are not limited to, the following activities:<sup>579</sup>

- |                            |                   |
|----------------------------|-------------------|
| 1) Caring for oneself      | 11) Bending       |
| 2) Speaking                | 12) Lifting       |
| 3) Performing manual tasks | 12) Breathing     |
| 4) Seeing                  | 13) Learning      |
| 5) Hearing                 | 14) Reading       |
| 6) Eating                  | 15) Concentrating |
| 7) Sleeping                | 16) Thinking      |
| 8) Walking                 | 17) Communicating |
| 9) Standing                | 18) Working       |

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<sup>577</sup> 5-137 Labor and Employment Law § 137.02, Matthew Bender & Company, Inc. (2010).

<sup>578</sup> See *Bragdon v. Abbott*, 524 U.S. 624 (1998).

<sup>579</sup> ADAAA § 4, 42 U.S.C. § 12102 (1990).

## WHAT DOES “SUBSTANTIALLY LIMIT” MEAN?

A person is substantially limited when **unable to perform or significantly restricted** as to the condition, manner, or duration under which he can perform a major life activity, **as compared to an average person in the general population.**<sup>580</sup>

## SHOULD MITIGATING MEASURES AFFECT THE DETERMINATION OF WHETHER OR NOT AN INDIVIDUAL HAS A DISABILITY?

Some people who have impairments can reduce how much the impairments affect their ability to engage in life activities. **Mitigating measures** include medication, hearing aids, prosthetics, mobility devices, assistive technology (not including contacts/eyeglasses), etc.<sup>581</sup>

After the Supreme Court issued a string of decisions in 1999 requiring mitigating measures to be taken into account,<sup>582</sup> Congress rejected those holdings in the ADAAA of 2008 and explicitly stated that “[t]he determination of whether an impairment substantially limits a major life activity shall be made **WITHOUT regard to the ameliorative effects of mitigating measures.**” (emphasis added).<sup>583</sup>

## WHAT CONSTITUTES REASONABLE ACCOMMODATION?

The EEOC has stated that an accommodation consists of any change in the work environment or the manner in which a job is usually performed that enables an individual with a disability to enjoy equal employment opportunities.<sup>584</sup>

A reasonable accommodation is any modification or adjustment to:

- 1) The **job application** process
- 2) The **work environment** or manner in which a job is performed
- 3) The availability of **equal benefits and privileges** of employment

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<sup>580</sup> ADAAA § 2.

<sup>581</sup> See EEOC Enforcement Guidance on the Americans with Disabilities Act and Psychiatric Disabilities, No. 915.002 (March 25, 1997) at 2-3.

<sup>582</sup> See *Sutton v. United Air Lines, Inc.*, 527 U.S. 471 (1999); *Murphy v. United Parcel Service, Inc.*, 527 U.S. 516 (1999); *Albertson's, Inc. v. Kirkingburg*, 527 U.S. 555 (1999).

<sup>583</sup> ADAAA § 2.

<sup>584</sup> 29 C.F.R. § 1630.2 (1991).

## Americans with Disabilities Act (ADA)

### WHAT ACCOMMODATIONS ARE FREQUENTLY PROVIDED BY EMPLOYERS?<sup>585</sup>

- 1) Job restructuring
- 2) Part-time or modified work schedules
- 3) Reassignment
- 4) Using new equipment or devices
- 5) Modifying equipment or devices
- 6) Adjustments to examinations, training, policies, etc.
- 7) Providing qualified readers or interpreters
- 8) Altering existing facilities
- 9) Permitting use of accrued paid leave for medical treatment of the disability
- 10) Providing additional unpaid leave for medical treatment
- 11) Making employer-provided transportation accessible
- 12) Providing personal assistants
- 13) Providing reserved parking spaces

### WHEN NEED AN EMPLOYER NOT MAKE A REQUESTED OR NECESSARY ACCOMMODATION FOR A DISABLED INDIVIDUAL?

The employer need NOT make an accommodation if that accommodation would impose an **undue hardship on the operation of the business.**<sup>586</sup>

### WHAT IS AN “UNDUE HARDSHIP?”

Under the ADA, an undue hardship is **an action that requires significant difficulty or expense.** Congress has indicated that an undue hardship would include an action that is “unduly costly, extensive, substantial, disruptive, or that will fundamentally alter the nature” of the job.<sup>587</sup> There are no fixed threshold amounts or dollar caps guiding an employer as to what level of expenditures constitutes an undue hardship.

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<sup>585</sup> The EEOC guidelines are not intended to include an exhaustive list and similar accommodations may be required under some circumstances.

<sup>586</sup> 42 U.S.C. § 12112 (1990).

<sup>587</sup> S. REP. NO. 101-116, at 35 (1989), *available in* WESTLAW, ADA-LH database (Senate Committee on Labor and Human Resources).



## **State Disability Law: Michigan's Persons with Disabilities Civil Rights Act (PWDCRA)**

### OVERVIEW OF THE LAW

The Persons with Disabilities Civil Rights Act (PWDCRA) was enacted by the state of Michigan and is a counterpart of the federal Americans with Disabilities Act (ADA). ([See Americans with Disabilities Act](#)) **The PWDCRA prohibits discrimination against individuals with disabilities in Michigan.**

### WHAT DOES THE LAW REQUIRE OF UMHS?

As in the ADA, UMHS is considered both an employer and a place of public accommodation under the PWDCRA. **Accordingly, compliance under the PWDCRA is substantially similar to that under the ADA.** ([See Americans with Disabilities Act](#))

The PWDCRA provides that:<sup>588</sup>

- 1) The opportunity to obtain employment and the full and equal utilization of public accommodations and public services without discrimination because of a disability is guaranteed by this act and is a civil right.
- 2) A person shall accommodate a person with a disability for purposes of employment, public accommodation, or a public service unless the person demonstrates that the accommodation would impose an undue hardship (except as otherwise provided in MICH. COMP. LAWS §§ 37.1201-1214).

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<sup>588</sup> MICH. COMP. LAWS § 37.1102 (1998).

## Laws Protecting Pregnant Employees

WHAT PROTECTIONS DO PREGNANT EMPLOYEES RECEIVE UNDER THE LAW?

- 1) Protection from **discrimination/adverse employment actions** on the basis of pregnancy, childbirth, and related medical conditions ([See Pregnancy Discrimination Act](#) and [Title VII](#))
- 2) Protection of **pregnancy-related leave** ([See Family and Medical Leave Act](#) and [Americans with Disabilities Act](#))

IS PREGNANCY CONSIDERED A DISABILITY UNDER THE AMERICANS WITH DISABILITIES ACT (ADA)?

A normal pregnancy is NOT covered under the ADA, but if a pregnant employee is:

- 1) experiencing **substantial medical complications** with the pregnancy that
- 2) **limit a major life activity**

a pregnant employee may be covered under the ADA and should receive **reasonable accommodation** from her employer. ([See Americans with Disabilities Act](#))

WHAT IS FMLA LEAVE?

An eligible employee can take UNPAID leave from work for **12 weeks during any 12 month period** for one or more of the following reasons ([See Family and Medical Leave Act](#))

- 1) **The birth of a child and to care for this child,**
- 2) **The placement of a child** with the employee through adoption or foster care,
- 3) To care for the spouse, child, or parent of the employee ONLY IF that person has a serious health condition, OR
- 4) For a **serious health condition** that makes the employee unable to do his job.

When an employee returns from FMLA leave, she is **entitled to be reinstated** to the same position OR an equivalent position with the same benefits, pay, and other terms and conditions of employment **UNLESS she is a “highly compensated employee” and reinstatement would cause substantial economic injury to the employer.**

CAN AN EMPLOYER, IN ORDER TO PROTECT A FETUS, REFUSE TO HIRE WOMEN FOR POSITIONS THAT EXPOSE THEM TO TOXIC SUBSTANCES OR RADIATION?

**No, the employer cannot refuse to hire women for this reason because gender-based fetal protection policies violate Title VII sex discrimination provisions. ([See Title VII](#))**

Because exposure to some substances involve a risk a reproductive harm, some employers made a policy decision to not hire women for jobs that require employees to work near such substances.<sup>589</sup> However, some hiring practices designed to maintain occupational health and safety did not square with equal employment opportunity.

In the 1991 “*Johnson Controls*” decision<sup>590</sup>, the Supreme Court struck down a company policy that denied jobs involving lead exposure to fertile female applicants. After the “*Johnson Controls*” decision, the EEOC issued an official statement on fetal protection policies. **The EEOC stated that employer policies that exclude members of one sex from a workplace in order to protect fetuses cannot be justified under Title VII.**<sup>591</sup> ([See Title VII](#))

CAN AN EMPLOYER SAY THAT A WOMAN MUST NOT BE PREGNANT TO QUALIFY FOR A JOB?

No, in almost all cases, an employer cannot claim that a woman’s non-pregnancy is a bona fide occupational qualification. ([See Pregnancy Discrimination Act](#))

In the past, airlines hiring flight attendants,<sup>592</sup> industries hiring for positions that involve risks to fetuses,<sup>593</sup> and schools or youth groups hiring teachers and counselors<sup>594</sup> have all attempted to establish non-pregnancy as a BFOQ. **Some jurisdictions have permitted it, but on the whole, Title VII has not been found to support the argument that non-pregnancy is a BFOQ.**

\*Change in status related to pregnancy has to be treated like any other temporary disability. ([See Americans with Disabilities Act](#))

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<sup>589</sup> Introduction to Proposed Guidelines on Employment Discrimination and Reproductive Hazards, 45 Fed. Reg. 7,514.

<sup>590</sup> *International Union, UAW v. Johnson Controls, Inc.*, 499 U.S. 187 (1991).

<sup>591</sup> EEOC Policy Guide on *United Auto Workers v. Johnson Controls* (June 28, 1991), reprinted in FEP Manual (BNA) 405: 6941.

<sup>592</sup> *Burwell v. Eastern Air Lines*, 633 F.2d 361 (4th Cir. 1980). *Harriss v. Pan Am. World Airways*, 649 F.2d 670 (9th Cir. 1980) (policy upheld); *In re Pan Am. World Airways*, 905 F.2d 1457 (11<sup>th</sup> Cir. 1990) (policy struck down).

<sup>593</sup> *Int'l Union, UAW v. Johnson Controls, Inc.*, 499 U.S. 187 (1991) (policy struck down).

<sup>594</sup> *Chambers v. Omaha Girls Club, Inc.*, 834 F.2d 697 (8<sup>th</sup> Cir. 1987).

## **Pregnancy Discrimination Act (PDA)**

### OVERVIEW OF THE LAW

One of the obstacles women encounter in getting equal access to employment opportunity is discrimination based on pregnancy. Federal law provides that employers cannot discriminate on the basis of pregnancy, childbirth, or related medical conditions.

The Pregnancy Discrimination Act (which was a 1978 amendment to [Title VII](#)) provides that **pregnancy, childbirth, and related medical conditions must be treated like other disabilities for purposes of sick leave and temporary disability benefits.**<sup>595</sup> ([See Americans with Disabilities Act](#))

### IS PREGNANCY DISCRIMINATION A FORM OF SEX DISCRIMINATION?

Yes, because a woman's ability to bear children makes her different from a man, **pregnancy discrimination is a form of sex discrimination that is prohibited by the federal law Title VII.** ([See Title VII](#))

### WHAT MUST UMHS DO TO COMPLY WITH THE PDA?

- 1) An employer must not discriminate on the basis of pregnancy, childbirth, or related medical conditions when hiring, firing, or setting the terms and conditions of employment.<sup>596</sup>
- 2) Because pregnancy may place some restrictions on a woman's normal range of activity, employees with disabilities related to pregnancy must be treated the same way as employees with temporary medical conditions are treated ([See Americans with Disabilities Act](#)).<sup>597</sup>
- 3) If the employer provides health insurance, the coverage must include expenses for pregnancy-related conditions on the same basis as costs for other medical conditions. **\*\*HOWEVER**, an employer need NOT provide health insurance for expenses arising from abortion, EXCEPT where the life of the mother is endangered. The employer can choose to provide health insurance for abortion-related expenses if it wishes.<sup>598</sup>

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<sup>595</sup> 42 U.S.C. § 2000e(k) (1978).

<sup>596</sup> 42 U.S.C. § 2000e(k) (1978).

<sup>597</sup> 29 C.F.R. § 1604.10 (1979).

<sup>598</sup> 29 C.F.R. § 1604.10 (1979).

## Pregnancy Discrimination Act (PDA)

- 4) The employer must not limit pregnancy-related benefits only to married employees. Married and unmarried pregnant employees must be treated the same.<sup>599</sup>

### WHAT SHOULD AN EMPLOYER DO WHEN INTERVIEWING A PREGNANT JOB APPLICANT?

The PDA requires that employers treat pregnant job applicants like any other applicant who may have a temporary medical condition or disability. This means that employers cannot deny a woman a job **based on her pregnancy** as long as she is qualified and capable of performing the job duties.

- 1) Avoid discussing the applicant's pregnancy.
- 2) Focus on the requirements of the job and the applicant's ability to fulfill them.
- 3) Make sure the job has the same requirements for all applicants.
- 4) If the applicant cannot meet the requirements, the employer need not hire her.

### CAN AN EMPLOYER SAY THAT A WOMAN MUST NOT BE PREGNANT TO QUALIFY FOR A JOB?

**No, in almost all cases, an employer cannot claim that a woman's non-pregnancy is a bona fide occupational qualification. ([See Title VII](#))**

In the past, airlines hiring flight attendants<sup>600</sup>, industries hiring for positions that involve risks to fetuses<sup>601</sup>, and schools or youth groups hiring teachers and counselors<sup>602</sup> have all attempted to establish non-pregnancy as a BFOQ. **Some jurisdictions have permitted it, but on the whole, Title VII has not been found to support the argument that non-pregnancy is a BFOQ.**

\*Disability related to pregnancy has to be treated like any other temporary disability. ([See Americans with Disabilities Act](#))

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<sup>599</sup> 29 C.F.R. § 1604.10 (1979).

<sup>600</sup> *Burwell v. Eastern Air Lines*, 633 F.2d 361 (4<sup>th</sup> Cir. 1980). *Harriss v. Pan Am. World Airways*, 649 F.2d 670 (9<sup>th</sup> Cir. 1980) (policy upheld); *In re Pan Am. World Airways*, 905 F.2d 1457 (11<sup>th</sup> Cir. 1990) (policy struck down).

<sup>601</sup> *Int'l Union, UAW v. Johnson Controls, Inc.*, 499 U.S. 187 (1991) (policy struck down).

<sup>602</sup> *Chambers v. Omaha Girls Club, Inc.*, 834 F.2d 697 (8<sup>th</sup> Cir. 1987).

## Pregnancy Discrimination Act (PDA)

### WHAT IF A PREGNANT EMPLOYEE STARTS SHOWING POOR PERFORMANCE OR PROBLEMS WITH ATTENDANCE?

The PDA does not say that an employer has to tolerate poor performance or attendance just because she is pregnant. **The employer simply must hold pregnant employees to the same work standards as other employees and apply those standards consistently.**

### WHAT IF A PREGNANT EMPLOYEE'S POOR PERFORMANCE OR ATTENDANCE PROBLEMS ARE RELATED TO THE PREGNANCY?

*Example:* An employee can't lift heavy items or is late to work due to morning sickness. Under the PDA, the employer should treat her the same as it does any other employee with a **temporary medical condition.**

Some absences might qualify as FMLA leave and should not be factored in when deciding whether an employee's attendance problems should result in an adverse employment action. ([See Family and Medical Leave Act](#))

### CAN AN EMPLOYER, IN ORDER TO PROTECT A FETUS, REFUSE TO HIRE WOMEN FOR POSITIONS THAT EXPOSE THEM TO TOXIC SUBSTANCES OR RADIATION?

**No, the employer cannot refuse to hire women for this reason because gender-based fetal protection policies violate Title VII sex discrimination provisions.** ([See Title VII](#))

Because exposure to some substances involve a risk a reproductive harm, some employers made a policy decision to not hire women for jobs that require employees to work near such substances.<sup>603</sup> However, some hiring practices designed to maintain occupational health and safety did not square with equal employment opportunity.

In the 1991 *Johnson Controls* decision<sup>604</sup>, the Supreme Court struck down a company policy that denied jobs involving lead exposure to fertile female applicants. After the "Johnson Controls" decision, the EEOC issued an official statement on fetal protection policies. **The EEOC stated that employer policies that exclude members of one sex from a workplace in order to protect fetuses cannot be justified under Title VII.**<sup>605</sup> ([See Title VII](#))

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<sup>603</sup> Introduction to Proposed Guidelines on Employment Discrimination and Reproductive Hazards, 45 Fed. Reg. 7,514.

<sup>604</sup> *Int'l Union, UAW v. Johnson Controls, Inc.*, 499 U.S. 187 (1991).

<sup>605</sup> EEOC Policy Guide on *United Auto Workers v. Johnson Controls* (June 28, 1991), reprinted in FEP Manual (BNA) 405: 6941.

## WHAT CAN THE EMPLOYER DO IF IT THINKS THAT THE JOB DUTIES MIGHT HARM THE PREGNANCY OF A PREGNANT EMPLOYEE?

- 1) If a pregnant employee is capable of performing her job duties, the employer cannot require her to take leave—even if the employer knows for sure that the pregnant employee will be exposed to hazardous material.
- 2) If a pregnant employee has a hazardous job, the employer should **notify the employee of the potential risks** and **suggest that she discuss them with her doctor** to decide whether or not she should keep working in that position.
- 3) If a pregnant employee cannot perform all of her job duties, the employer can offer her a leave, transfer her to another available position, or make some other change that is consistent with the employer's normal FMLA policies. ([See Family and Medical Leave Act](#))

## DOES THE LAW REQUIRE AN EMPLOYER TO GIVE REASONABLE ACCOMMODATION TO A PREGNANT WORKER?

- 1) **Maybe.** The U.S. Equal Employment Opportunity Commission issued controversial Guidance documents in 2014 favoring accommodation.<sup>606</sup>
- 2) **Maybe.** The U.S. Supreme Court is currently deliberating a highly relevant case.<sup>607</sup>

A final answer to this question is impossible until the Supreme Court reaches its decision or, alternately, if Michigan follows other states in enacting protections at the state level.

## WHAT IF A PREGNANT EMPLOYEE FAILS TO PERFORM A REQUIRED JOB DUTY BECAUSE SHE FEARS THAT IT WILL EXPOSE HER FETUS TO RISK?

As long as the employer's policies are **neutral** and do not require anything more of pregnant employees when compared to non-pregnant employees, the employer can discipline or fire the employee for not performing the job duty.

In one case, a pregnant nurse filed suit claiming that she was treated the same as other employees rather than differently.<sup>608</sup> The nurse had refused to provide treatment to a patient with HIV because she felt that it increased risk to her fetus. The employer fired the nurse because the hospital had a policy that any nurse who refuses to provide treatment must resign or can be fired. The court sided with the employer because the hospital had applied the policy in a **neutral and nondiscriminatory way**.

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<sup>606</sup> Seyforth Shaw, *New Guidance From The EEOC Requires Employers To Provide Reasonable Accommodations Under The Pregnancy Discrimination Act*, Jul. 14, 2014, <http://www.eeocountdown.com/2014/07/14/new-guidance-from-the-eec-requires-employers-to-provide-reasonable-accommodations-under-the-pregnancy-discrimination-act/>.

<sup>607</sup> *Young v. UPS*, No. 12-1226 (*argued*, Dec. 3, 2014).

<sup>608</sup> *Armstrong v. Flowers Hosp.*, 33 F.3d 1308 (11<sup>th</sup> Cir. 1994).

## Pregnancy Discrimination Act (PDA)

### ARE PREGNANT EMPLOYEES WHO WANT OR HAVE HAD AN ABORTION PROTECTED BY THE PDA?

Yes, an employer cannot take an adverse employment action against an employee because she had an abortion or is considering having one.<sup>609</sup>

### IS INFERTILITY A “RELATED MEDICAL CONDITION” UNDER THE PDA?

An employee who wants leave for fertility treatments may be protected by the PDA, the [Family and Medical Leave Act](#) if the employee has a serious health condition, and/or by the [Americans with Disabilities Act](#) (infertility is a disability because it is a substantial limitation on the ability to reproduce).

While infertility affects both men and women, at least one Circuit Court has ruled that employees who are fired for taking time off to get IVF treatments—just like employees who are fired for taking time off to give birth—will always be women.<sup>610</sup> **As such, infertility can be a “related medical condition” under the PDA.**

### ARE MENSTRUAL CRAMPS CONSIDERED TO BE A “RELATED MEDICAL CONDITION” UNDER THE PDA?

No, menstrual cramps are not considered to be related to pregnancy or childbirth and are not covered by the PDA.<sup>611</sup>

### CAN A MAN CLAIM THAT HE HAS BEEN DISCRIMINATED AGAINST ON THE BASIS OF PREGNANCY?

Historically, men did not bring many PDA claims because men did not get pregnant. However, nothing bars a pregnant person who identifies as a man from bringing such a claim. In addition, if a man is discriminated against because of his wife’s pregnancy, he may have a PDA claim. **Courts have explained that discrimination against men who have pregnant wives is a form of gender discrimination because only males have pregnant spouses.**<sup>612</sup> Again, should a woman be married to a pregnant person who identifies as a man, if that marriage is recognized by the state, the woman could theoretically bring a case based on the pregnancy of her spouse.

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<sup>609</sup> *Turic v. Holland Hospitality, Inc.*, 842 F. Supp. 971 (W.D. Mich. 1994), 849 F. Supp. 544 (W.D. Mich. 1994), *aff’d in pertinent part*, 85 F.3d 1211 (6<sup>th</sup> Cir. 1996).

<sup>610</sup> *Hall v. Nalco Co.*, 534 F.3d 644 (7<sup>th</sup> Cir. 2008).

<sup>611</sup> *Jirak v. Fed. Express Corp.*, 805 F. Supp. 193 (S.D.N.Y. 1992).

<sup>612</sup> *Nicol v. Imagematrix, Inc.*, 773 F. Supp. 802 (E.D. Va. 1991); *Griffin v. Sisters of Saint Francis Inc.*, 489 F.3d 838 (7<sup>th</sup> Cir. 2007).



# **Genetic Information Nondiscrimination Act (GINA)**

## OVERVIEW OF THE LAW

The Genetic Information Nondiscrimination Act (GINA) is a federal law that was passed in 2008 to protect employees from employment or health insurance discrimination based on genetic information.<sup>613</sup> Many laws are enacted as a response to a lengthy list of reported cases of discrimination. However, as of 2008, the number of reported *genetic* discrimination cases was relatively low.

**GINA addressed public concerns about the growing potential for discrimination based on genetic information in light of greater availability of genetic testing.**<sup>614</sup> Surveys and polls of the American population from 2006-2007 suggest that the vast majority of Americans believe that employers would use genetic information to discriminate and that genetic nondiscrimination legislation was necessary.<sup>615</sup>

## WHAT IS GENETIC INFORMATION?

Genetic information includes:<sup>616</sup>

- 1) Information about a person's genetic tests
- 2) Information about the genetic tests of a person's family members or relatives
- 3) Information about the genetic tests of the fetus of a pregnant women
- 4) Information about the genetic tests of an embryo held by a person for use in assisted reproductive technology (ART)

Genetic information does NOT include information about age or gender.<sup>617</sup>

## WHAT IS A GENETIC TEST?

A genetic test is “an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detects genotypes, mutations, or chromosomal changes.”<sup>618</sup>

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<sup>613</sup> 42 U.S.C. § 2000ff et seq. (2008).

<sup>614</sup> See *Hearing on Genetic Non-Discrimination Before the Subcomm. on Health of the H. Comm. on Ways and Means*, 110<sup>th</sup> Cong. (2007).

<sup>615</sup> Genetics & Public Policy Center, Johns Hopkins University, *U.S. Public Opinion on Uses of Genetic Information and Genetic Discrimination*, Apr. 24, 2007, available at [http://www.dnapolicy.org/resources/GINAPublic\\_Opinion\\_Genetic\\_Information\\_Discrimination.pdf](http://www.dnapolicy.org/resources/GINAPublic_Opinion_Genetic_Information_Discrimination.pdf)); Christy White, Cogent Research, *Survey on Public Attitudes Toward Genetic Technologies and Genetic Discrimination*, Mar. 27-28, 2006, available at <http://www4.od.nih.gov/oba/SACGHS/meetings/March2006/White.pdf>.

<sup>616</sup> 42 U.S.C. § 2000ff(4)-(8); (GINA § 201(4)-(8)) (2008).

<sup>617</sup> 42 U.S.C. § 2000ff (4)(C); (GINA § 201(4)(C)) (2008).

WHAT DOES GINA REQUIRE OF UMHS?

**GINA requires:**

- 1) **No Discrimination in Health Insurance**—Employers cannot use genetic information to set health insurance premium amounts, nor can they require employees to undergo genetic testing in order to obtain a health plan.<sup>619</sup> GINA does **not** apply to employer-provided disability or life insurance.
- 2) **No Discrimination in Hiring, Firing, and Setting the Terms and Conditions of Employment**—Employers cannot limit, segregate, or classify employees based on genetic information in any way that would harm or tend to harm the employee’s employment opportunities.<sup>620</sup>
- 3) **No Retaliation**—Employers cannot take an adverse employment action against employees who have tried to assert their rights under GINA and/or brought a genetic discrimination claim.<sup>621</sup>
- 4) **Treatment of the Employee’s Genetic Information as a Confidential Medical Record**<sup>622</sup>
- 5) **No Disclosure of Employee’s Genetic Information EXCEPT:**<sup>623</sup>
  - a) Disclosure to the employee that the genetic information belongs to in response to a written request
  - b) Disclosure to a health researcher
  - c) Disclosure pursuant to a court order or to a government investigation of GINA compliance
  - d) Disclosure related to certification provisions of family and medical leave laws ([See Family and Medical Leave Act](#))
  - e) Disclosures to public health officials if information is about a contagious disease or illness that presents imminent hazard of death
- 6) **No Acquisition or Collection of Employee’s Genetic Information EXCEPT** where:<sup>624</sup>
  - a) The employer requires or accidentally requests the employee’s family medical history

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<sup>618</sup> 42 U.S.C. § 2000ff(7)(A); (GINA § 201(7)(A)) (2008).

<sup>619</sup> See GINA § 101-104 (2008).

<sup>620</sup> 42 U.S.C. § 2000ff-1(a) (GINA § 202(a)) (2008).

<sup>621</sup> 42 U.S.C. § 2000ff-6(f) (GINA § 207(f)) (2008).

<sup>622</sup> 42 U.S.C. § 2000ff-5(a) (GINA § 206(a)) (2008).

<sup>623</sup> 42 U.S.C. § 2000ff-5(b) (GINA § 206(b)) (2008).

<sup>624</sup> 42 U.S.C. § 2000ff-1(b) (GINA § 202(b)) (2008).

## Genetic Information Nondiscrimination Act (GINA)

- b) The employer views the family medical history in documents that are commercially and/or publicly available (\*\*BUT no medical databases or court records can be used)
- c) The employer wants the genetic information to provide health or genetic services to the employee AND the employee has given prior, voluntary, and written authorization AND the employer does not receive individual identifying information
- d) The employer needs the genetic information for genetic monitoring of the biological effects of toxic substances in the workplace AND EITHER the employee has given prior, voluntary, and written authorization OR the monitoring is required by law, the employee is informed of the results, and the employer does not receive individual identifying information
- e) The employer is a forensic lab that analyzes DNA for law enforcement purposes or to identify human remains

## RELATIONSHIP OF GINA TO OTHER LAWS

GINA does not preempt other federal or state laws that provide MORE protection against genetic discrimination. Sometimes, a genetic discrimination claim can be brought under other employment discrimination laws.

- 1) [Americans with Disabilities Act](#) (ADA)—If an employee has a genetic trait or condition that substantially limits a major life activity, or is regarded as having such a condition, he or she may be protected by the ADA.
- 2) [Title VII](#)—Although Title VII does not explicitly cover genetic traits, it may protect people who have a genetic trait or condition that is connected to a certain gender, race, or ethnicity.
- 3) [Persons With Disabilities Civil Rights Act](#) (PWDCRA)—This Michigan state law also prohibits employers from discriminating on the basis of genetic information.<sup>625</sup>

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<sup>625</sup> MICH. COMP. LAWS §§ 37.1201-1202 (2000).

## Age Discrimination in Employment Act (ADEA)

### OVERVIEW OF THE LAW

The Age Discrimination in Employment Act (ADEA)<sup>626</sup> is a federal law that was enacted in 1967 to **prohibit employment discrimination on the basis of age**. The ADEA applies to people who are at least **40 years of age**.

### WHAT DOES THE ADEA REQUIRE OF UMHS?

- 1) **UMHS cannot make employment decisions** (including hiring, promotions, firing, transfers, disciplinary actions, setting the terms and conditions of employment, etc.) **based on age UNLESS age is a bona fide occupational qualification.**
- 2) UMHS should **maintain a working environment that is free of hostility** to older employees.
- 3) **UMHS cannot retaliate against an employee for filing a complaint alleging ADEA violations** with the Equal Employment Opportunity Commission (EEOC) or for reasonable opposition to discriminatory practices.

### WHAT IS A BONA FIDE OCCUPATIONAL QUALIFICATION (BFOQ)?

Employers can treat employees or applicants differently because of their age **when age is a job qualification that is reasonably necessary to the normal operation of that business**. While the BFOQ exception is an extremely narrow one,<sup>627</sup> it has been a successful defense in cases where public safety is at stake.<sup>628</sup>

### WHAT ARE REASONABLE FACTORS OTHER THAN AGE THAT AN EMPLOYER CAN CONSIDER WHEN MAKING AN EMPLOYMENT DECISION?

Just because an employee is over 40 years old, it does not mean that an employer cannot take an employment action against that employee for **legitimate reasons other than the employee's age**.

- 1) **Business Cutbacks**—An employer may have an economic reason for terminating or otherwise disciplining an employee. Forced retirements based on economic necessity will be allowed under the ADEA only if 1) the necessity of drastic reduction of costs

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<sup>626</sup> 29 U.S.C. §§ 621-634 (1967).

<sup>627</sup> *Western Air Lines, Inc. v. Criswell*, 472 U.S. 400 (1985).

<sup>628</sup> When reviewing the enforceability of mandatory retirement plans, courts have typically accepted age as a BFOQ for bus drivers, airline pilots, law enforcement officers, firefighters, etc.

## Age Discrimination in Employment Act (ADEA)

- is real, and 2) the forced retirements are the least detrimental means to reduce costs.<sup>629</sup>
- 2) **Job Performance**— An employer will have good cause to terminate or otherwise discipline an employee if the employee has a poor performance record.<sup>630</sup>
  - 3) **Training or Qualifications**—An employer can refuse to hire employees who do not have the training or qualifications needed for the job.<sup>631</sup>
  - 4) **Loss of Funding for Employee’s Position**—An employer can terminate an employee if funding for the employee’s position has been lost.<sup>632</sup>
  - 5) **Costs That Are NOT Proxies for Age**—An employer can make an employment decision based on a cost assessment of a particular employee (as opposed to an assessment based on cost differentials between older and younger employees).<sup>633</sup> Some costs (such as pensions) are often age-based and may be less likely to be considered reasonable factors if based on age rather than on years of service.<sup>634</sup>
  - 6) **Physical Fitness and Health**—If an employee’s job is a strenuous one that involves physical demands, an employer can terminate an employee without violating the ADEA if the employee’s poor health makes him or her unable to perform the job functions.<sup>635</sup>
  - 7) **Testing and Other Selection Criteria**—An employer can administer a selection test or use other selection criteria as long as the tests are justified by business necessity.<sup>636</sup>

### WHAT EMPLOYER PRACTICES ARE EXEMPT FROM THE ADEA?

**Bona fide employee benefits plans and bona fide seniority systems may be exempt from the ADEA if they meet certain requirements.**

- 1) **For an employee benefit plan to be exempt, the plan must meet 5 requirements:**<sup>637</sup>
  - a) The plan has to cover employee benefits.
  - b) The plan must be bona fide.

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<sup>629</sup> *EEOC v. Chrysler Corp.*, 733 F.2d 1183-86 (6<sup>th</sup> Cir. 1984) .

<sup>630</sup> *See, e.g., Simmons v. McGuffey Nursing Home*, 619 F.2d 369 (5<sup>th</sup> Cir. 1980); *Huhn v. Koehring Co.*, 718 F.2d 239 (7<sup>th</sup> Cir. 1983); *Grohs v. Gold Bond Bldg. Prods.*, 859 F.2d 1283 (7<sup>th</sup> Cir. 1988); *Scharnhorst v. Indep. School Dist.*, 686 F.2d 637, 710 (8<sup>th</sup> Cir. 1982).

<sup>631</sup> *Landron Trinidad v. Pan Am. World Airways*, 575 F.2d 983 (1<sup>st</sup> Cir. 1978).

<sup>632</sup> *Palmer v. United States*, 794 F.2d 534 (9<sup>th</sup> Cir. 1986).

<sup>633</sup> *Mastie v. Great Lakes Steel Corp.*, 424 F. Supp. 1299 (E.D. Mich. 1976).

<sup>634</sup> *Hazen Paper Co. v. Biggins*, 507 U.S. 604 (1993).

<sup>635</sup> *Loeb v. Textron, Inc.* 600 F.2d 1003 (1<sup>st</sup> Cir. 1979).

<sup>636</sup> 29 C.F.R. § 1625.7(d) (1967).

<sup>637</sup> 29 U.S.C. § 623(f)(2) (2004).

## Age Discrimination in Employment Act (ADEA)

- c) The employer's action has to be a result of following the plan.
  - d) The cost incurred in providing benefits in the plan to older workers must be at least equal to the amount spent on younger workers.
  - e) The plan must not require or permit involuntary retirement on account of age.
- 2) **For a seniority system to be exempt, the system must meet 5 requirements:**<sup>638</sup>
- a) The system must be based primarily on length of service.
  - b) The system must give workers with greater seniority more rights (as opposed to fewer).
  - c) The principal terms and conditions of the system must be communicated to all affected employees, without regard to age.
  - d) The system must be applied uniformly to all affected employees, without regard to age.
  - e) The system cannot require or permit involuntary retirement.

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<sup>638</sup> 29 C.F.R. § 1625.8-9 (1967).

## Title IX

### OVERVIEW OF THE LAW

Title IX of the Education Act Amendments of 1972 **prohibits sex discrimination in any education program or activity that receives federal financial assistance.**<sup>639</sup> While this law is best known for its application to sex discrimination in college athletics, Title IX also covers UMHS because UMHS is a university hospital that receives federal funding.

### WHO DOES TITLE IX PROTECT?

**Title IX protects not only students, but also employees** of an educational institution with programs or activities that receive federal financial assistance.<sup>640</sup>

### WHAT KINDS OF DISCRIMINATION DOES TITLE IX PROHIBIT?

Title IX discrimination generally covers 3 different kinds of behavior or practices for which educational institutions can be sued:

- 1) **Disparate Treatment**—Treating someone less favorably because of the person's sex. Discriminatory motive is an element of these cases.
- 2) **Disparate Impact**—Using a selection criteria, tests, rules, etc. that look neutral on the surface, but have an adverse impact on members of a protected group. The intent to discriminate is not necessary for an employer to be liable in these cases.
- 3) **Retaliation**—Intimidating, threatening, coercing, or treating someone differently because the person has asserted or attempted to assert rights under Title IX.

### RELATIONSHIP TO TITLE VII

Title VII of the Civil Rights Act of 1964<sup>641</sup> also prohibits discrimination on the basis of sex. ([See Title VII](#)) Generally speaking, the Title VII framework can be used to determine whether discrimination that would violate Title IX has occurred.<sup>642</sup>

However, in a case of **sexual harassment**, in order to be liable for monetary damages under Title IX, an employer must.<sup>643</sup>

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<sup>639</sup> 20 U.S.C. § 1681 (2000).

<sup>640</sup> *North Haven v. Bell*, 456 U.S. at 521 (quoting *United States v. Price*, 383 U.S. 787, 801 (1966) (Congress's use of the phrase "no person shall be subjected to discrimination" in Title IX means that employees, as well as students, are covered by its antidiscrimination provision).

<sup>641</sup> 42 U.S.C. § 2000e et seq (1978).

<sup>642</sup> 29 C.F.R. §1691.4 (2000).

<sup>643</sup> *Gebser v. Lago Vista Independent School District*, 524 U.S. 274, 118 S. Ct. 1989, 141 L. Ed. 2d 277 (1998).

## Title IX

- 1) Have **actual knowledge** about the sexual harassment or misconduct AND
- 2) Be **deliberately indifferent** in failing to address the situation

**This standard differs from the Title VII standard**, under which an employer can be liable for a supervisor's harassment even if the employer has **no knowledge** of the supervisor's conduct.<sup>644</sup>

### WHEN DOES UNLAWFUL SEX DISCRIMINATION OCCUR?

Sex discrimination occurs when:

- 1) An employer takes an **employment action** against a person based on **his/her gender**.
- 2) An employer **treats a member of one sex with a certain characteristic or circumstance differently** than members of the other sex who have that same characteristic or circumstance. (*Example*: Married female employees are treated differently than married male employees.)
- 3) An employer **treats men and women differently on the basis of a trait** that is either only or mostly **associated with one sex**. (*Ex.*: A woman is fired for being pregnant).
- 4) An employer has a **rule, policy, or requirement** that seems to be neutral on the surface, but ends up having a **disproportionate effect on one sex** AND there is **no valid business justification**.
- 5) An employer places **appearance or grooming standards** on its employees, **which affect one sex more than the other**.
- 6) An employer:<sup>645</sup>
  - a) Who **sexually harasses** employees of one gender more than the other OR,
  - b) Whose workplace is a hostile work environment for members of one sex due to unwelcome **sexual harassment**.
- 8) An employer discriminates **on the basis of pregnancy, childbirth, or related medical conditions**. ([See Pregnancy Discrimination Act](#))

\*Disability related to pregnancy must be treated like any other temporary disability, *if* the disability is not routine pregnancy discomfort. ([See Americans with Disabilities Act](#))

### WHEN CAN EMPLOYERS TREAT MEN AND WOMEN DIFFERENTLY?

Employers may do so only if employee gender is a **bona fide occupational qualification** that is **reasonably necessary to normal operations of the business**. ([See Title VII](#)).<sup>646</sup>

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<sup>644</sup> *Faragher v. City of Boca Raton*, 524 U.S. 775, 807 (1998).

<sup>645</sup> *Meritor Sav. Bank, FSB v. Vinson*, 477 U.S. 57, 106 S. Ct. 2399, (1986); 29 C.F.R. § 1604.11.

<sup>646</sup> *Dothard v. Rawlinson*, 433 U.S. 321 (1977).