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FAMILY LAW REFORM AND JUSTICE COUNCIL OF ALASKA, INC.

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RUDY JOHNSON, PRESIDENT
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"ALASKANS FOR CHILDRENS RIGHTS"

FAIRBANKS - BOX 73256
KETCHIKAN - BOX 7176
SITKA - BOX 913

April 26, 1981

WRITTEN TESTIMONY
by
RUDY JOHNSON

IN SUPPORT
of
H. B. 210
JOINT CUSTODY

presented
April 22, 1981

via Teleconference Network
Anchorage

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Present and past methods of dealing with disputed child custody issues have been a disasterous failure. Historically we have allowed biases and not the best interest of the children to be the determining factors in the millions of cases that have filtered through our court systems. The results of over a century of abusive dispositions of these cases are measurable as will be mentioned later. To thoroughly appreciate the need for H.B. 210 we must understand the failures of the present system and be realistic enough to accept the fact it is <u>failing!</u>

In a 1860 opinion the New Hamshire Supreme Court ruled in upholding an award of custody to a father;

> "It is a well settled doctine of the common law, that the father is entitled to the custody of his minor children, as against the mother and everybody else: that he is bound for their maintenance and nurture and has the corresponding right to their obedience and their services."
>
> "It is one of the cardinal principles of nature and of law that, as against strangers, the father, however poor and humble, if able to support the child in his own lifestyle and of good moral character, cannot without the most shocking injustice, be deprived of the privilege by anyone whatever, however brilliant the advantage he may offer. It is not enough to consider the interests of the child alone." (American Journal of Psychistry 133:12107, 1976, page 1370)

From this 18th century mentality we went to the other extreme as espoused in the Minnesota Family Law Practice Manual.

"Except in very rare cases the father should not have custody of the minor children of the parties. He is usually unqualified psychologically and emotionally; nor does he have the time and care to supervise the children. A lawyer not only does an injustice to himself, but he is unfair to his client, to the state, and to society if he gives any encouragement to the father that he should have custody of his children. A lawyer who encourages his client to file for custody, unless it is one of the classic exceptions, has difficulty collecting his fees, has a most unreasonable client, has taken the time of the court and the welfare agencies involved, and has put a burden on his legal brethren." (Volume 50, pg 75)

Has the tender years doctine been eliminated in our system today? In theory yes, we have very good case law and Alaska has some of the most progressive statatory law in the nation. But the facts are the biases still exist and preconcluded decisions are being made before the facts are ever established in awarding custody of children, to the detriment of the children.

Since 1977, we have been associated with over 185 divorce reform organizations around the nation that have collectively gathered the results of over 350,000 disputed child custody cases. The results shockingly demonstrate the above statements. Out of these cases only 4.5% of them were decided in favor of fathers. It is not remotely the intent of this writer to suggest fathers should receive custody most of the time but common sense tells us that it is not in the best interest of children to be placed in a single parent home headed by a mother 95.5% of the time, the long term negative effects on the children would no doubt be just as disturbing with the figures reversed. This organization is currently doing a study of the Anchorage Court System where we are examining the records of each divorce case for the past two years and the initial results show that in this city the statistical conclusions will not even be as impartial as the national study, as appauling as those figures are.

What are the results of the abuses spoken of so far?

1. 90% of all homocides are a direct result of domestic relation problems.

2. 90% of the american prision population is from a broken home.

3. 90% of all women murdered between the ages of 20 and 30 are killed by their husbands or ex-husbands.

4. 9 out of 10 women on welfare are products of divorce.

5. 20% of the civil case load in the Alaska Court system is domestic relations.

The criminal activities related to these problems are the results of people, normal everyday Americans, being pushed too far by an apathetic system. By being denied the access to their children, by being forced to be financially obligated to their ex-spouse to the point of ridiculousness, by having gasoline poured onto the smoldering pile of emotions by attorneys and others involved with the case as these people are going through the most difficult emotional experience they will ever encounter next to losing a loved one in death. H.B. 210 will elliviate a lot of the grief for these people and give them alternatives that are encouraged by the courts and the related legal establishment that are more comfortable and that they can live with.

As the law has developed some courts have recognized the failures of the present system and have provided direction to the lower courts in their written opinions.

> "Parenthood is a continuing bilateral responsibility and opportunity. It cannot be avoided or successfully divided. A decree of divorce offers no excuse or alibi for the abatement of parental interest or obligation. The dissolution of the marriage contract, leaving in its wake children who are the innocent victims of the resultant broken home, should be a challenge to the fathers and mothers of such children to make an even greater effort to minimize, as far as possible, the incidental and unavoidable losses of love, council and guidance."
> (McBetrick vs. McBetrick 284 P2d 352, Oregon)

> "Whoever may have custody, it is the duty of each parent and each family member to the children to set asid personal feelings and act in a manner which is supportive of the relationship of the children to the other parent."
> (Warren vs. Warren 528 P2d 1088, Oregon, 1974)

Attitudes are slowly being changed and direction is being provided by the Alaskan courts on an individual basis. In a 1975 opinion from the Ketchikan Superior Court, Judge Thomas Schultz emphasized the positions taken here in his remarks as he awarded custody of a 4 year old boy and a 7 year old girl to the father.

> "Certainly a factor in determing the fitness of the parent is the kind of learning which might be called fitness that either or both parents are able and willing to provide. In terms of fitness, to provide the care that these children require and in terms of the relationship that the parties bear to the children I find both are fit and both are in fact good parents, have taken good care of the children, love the children and both have a good relationship with them. I am left with the very narrow basis on which to resolve the question and that is the view that I can take from the testimony that I've heard up till now, of which parent is better able to maintain the status quo to facilitate the children and their desire at this point as its reflected in the testimony the relationship they have with the parents, and maintaining a meaningful relation-

ship with both. I am satisfied from what I've heard that the father is better able to do that at this point. And ultimately in this case, it's my considered opinion that the parent most fit will be that parent that demonstrates the best ability to maintain open communications between both. These children were, as all others are, brought into the world without being asked about it and they're being left now in a situation that they didn't particularly ask for and probably don't want but they are entitled to the guidance and assistance from both their parents." (Johnson vs. Johnson, Transcript 186 to 189, Ketchikan Superior Court, April 7, 1975)

In considering child custody matters we must recognize the fact that most parents that come before the court are not only fit, they are very fit parents and the state would never consider interfering in their lives so long as there was not a divorce petition filed. H.B. 210 is a necessary vehicle to help change attitudes. It also recognizes the right of the parents to control their own families and it encourages them to do this. It paves the road to making decisions in disputed custody cases based upon what is right with this family and these parents rather than what is wrong with the parents and the children. It provides a means for settlement that feels better for the parents which in turn helps the children feel better. Recent studies such as the one from California reporting the results of families in transition after divorce over a period of 5 years,(Psychology Today, January 1980, Enclosed) show that when the parents deal with their divorce constructively and creatively then the children are not adversely affected on the long run whereas if the parents have a lot of turmoil and grief for extended periods of time these children will be affected adversely for years to come and even into their adulthood.

Mediation and joint custody works! The Association of Family Conciliation Courts is an organization made up of judges, social scientists, attorneys and a few lay people like myself and they have concluded with their studies that 60 to 80% of all disputed child custody cases are settled out of court with the existing mediation programs by the parents themselves. The Association has officially endorsed joint custody as the best first choice in resolution of disputed cases and has published hundreds of studies showing joint custody, joint parenting, does and is working. The concept has been being used for up to 3 years in various jurisdictions and is working even when mediation is required rather than voluntary. Of course, the success rate is lower under those circumstances but if we can settle on the average, 70% of all cases out of court the dollar value alone is astronomical in terms of judicial costs not to mention the emotional benefits to the parties themselves and the resultant decrease in the criminal activities that are related and the welfare costs. But the most important consideration is how all this benefits the children of divorce. The results of the study from California can not be given too much emphasis.

What I have stated here is based upon fact not my opinion. Some people have opposed H.B. 210 but I say anyone who opposes it simply does not know enough about it and the facts surrounding the concept. One attorney for instance testified that by encouraging mediation a man could and will intimidate a women into agreeing to something she really does not want. I am positive that is not the rule as my experience has shown me and when such a rare thing happens the checks and balances written into the existing law are designed to catch it. For instance in the do it yourself kits available from the efforts of Representative Bradner and Gardiner in 1977 it is a requirement that one of the spouses appear before the court before the divorce is granted. The legislative intent was to allow the judge to ascertain from that party that the agreement was indeed mutual and not coerced.

Other checks and balances exist in H.B. 210. If the court finds that joint custody is not in the best interest of the family he only needs to state his reasons for that conclusion and dismiss the concept. The bill specifically states the presumption for joint cusotdy is rebutable. It is a long way past due that we require the courts to justify their disposition of child custody decisions, that is all this bill requires and it still leaves them a lot of discreation, too much discreation in my opinion but I am willing to compromise on that to get the bill.

Joint custody is not for everyone but it works for most, with direction, and I think it would be inhuman to deny this wonderful alternative to the present system to parents and children because of those few that are too immature to make it work. The courts and the present system will always be available for those people who decide they want to go that way.

It was reported that under present law we do not need H.B. 210. This is theoretically correct but what is so important about the bill is it will help change attitudes and attitudes are the key to helping divorcing people experience a creative divorce that will strengthen the family instead of destroying it.

If I have appeared anxious in my oral testimony as well as this written testimony, it is because I know that in the time it takes you to read this:

> there will be over 1,000 divorces in the United states affecting over 3,000 children;
>
> there will be at least two homocides as a result of the activities surrounding these people;
>
> there will be four more prison inmates;
>
> and we have just gotten 150 more people on our welfare rolls;

40 Alaskans were divorced today!

JOINT CUSTODY IS THE ONLY LOGICAL AND MORALLY ACCEPTABLE ALTERNATIVE TO A HAPPY INTACT HOME FOR CHILDREN OF DIVORCE. PARENTS DIVORCE EACH OTHER, CHILDREN NEVER DIVORCE THEIR PARENTS.

Enclosure: California Report

Carbon Copies sent to the following:

Governor Jay Hammond
Representative Rogers
Representative Gardiner
Representative Meekins
Senator Parr
Mr. Mark Lewis, Chicago, Illinois
Mr. Vern Lee, Fairbanks, Alaska
Mr. Wayne Ross, Esquire, Anchorage, Alaska
Mr. Bill Riech, Sitka, Alaska
Mr. John Reese, Esquire, Anchorage, Alaska
United Fathers Organization, Santa Ana, California
M.E.N. International, Wilmington, Delaware
Mr. Max Gruenberg, Esquire, Anchorage, Alaska

Respectfully Submitted:

RUDY JOHNSON

custody misery

by David N. Rorenthal
Knight-Ridder Newspapers

San Jose, Calif. — Kramer vs. Kramer might never have made it to court, let alone to the big screen, if a new California law had been in effect when Ted and Joanna Kramer began their brutal fight over custody of little Billy.

Because, as of Jan. 1, all couples getting divorced and fighting over custody of their children in the state must go through mediation counseling.

If, after such counseling, they still want to go through the gut-wrenching process depicted in the Oscar-winning movie, they are welcome to it.

"The new law would have destroyed the movie, but it might have saved the family," quips Hugh McIsaac, the head of the Los Angeles conciliation court and a pioneer in mediation counseling. "It doesn't work for everyone, but those that it does work for are spared a lot of grief."

"In our case, it was definitely beneficial," says a 28-year-old San Jose woman who recently went through mediation with her husband of seven years over who would get custody of their three children. "We are one of those couples who cannot communicate."

She admits she was leery at first but found the counseling surprisingly relaxed. "We met with a mediator twice and agreed to share custody. I don't think we could have reached that agreement otherwise without trial."

The mediation law, the nation's first, is a companion to last year's trend-setter: joint custody. That measure set as public policy the idea that children be assured frequent contact with their parents and that parents be encouraged to share the responsibilities of child rearing.

Under the statute, joint custody is a legal priority instead of an option. When both parents agree, shared custody is decreed. When only one parent applies for joint custody, that option is considered by judges along with the more traditional arrangement of sole custody to one parent and visitation rights to the other.

The new mediation measure, sponsored by state Sen. Alan Sieroty, D-Los Angeles, requires mediation whenever custody or visitation rights are divorce issues. The measure also requires that custody disputes be settled before other matters at stake in the divorce.

Under the law, individual counties set up their own procedures for mediation. In Santa Clara County, contested custody cases go first to the special investigation unit of the Juvenile Probation Department for a temporary custody recommendation.

All contested cases must then be scheduled for mediation through Blacker, a San Jose attorney who has handled divorce cases in Santa Clara County for 15 years. "I have encouraged my clients for some time to try mediation. It doesn't always work, but when it does, it saves money and a lot of emotional wear and tear."

"I have found that the mediators at the county are very good, but there are a couple of drawbacks to the public system.

"One, the public mediators don't have the time that a private person does; and two, the hours aren't as flexible. The positive part, of cours, is that public mediators are free."

Weiss, whose office has five trained mediators to handle custody cases, says that so far, only a few couples have been referred to private mediators. The law does not specify who is a qualified mediator, but in Santa Clara County at least, those receiving referrals from Weiss' office must have a masters' degree in marriage and family counseling and have at least two years practical experience.

"At first," Weiss says, "I set up the referrals to be a random thing, whoever's name came up. But now, I am re-evaluating it and will probably match people according to geography and perhaps their area of expertise."

Lisa Williams is one of the qualified mediators on Weiss' list. Twice divorced and the survivor of a custody fight of her own, she has handled about 200 cases of custody mediation the last two years. She heads the non-profit Center for New Beginnings in San Jose, with about 90 percent of her practice dealing with custody problems.

"I'm glad that the law is in effect," she says. "I obviously believe in the process or I wouldn't be doing this. I think it gives couples a chance to determine their own lives. Even in instances when mediation doesn't work, I have had cases where couples who have not spoken in eight or nine years at least began to talk to each other. That's progress, even if it doesn't solve all the problems between them."

McIsaac believes the mere fact the law exists may be more constructive in the long run than the measure's practical effect. "This is an instance where the shadow of the law can be more important than what the law actually says," he says. "Lawyers will be advising their clients more about mediation because of it and there will be more negotiation. The law now rewards cooperation and that is something it didn't used to do."

A Santa Clara man whose 25-year marriage is breaking up agrees with McIsaac after having settled a visitation dispute with his wife through mediation.

"I think the only people who benefit from the court deciding are law-

the special investigation unit of the Juvenile Probation Department for a temporary custody recommendation.

All contested cases must then be scheduled for mediation through Conciliation Court, which provides up to three sessions with one of its mediators. If longer mediation seems necessary, referrals are made to private mediators, whose costs vary with the parents' ability to pay.

If no agreement is reached, the case is returned to Juvenile Probation or Family Court Services for evaluation before the trial.

In any case, the mediation process is supposed to remain confidential unless both parties agree otherwise.

The results of mediation are impressive.

"I would guess that about 60 percent of the cases we get are being resolved prior to trial now because of mediation," Hugh McIsaac says of the three years of mediation in Los Angeles. "What we have found is that in most cases the two parents really do care for their children, if not for each other. If given a forum that doesn't inflame the dispute, they can often reach an agreement. The worst possiblatmosphere is in an adversary setting like court. That only skews things and shows people at their worst instead of their best."

In an age of limits and budget cuts, the funding of the mandatory mediation law is another plus. General state revenues are not used for the program; instead it is funded by each county raising fees charged for divorce filings and decree modifications as much as $15 and marriage licenses and burden of payment on those who use the service rather than on the public.

The new law is popular with attorneys who have found themselves embroiled in nasty custody hassles. "To me, the last and worst alternative is going to court," says Norden

marriage is breaking up agrees with McIsaac after having settled a visitation dispute with his wife through mediation.

"I think the only people who benefit from the court deciding are lawyers," he said. "I would be in favor of mediation in other areas such as property settlement. Divorce is traumatic but mediation makes the best of a bad situation."

CALIFORNIA'S CHILDREN OF DIVORCE

BY JUDITH S. WALLERSTEIN
AND JOAN B. KELLY

Five years after the breakup, 34 percent of the kids are happy and thriving, 29 percent are doing reasonably well, but 37 percent are depressed. An in-depth study of 60 families traces patterns in these different outcomes. As in married families, what counts most are the two parents' attitudes.

The conventional wisdom used to be that unhappily married people should remain married "for the good of the children." Today's conventional wisdom holds, with equal vigor, that an unhappy couple might well *divorce* for the good of the children; that an unhappy marriage for the adults is unhappy also for the children; and that divorce that promotes the happiness of the adults will benefit the children as well.

Testing that new dogma was among our goals in 1971 when we started what became known as the Children of Divorce Project. We interviewed all the members of 60 families with children that had recently gone through divorce, and reinterviewed them 18 months later. Recently, we saw them again, after a lapse of five years (see box, page 70). Our study has no counterpart in the United States or in Europe in the span of years it covers, in the participation of so many children of different ages, and in the kinds of questions that were posed.

Our results called into sharp question much more than the idea that what is good for the parents is always good for the kids. For example, we thought that by five years after the initial separation, new family structures would be an accepted part of life, and our observations would be made within a social and psychological landscape that had come to rest. Yet we found more people than we expected to find still in various degrees of turmoil.

Our overall conclusion is that divorce produces not a single pattern in people's lives, as the conventional wisdom of any era tends to claim, but at least three patterns, with many variations. Among both adults and children five years afterward, we found about a quarter to be resilient (those for whom the divorce was successful), half to be muddling through, coping when and as they could, and a final quarter to be bruised: failing to recover from the divorce or looking back to the predivorce family with intense longing. Some in each group had been that way before and continued unchanged; for the rest, we found roughly equal numbers for whom the divorce seemed connected to improvement and decline.

What made the biggest difference for the children was not the divorce itself, but the factors that make for good adjustment and satisfaction in intact families: psychologically healthy parents and children who are involved with one another in appropriate ways. Yet providing these optimal conditions is difficult in the postdivorce family, with its characteristic climate of anger, rejection, and attempts to exclude the absent parent.

Changing Family Circumstances

News of their parents' divorce clearly had been an unhappy shock to most of the children. We found that although many of them had lived for years in an unhappy home, they did not experience the divorce as a solution to their unhappiness, nor did they greet it with relief at the time, or for several years thereafter.

To be sure, as many of the children matured, they often acquired a different perspective. But at the time of the family disruption, many of the children considered their situation neither better nor worse than that of other families around them. They would, in fact, have been content to hobble along. The divorce was a bolt of lightning that struck them when they had not even been aware of a need to come in from the storm.

Five years later, there had been little shifting of the children from the custody of one parent to the other. Seventy-seven percent of the youngsters continued to live in the custody of their

From Surviving the Breakup: How Children Actually Cope with Divorce, by Judith S. Wallerstein and Joan B. Kelly. Copyright © 1980 Judith S. Wallerstein and Joan B. Kelly. Reprinted by permission of Basic Books.

Five years afterward, 50 percent of the children still strongly disapproved of their parents' divorce.

mothers. Eight percent now lived with the fathers, a slight increase; another 3 percent shuttled back and forth from one home to the other, usually not in a planned joint-custody arrangement, but under duress when their relationship with one or the other parent became overwhelmed with ill will. An additional 11 percent of the children—adolescents—were now living on their own.

Almost two-thirds of the youngsters had changed their place of residence, and a substantial number of these had moved three or more times. The moves were generally within a radius of 30 miles, however; very few families left the region. The fathers tended to stay close by as well. One-half continued to live within the same county as their children, some still within biking distance. An additional 30 percent of the fathers were within a one-hour drive.

Twenty-four (43 percent) of the fathers had remarried in the intervening four years, of whom five were then redivorced and two subsequently remarried. Thus, 44 percent of the youngsters had a new stepmother. Nineteen of the mothers—one-third—had remarried; two of these women were then redivorced, and two widowed. Hence, nearly a quarter of the children lived with a stepparent.

The majority of the fathers (68 percent) had made their child-support payments with considerable regularity, and an additional 19 percent paid some support, but irregularly and in varying amounts. (Nationally, the estimated figures are considerably lower.) Only 13 percent were completely delinquent. Still, far more of the mothers than the fathers had traveled downward from their former economic status.

At the time of divorce, two-fifths of the families had been solidly upper class or upper middle class, whereas two-thirds of the women and their children were now either solidly middle class or lower middle class.

The Children's Differing Reactions

Hardly a child of divorce we came to know did not cling to the fantasy of a magical reconciliation between his parents. Danny, age seven, whose parents had been divorced for several years when we first saw him, softly confided his "best" fantasy. He had, he said, always wanted to fix up Hazel Street and Pine Street. "They're all filled with mud and they don't join, but a long time ago, they did, and I'd like to cut the two streets so they join. But this," he sighed, "will be a long time off."

When we saw Danny again, he was 11. "Divorce is not as bad as you think . . . not near as bad as it looks in movies or on television," he said. He had thought a lot about divorce, he told us; and had just recently figured it all out. "It's something like if you break a glass and pick the pieces up right away, they will fit back together perfectly, but if you take one piece and sand the edge, it will never fit again."

Five years after the separation, 28 percent of the children strongly approved of their parent's divorce, 42 percent were somewhere in the middle, accepting the changed family but not taking a strong position for or against the divorce, and 30 percent strongly disapproved—a major shift from the initial count. Then, three-quarters of the children strongly disapproved. Still, the faithfulness of so many youngsters to their predivorce families was unsettling, and more loyal than many parents welcomed.

Nancy, now in the second grade, said, "when they first divorced, I was kind of sad." Then, she said, she found out life was still fun because "we got to see Daddy in his house . . . . There are lots of good things to do . . . . Things are not so different . . . . You can meet a lot of new dogs and new people."

Thirty-four percent of the children and adolescents appeared to be doing especially well psychologically at the five-year mark. Their self-esteem was high and they were coping competently with the tasks of school, playground, and home. There were no significant age or sex differences among these resilient youngsters. The boys appeared to have caught up with their sisters in the years since the first follow-up, which had found the boys lagging behind. Characteristic of these children was their sense of sufficiency: the divorce had not depleted their lives by removing a loving parent, or by pairing them with an angry, disturbed one. At times, they still felt lonely, unhappy, or sorrowful about the divorce, but these misgivings did not make them aggrieved or angry at either parent.

Roughly 29 percent of the children were in the middle range of psychological health. They were learning at grade level at school and showing reasonably appropriate social behavior and judgment in their relationships with adults and children. They were considered average by their teachers. Nevertheless, islands of unhappiness and diminished self-esteem or anger continued to demand significant portions of their attention and energy, and sometimes hampered the full potential of their development.

Sonja, age 11, was typical of the middle group. "I don't think about the divorce as much as I used to," she said. "Before, I wasn't right. I was all mad and yelling at Mom. . . . Usually, I still yell at her. I tell her I don't mean it, but I can't control myself." Disquietingly, Sonja talked with considerable pleasure about hurting and slapping people. She laughed excitedly as she recounted several stories of people, adults and children, getting into

"When we see Daddy," one child said, "it's not so different, and you can meet lots of new dogs and people."

difficulties. Recently, Sonja was caught stealing some things from a shopping center and also from the school. Yet Sonja's mother indicated that the child is not as demanding as she used to be, and that, overall, her behavior is improving.

We found a final third of the children and adolescents to be consciously and intensely unhappy and dissatisfied with their life in the postdivorce family. Among this group were those with moderate to severe depression, although at least half of the depressed children had islands of relatively unburdened development within them and were able to move ahead in ways appropriate for their age in several important parts of their lives, such as school.

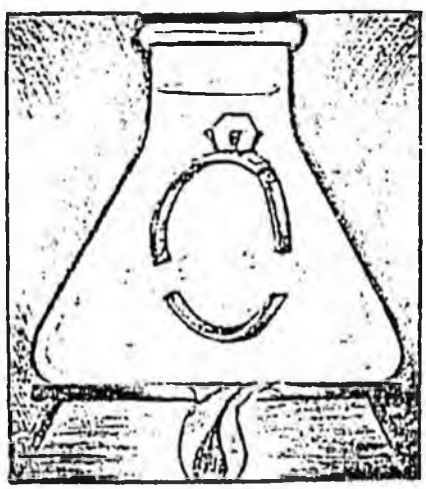
We were struck as well by the high incidence of intense loneliness that we observed in 27 percent of the children, a little higher than at the 18 month mark. These children complained of coming home to empty houses after school to await the return

CONTROLLING THE DIVORCE VARIABLE

The 60 families in our study came initially for a six-week divorce counseling service. We advertised the service as a preventive program, offered free to all families in the midst of divorce. The parents and their 131 children, aged 2 to 18, knew from the start that this brief intervention in their lives was part of a larger research project, and that our roles as clinicians and researchers were intertwined.

How typical was our group? Of the 60 families, 88 percent were white, 3 percent black, and 9 percent interracial with one Asian spouse. They were predominantly middle class and well educated, although 28 percent were in the lowest socioeconomic class, and some were on welfare.

All the families lived in Marin County, California, nationally known for its high divorce rate. Indeed, in 1970, when the study was formally established, the number of people who applied for a divorce in the county exceeded those who applied for a marriage license, a ratio higher than the national average. Now, however, we find that the divorce rate in many parts of the country has caught up. Precisely because most of the children were neither stressed by chronic poverty nor by inner-city problems, we felt our



sample gave us a good chance to study divorce as a relatively uncontaminated vector of change.

Our interdisciplinary team included six psychologists and psychiatric social workers, all trained in clinical work with children. Initially, we saw each family member alone four to six times. With family permission, we talked with the children's teachers.

All family members were interviewed again in two successive follow-ups, almost always by the same member of the team who had seen them initially. The first follow-up came approximately one year after the initial contact, the second nearly five years after separation. At the five-year mark, we were able to locate 58 of the original 60 families and 101 of the original 131 youngsters—an unusually high ratio.

Because we were interested in studying the experience and impact of divorce among psychologically normal children and adolescents, we excluded any families in which a child had a history of psychological difficulties or was currently in psychotherapy. We did not exclude parents with psychological problems, however, and on the basis of our first interviews, we diagnosed one-third of the parents as being in adequate to excellent psychological health. Half the men and slightly fewer women were in considerable psychological difficulty, with problems such as severe depression, alcoholism, or difficulty in relating to other adults and children. Some 20 percent of the parents—usually those who had been left by a healthier spouse—were seriously troubled or disturbed.

The counseling we gave helped parents refocus on the needs of their children and encouraged some parents to seek additional psychotherapy. Hence, the number of unsatisfactory outcomes revealed in our current study might be smaller than in the general population, who do not get such help. —J. S. W. and J. B. K.

The lingering faithfulness of so many youngsters to their predivorce families was unsettling.

of the working parent. On weekends, these youngsters often felt left out of the social life of both divorced parents. Several also complained of loneliness within a remarriage, while recognizing ruefully that the newly married adults wanted privacy and time away from curious children.

Anger played a significant role in the psychological life of 23 percent of the children and adolescents, who were not coping well. Most of the anger was defensive and reflected the underlying fear, sorrow, and sense of powerlessness of these youngsters. Anger at the father was especially likely to be sustained, especially in older boys and adolescents. Three children had rejected their fathers' overtures, including Paul, who returned unopened his father's birthday present to him on his 14th birthday. Other children's anger took other forms, including explosive outbursts of temper and delinquent behavior, such as drug involvement and stealing.

The Importance of Involved Fathers

What accounted for the successful outcomes? Some children improved simply by escaping a disturbed and cruel parent to be left in the custody of a concerned and loving one. Some of these youngsters developed good relationships with a stepparent. Little boys, especially, appeared to spurt ahead with excitement and new growth with a stepfather whom they grew quickly to love.

A number of other factors seemed common to the children who dealt most resiliently with divorce. One factor, not surprisingly, was having a strong personality to start with. As we followed the course of the children whom we had placed initially within the ranks of the very well adjusted, it appeared that two-thirds of these resilient, successful copers were still functioning very well five years later. Sad to say, some boys and girls in all age groups who had been able to cope during a conflict-ridden marriage deteriorated notably in the post-separation period.

The most unpredictable change occurred among those children whose adjustment initially was a mixed bag of successes and failures. Very few of the boys and girls who were originally at the midpoint of the scale were still there after five years. Those youngsters were the most vulnerable to change, and stood in equal measure to either deteriorate or improve.

Perhaps the most crucial factor influencing a good readjustment was a stable, loving relationship with both parents, between whom friction had largely dissipated, leaving regular, dependable visiting patterns that the parent with custody encouraged. (For a description of the parents' adjustment, see box, page 72.) Forty percent of the mother-child relationships were adequate to very good, with an additional 20 percent at the adequate mark. Occasionally, when the father had been abusive or was psychologically disturbed, a strong mother bore the emotional load by herself and seemed able to give the children all the emotional support they needed. Usually, however, it took two, and a custodial parent's efforts to impr[illegible] child's life were burdened [illegible] seeming disinterest of the other p[illegible]

The contribution that the out-[illegible] home parent could make emerged with clarity at five years. Frequent, flexible visiting patterns remained important to the majority of the children. Nearly one-quarter of the youngsters continued to see their fathers weekly, if not several times weekly. An additional 20 percent visited two to three times a month. Thus, 45 percent of the children and adolescents continued to enjoy what society deems "reasonable visitation," although many of the children continued to complain of not enough contact.

The 17 percent of youngsters with erratic visits (less than once a month) continued to be anguished by the father's inconstancy; the passage of five years had not lessened their wish to be loved by both parents. The same percentage as before (9 percent) had no contact.

Overall, we found that 30 percent of the children had an emotionally nurturant relationship with their father five years after the marital separation, and that this sense of a continuing, close relationship was critical to the good adjustment of both boys and girls.

These men had worked hard to earn the parenthood that fathers in intact families customarily take for granted. Some had persevered despite such irritations as one former wife who, four years after the separation, was still regularly calling her former husband during their son's visits with him to order the boy to shower. One man described the special personalities of his three children so vividly that hearing him talk, one would have been hard put to know that there had been a divorce in the family five years earlier. The children of these men, in turn, were spared the sense of loss and rejection that many less fortunate children experienced.

In contrast to the youngsters who yearned for more visits, almost one-fifth of the youngsters did not find the visits pleasurable or gratifying. A number of them resented being used to carry hostile messages between parents. Noted Larry, a 13-year-old, "My father has to understand that when he shoots arrows at my mother, they first have to go through our bodies before they reach her."

In the most unsatisfactory visiting arrangements, a range of parental behavior, from outright abandonment to general unreliability, often disap-

Or e woman still regularly called her former husband during their son's visits to order the boy to shower.

pointed a child repeatedly, usually leading the child to feel rejected, rebuffed, and unloved and unlovable. Anger at the rejecting father usually did not undo the child's unhappy conclusion about his or her essential unlovability to the father. Lea, for example, was an abnormally quiet girl whose teacher said she did not believe she could succeed at anything. We interviewed her at home. When asked about her father, she brought out a box containing all of the letters her father had written to her during the past three years. These letters, possibly 15 in number, were dog-eared, folded and refolded, and the interviewer couldn't help but be reminded of a precious collection of love letters that had been read and reread with tears. The father had actually visited only once in the past two years.

Peter, age nine, had not seen his father, who lives nearby, more than once every two to three months. We expected that he would be troubled, but we were entirely unprepared for the extent of this child's misery. The interviewer observed: "I asked Peter when he had last seen his dad. The child looked at me blankly and his thinking became confused, his speech halting. Just then, a police car went by with its siren screaming. The child stared into space and seemed lost in reverie. As this continued for a few minutes, I gently suggested that the police car had reminded him of his father, a police officer. Peter began to cry and sobbed without stopping for 35 minutes."

Even though the majority of fathers and children continued to see each other fairly often, by the five-year mark three-quarters of these relationships offered the children little in fully addressing the complex tasks of growing up. Yet, paradoxically, by his absence a father continued to influence the thoughts and feelings of his children; most particularly, the disinterested father left behind a legacy of depression and damaged self-esteem.

Except in extreme cases in which a father was clearly abusing children or seriously disturbed, some contact seemed better than none at all. The father's presence kept the child from a worrisome concern with abandonment and total rejection and from the nagging self-doubts that follow such worry. The father's presence, however limited, also diminished the child's vulnerability and aloneness and total dependency on the one parent.

A few other factors that we had expected to be significant in helping children adjust turned out not to be. Children were incapable of using friends to make up for troubled conditions at home; rather, those with comparatively stable homes were the ones most likely to have friends outside. Grandparents provided some solid supports for both divorced mothers and their children—when they supported the idea of the divorce—but were not a strong enough influence to make up for problems elsewhere.

THE PARENTS' ADJUSTMENT

The transition to a stabilized life after divorce can be difficult and prolonged. Most of the men said they had regained a sense of coherence and stability within the second year after divorce, but the average woman was well into her third postseparation year before reaching that point.

While two-thirds of the men and slightly more than half the women now viewed the divorce positively—a significant increase—a more sobering finding was that close to one-fifth of the men and women viewed the divorce as totally negative, which left them without resources for helping their children understand it.

In terms of the men's and women's psychological health, the people who were enjoying adequate to excellent psychological health (a third of the adults when we started the study) had expanded to include half the men and 57 percent of the women. Notable among the women in particular was a greatly enhanced self-esteem and lifting of depression. The group of men and women who previously had been troubled were essentially unchanged. For them, divorce provided no relief and made daily coping harder.

A successful resolution for one parent was not necessarily so for the other. And if the divorce worked for one or both parents, that did not necessarily portend a successful resolution for the children, though the reverse could also be true. As one woman said, "The kids are great, mama's a wreck!" —J. S. W. and J. B. K.

When a parent remarried, most children enlarged their family view, making room for three major figures.

Most children did not seem to be influenced either for good or ill if their mother worked, although some of the youngest boys appeared to do significantly better in school and in their overall adjustment when the mother did not work full time.

One-third of the children once again confronted far-reaching change in their daily lives when one or both of their divorced parents remarried. (Only two of the fathers with custody remarried.) The arrival of a stepfather seemed to create particular friction for a short while. Most of the stepfathers had been married before, expected to assume the role of parent to their wives' children, and, encouraged by the women, moved quickly into the prerequisites, prerogatives, and authority that this position traditionally conveyed. Only a few men appeared sensitive to the need to cultivate a relationship with stepchildren gradually and to make due allowance for suspiciousness and resistance in the initial stages.

Still, after some early tensions, the relationships with the children from two to eight years old took root fairly

THE CHILDREN OF DIVORCE AS ADULTS

At about the same time Wallerstein and Kelly began their West Coast study of children of divorce, the psychologist E. Mavis Hetherington began a similar investigation at the University of Virginia. She focused on preschool children and their parents during the two years following divorce. Both sets of findings suggest a consistent pattern: initial pain—experienced by children of all ages, including those whose parents fought constantly before the divorce—followed by feelings of fear, anger, depression, and guilt that give way, often within 18 months, to an adjustment to the new single-parent family. (Children who must cope with many changes at once, such as moving to a new home, starting in a new school, or becoming a member of a stepfamily, take longer to make the transition.)

Sometimes, says Hetherington, an adjustment strategy that might be beneficial for a newly divorced mother can be harmful to her children. For example, in order to gain a sense of themselves as single people, some mothers in the study immediately plunged into an active social, business, or community life, leaving

the children feeling abandoned.

Since living with the same-sex parent aids a child's adjustment to divorce and because most children of divorce live with their mothers, boys initially often have greater difficulty coping with parental separation than girls do, according to Hetherington. She posits that boys suffer from the lack of a male model and from the absence of a father's discipline.

Unfortunately, these studies do not offer information about the one overriding concern of most parents: what are the lasting consequences, if any, of divorce on children? Regrettably, no one yet knows for sure.

Recently, several different research groups have begun to explore the issue for an even longer period than the five years of the Kelly-Wallerstein study. Social psychologists Richard Kulka and Helen Weingarten of the Survey Research Center at the University of Michigan examined the results of two random national surveys of 2,400 Americans, one conducted in 1957 and the other in 1976. Their study was designed to explore generational differences. Divorce has doubled since 1957; are reactions to it different now?

Although much of society has changed over the last 20 years, Kulka and Weingarten concluded that reactions to parental divorce have not. They found no differences between people from intact and nonintact families in overall adjustment or depression in adulthood. However, young adults (between 21 and 34 years old) from divorced families were less likely to be "very happy" and more likely to report symptoms of poor physical health than those from intact families. Throughout life, people of all ages from divorced families remembered their child-

Paradoxically, many fathers continued to influence their children's thoughts and feelings by their absence.

quickly and were happy and gratifying to both child and adult. Yet children with a stepfather seemed particularly sensitive to friction between parents.

Many people expect children to experience conflict as they turn from father to stepfather during their growing-up years. This was not borne out by our observations. Nor was the expectation that in the happily remarried family the biological father was likely to fade out of the children's lives. The great majority of fathers in the remarried families continued to visit, much as they had earlier. Mostly, children enlarged their view of the family and made room for three major figures. Jerry, age 10, when asked how often he saw his father, responded, "Which dad do you mean?" When a child did experience painful psychological conflict between the father and the stepfather, the adults were likely to be jealous or competitive, pulling hard in opposite directions.

The most tragic situations for the child were those in which mother and stepfather demanded that the child renounce his or her love for the father as the price for acceptance and affection

hood as the most unhappy time of life. They were also more likely to say that as adults, they had been "on the verge of a nervous breakdown." Feelings of anxiety were more prevalent among men whose parents were divorced, lending support to Hetherington's notion that the effects of divorce may be more pervasive and long-lasting for men than for women.

According to Kulka and Weingarten, the aftershock of parental divorce seemed, for both generations, to persist in subtle ways throughout adulthood. Adults from divorced families were more likely to report that "bad things" frequently happen to them. The Michigan research team reports that grown children of divorce not only are more likely to experience marital problems but also seem to have an orientation to the marital role different from other people's. Men whose parents were divorced tend to be less involved fathers, while women tend to be strongly involved mothers, perhaps unconsciously anticipating their own possible status as single parents.

In our Loneliness Research Project at New York University, Phillip Shaver and I have found that people whose parents were divorced are lonelier as adults than those from intact families. Our work was based on several thousand responses to surveys carried in several U.S. newspapers. We found that children of divorce had lower self-esteem than those whose parents had remained together. The younger the person was when the parents divorced, the lower the person's self-esteem and the more lonely he was as an adult.

We found striking differences between those whose parents were divorced during childhood, and those whose parents were not, in what people say about their mental health. As adults, those from divorced families were more likely to be bothered by crying spells, insomnia, constant worry, feelings of worthlessness, guilt, and despair. Adults who experienced parental divorce during childhood were more likely to feel afraid, anxious, and angry when they are alone. These are feelings usually associated with separation anxiety: what children feel when separated from their closest attachment figures, usually mothers or fathers.

Because of the limitations of our method, we simply don't know whether adult problems can be directly attributed to parental divorce, or to deficits resulting from parental divorce (which may, for instance, make people more vulnerable to separation anxiety), or merely to a current stressful situation (for example, a recent move, a divorce, or unemployment). Children who perceive their parents' divorce as a deliberate rejection or as a personal failure may respond differently, and perhaps develop differently, from those who see the divorce merely as an unlucky family situation. Custody arrangements and the way in which both parents adjust to divorce probably have a strong impact on these perceptions. Only recently have innovative custody arrangements become prevalent—such as joint custody, or active involvement of the noncustodial parent or stepparent. To date, none of these factors has received adequate research attention.

A 20-year longitudinal study of children of divorce would provide more robust information about long-term effects. Meanwhile, the National Institute of Mental Health is offering $1,000,000 for research to study the effects of divorce on children and useful strategies to help children adjust to parental divorce. What is clear now is that for some children, divorce can have a lasting psychological impact, while for others, it comes to exist only as a shadowy memory of an unhappy year of childhood. —Carin Rubenstein

Psychologist Carin Rubenstein is an associate editor of *Psychology Today*.

Despite popular beliefs, a divorce is neither more nor less beneficial to children than an unhappy marriage.

within the remarried family. Such children were severely troubled and depressed, too preoccupied with the chronic unresolvable conflict to learn or to develop at a normal pace.

Eventual Softening of the Strains

Most of the adults in our study, especially the women, were feeling better five years after divorce than they had when we first saw them, despite the greater economic pressure and the many stresses of the postdivorce family. But among the children, although individuals had improved or worsened, the percentages within broad categories of good and poor adjustment had remained relatively stable. Hence, it seems that a divorced family per se is neither more nor less beneficial for children than an unhappy marriage. Unfortunately, neither unhappy marriage nor divorce is especially congenial for children. Each imposes its own set of differing stresses.

Our other major finding about how important it is for a child to keep a relationship with both original parents points to the need for a concept of greater shared parental responsibility after divorce. In this condition, each parent continues to be responsible for, and genuinely concerned about, the wellbeing of his or her children, and allows the other parent this option as well.

The concept of joint legal custody, in which each parent has the right to make important decisions about the life of the child, is a step in the right direction. The newer idea of shared *physical* custody, whether parents share the children 50-50, 80-20, or in other proportions, may also be a positive step, but it needs to be studied to determine its advantages and disadvantages for children at different developmental stages. Many people object that parents who cannot agree during marriage certainly cannot be expected to reach agreement on child-related matters after divorce. Indeed, some infuriated or disturbed parents will never chart a rational course with regard to their children. Yet it seems clear that our society must encourage fathers and mothers to accept the importance of continuity in parent-child relationships after divorce. Perhaps in changing legal expectations, we can take the first steps in a necessary re-education about meeting the needs of children in the postdivorce family.

Unfortunately, it seems clear that the divorced family is, in many ways, less adaptive economically, socially, and psychologically to the raising of children than the two-parent family, or at least the two-adult family. This does not mean that it cannot be done. But the fact remains that the divorced family in which the burden falls entirely or mostly on one parent is more vulnerable to stress, has more limited economic and psychological reserves, and lacks the supporting or buffering presence of another adult for the expected and unexpected crises of life.

In order to fulfill the responsibility of child-rearing and provide even minimally for the needs of the adult, many divorced families are in urgent need of a network of services that are not now available in most communities, ranging from educational, vocational, and financial counseling to enriched child care and after-school programs. At the five-year point in our own study, two-fifths of the men and a somewhat greater number of the women characterized the brief counseling we offered as useful and supportive and were still following suggestions that we had made at the first meetings five years earlier.

Divorcing with children requires in adults the capacity to maintain entirely separate social and sexual roles while they continue to cooperate as parents. This is very difficult. We began our work with the conviction that divorce should remain a readily available option to adults who are locked into an unhappy marriage. Our findings, although somewhat graver than expected, have not changed our conviction. They have given greater impetus to our interest in easing the family rupture for children and adults alike. ☐

Currently a fellow at the Center for the Advanced Study in the Behavioral Sciences, Judith S. Wallerstein is a lecturer in the School of Social Welfare at the University of California, Berkeley, and has been the principal investigator of the Children of Divorce Project since it began in 1970. As a psychiatric social worker, she received her Ph.D. from the University of Lund in Sweden and trained in child psychoanalysis at the Menninger Foundation. She is a member of the Family Law Advisory Commission to the California Senate, and consults widely with clinics, departments of child psychiatry, social agencies, and courts on the effect of divorce on children and how such institutions can respond most appropriately.

Joan B. Kelly, coprincipal investigator of the divorce project, is a clinical psychologist with a private practice, and teaches continuing-education courses for professionals, including preventive intervention with divorcing families. She received her Ph.D. in child clinical psychology from Yale University and taught in the Department of Psychology and Psychiatry at the University of Michigan. At the time the divorce project began, she was director of child services at the Marin County Community Mental Health Center.

For further information, read:

Abarbanel, Alice. "Shared Parenting After Separation and Divorce: A Study of Joint Custody." *American Journal of Orthopsychiatry* 49(1979): 320-329.

Hetherington, E. Mavis, Martha Cox, and Roger Cox. "The Aftermath of Divorce." In *Mother-Child Father-Child Relationships*. Joseph H. Stevens, Jr., and Marilyn Mathews, eds. National Association for the Education of Young Children. Washington, D.C. 1978.

Hetherington, E. Mavis, Martha Cox, and Roger Cox. "The Development of Children in Mother-headed Families." In *The American Family: Dying or Developing*. Henry Grunebaum and David Reiss, eds. Plenum. 1978.

Wallerstein, Judith S. "For the Sake of the Children: A Review of the Psychological Effects of Divorce." *Journal of Divorce* 1(1977): 223-237.

3

MSG 81-00016035 PRTY 1 05/11/81 10:26:12 ORIG: LF01 IN= 0002 OUT= 0012
FROM: ANNIE IN FAIRBANKS TO: JUNEAU INFO.
TARGET. LJH2 SUBJ: POM PAGE 0001

TO: REP. BROWN AND SEN. PARR

FROM: LARRY SWEET, 1859 ROBERTS RD., FAIRBANKS 99701 479-6762/479-2241

RE: HOUSE BILL 210 JOINT CUSTODY FOR CHILDREN

AS YOU REQUESTED LAST SATURDAY IN FAIRBANKS THIS MESSAGE IS A REMINDER TO CHECK WITH DON CLOCKSIN TODAY REGARDING MOVING HB210 THIS YEAR AND HAVING JOINT HEARINGS. I WILL HAVE CALLED HIM THIS MORNING. I PLAN TO COME TO JUNEAU TOMORROW (TUESDAY) AND HOPE TO MEET WITH CLOCKSIN AND/OR HOLLY-PLOSS.

mediators qualified meet standards of bar or M.H. Association

Divorce Mediation therapy and pract. — Assoc. of Family Conciliation Courts tried to determine who mediates.
M.H. prof. - Ct. appt.
Lawyers - Ct. appt.

best - MH profess & lawyers as team

— court will set standards - trained mediators

Stevens makes rec. to lawyers

no counsel present unless they are present they are observers.

rules of procedure & standards will be developed by the court system.

Calif. money for training of mediators.

payment for mediation?

1 — compelling evidence to suggest parents agreement is not in best interests of the child.

2 — requirement — joint agreement be worked out w/ Master 2 — mediator —

3 — establish a "marital relations specialist" in each judicial district to work with parents to get agreement.

1 Joint custody
2. Sole custody — visitation
3. Sole custody — no access

20% Joint Custody — 264-0428
Carla Forsythe - attorney for the court.
Family Court "Conciliation Court" - Los Angeles.

Mandate - statewide domestic relations a specialty. (Superior Ct.)
Conciliation court for counseling.
judicial leadership - judges
in each 2 profes doing only custody
evaluation (each over) 60 cases) (each would need 5 mediators. 2 clerical.

developed

ACSW
Marriage family Counselor - Masters level.
Check A.S. - mediation in divorce proceedings.
Calif - Los Angeles.

16-19 in Petaluma w/ Judge Schultz.

SB
726

STATE OF ALASKA

DEPARTMENT OF PUBLIC SAFETY

COUNCIL ON DOMESTIC VIOLENCE AND SEXUAL ASSAULT

JAY S. HAMMOND, GOVERNOR

POUCH N
ROOM 312, GOLDSTEIN BUILDING
JUNEAU, ALASKA 99811
PHONE:

March 17, 1982

The Honorable Charles Parr
Chair, Senate Health, Education,
Social Services Committee
Alaska State Senate
Pouch V
Juneau, Ak. 99811

Dear Senator Parr:

Attached is a Position Paper from the Council on Domestic Violence and Sexual Assault on Senate Bill 726, an act relating to medical and psychological assistance to victims of sexual assault.

If you or your staff have any questions, please do not hesitate to call me at 465-4356.

Sincerely

Betsey W. McGuire

Betsey W. McGuire
Executive Director

BWMC

12-L16LH

STATE OF ALASKA

DEPARTMENT OF PUBLIC SAFETY

COUNCIL ON DOMESTIC VIOLENCE AND SEXUAL ASSAULT

JAY S. HAMMOND, GOVERNOR

POUCH N
ROOM 312, GOLDSTEIN BUILDING
JUNEAU, ALASKA 99811

PHONE:

March 16, 1982

POSITION PAPER

SENATE BILL NO. 726

Senate Bill 726 is an act relating to medical and psychological assistance to victims of sexual assault. Payment for costs of victims who receive medical care in a hospital as a result of injuries from sexual assault would be paid by the Department of Health and Social Services as well as psychological and psychiatric treatment costs.

While the Council on Domestic Violence and Sexual Assault supports the concept of this bill, it is concerned that it would fragment the services to victims since the Council was established to coordinate the services to victims of domestic violence and sexual assault. However, the Council is not in a position to provide individual payments to persons, and such a function would add considerably to the administrative costs of the Council; the Department of Health and Social Services already has such a capability.

William R. Nix, Chair

12-L16LH

SB

737

COMMITTEE REPORT

SENATE

2/10/82

FURTHER: Finance

Date: 3/10/82

Mr. President:

The Committee on HEALTH, EDUCATION AND SOCIAL SERVICES has had SB 737

making a special appropriation to the Dept. of Health & Social Services to be used to combat the causes and effects of birth defects

under consideration and (a majority of the committee) (the committee) reports it back with the following recommendations:

[X] do pass [ ] do not pass

[ ] do pass with attached amendments(s)

[ ] replace with CS for _____ [ ] same title [ ] new title

and recommends _____

[ ] AND attaches a "Letter of Intent" [ ] New Fiscal Note

[ ] reports it back without recommendation

[ ] referred to the _____ Committee

MEMBERS SIGNING
DO PASS

MEMBERS HAVING
OTHER RECOMMENDATIONS:

_____ CHAIRMAN

S 60 (Rev. 12/78)

SENATE AMENDMENT

By Senate HealtheEducation & Social Aervices

To: _____ SENATE BILL No. 723

To: _____ HOUSE BILL No. _____

PAGE: LINE:

Page 1, line 12:

Delete (shall) and Insert may in its place.

Page 2 line 13:

Add Costs of mediation shall be paid by one party or both as ordered by the court.

Page 3, line 1:

Delete:(shall) and Insert May in its place.

Introduced: 2/5/82
Referred: Health, Education & Social Services and Judiciary

IN THE SENATE BY HARR

SENATE BILL NO. 723

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWELFTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to child custody."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

Section 1. AS 09.55.205 is amended to read:

Sec. 09.55.205. JUDGMENTS FOR CUSTODY. (a) In an action for divorce or for legal separation the court may, if it has jurisdiction under AS 25.30.020 [,] and is an appropriate forum under AS 25.30.050 and 25.30.060, during the pendency of the action, [OR] at the final hearing, and [OR] at any time thereafter during the minority of a [ANY] child of the marriage, make an order for the custody of or visitation with the minor child that [WHICH] may seem necessary or proper and may at any time modify or vacate the order.

(b) If [ANY APPOINTMENT OF] a guardian ad litem for a child is appointed in an action under this section, the appointment shall be made under [THE TERMS OF] AS 09.65.130.

(c) The court shall determine custody in accordance with the best interests of the child under AS 25.20.060. [NEITHER PARENT IS ENTITLED TO PREFERENCE AS A MATTER OF RIGHT IN AWARDING CUSTODY OF THE CHILD.] In determining the best interests of the child the court shall consider [ALL RELEVANT FACTORS INCLUDING:]

(1) the physical, emotional, mental, religious, and social needs of the child;

(2) the capability and desire of each parent to meet these needs;

(3) the child's preference;

(4) the love and affection existing between the child and each parent;

(5) the length of time the child has lived in a stable, satisfactory environment and the desirability of maintaining continuity;

(6) the desire and ability of each parent to allow an open and loving frequent relationship between the child and his other parent.

* Sec. 2. AS 25.20.060 is amended to read:

Sec. 25.20.060. CUSTODY OF THE CHILD. (a) If there is a dispute over child custody, either parent may petition the superior court for resolution of the matter under this section [UNLESS AN ACTION BETWEEN THE PARENTS IS PENDING UNDER AS 09.55]. A court considering a petition for custody of a child may shall order the parties to participate in pre-trial mediation of the custody matter under AS 25.20.070. add

Costs of mediation shall be paid by one party or both as ordered by the court.

(b) After mediation of the custody matter, the [THE] court shall award custody on the basis of the best interests of the child. In determining the best interests of the child, the court shall consider all relevant factors including those factors enumerated in AS 09.55.205(c) [AS 09.55.205].

(c) Neither parent, regardless of the question of the child's legitimacy, is entitled to preference in the awarding of custody.

(d) Unless the court finds that it is not in the best interests of the child,

(1) the court shall award custody in accordance with a custody agreement between the parents; or

(2) if the parents do not agree on custody, the court shall award

(A) joint custody; or

(B) custody to one parent with frequent visitation rights to the other parent.

* Sec. 3. AS 25.20 is amended by adding a new section to read:

Sec. 25.20.070. MEDIATION OF CUSTODY MATTER. (a) At any time within 30 days after a petition for child custody is filed under AS 25.20.060 the court ~~shall~~ may order the parties to submit to mediation. Each party shall have the right to challenge peremptorily one mediator appointed.

(b) Mediation shall be conducted informally as a conference or series of conferences. The parties to the action and a court-appointed representative of the minor children shall attend.

(c) After the first conference either party may withdraw, or the mediator may terminate mediation if he determines that mediation efforts are unsuccessful. Upon withdrawal by either party or termination by the mediator, the mediator shall notify the court that mediation efforts have failed, and the custody proceeding shall proceed in the usual manner.

(d) Upon submission of the parties to mediation under this section, a pending child custody proceeding shall be stayed for a period of 30 days or until the court is notified that mediation efforts have failed. All court orders made during the pending custody proceeding remain in effect during the period of mediation.

2/25/82

FACT SHEET IN SUPPORT OF SENATE BILL 737

Each year since 1970 the March of Dimes has provided a grant to the University of Alaska to help develop genetics clinics, general pediatric clinics, Ob-Gyn clinics and in-service professional education programs at least every two months in the larger communities throughout Alaska. These are conducted by visiting medical professors from the School of Medicine, University of Washington.

More recently this program has complemented, and has been complemented by, the WAMI program whereby first year medical students receive their training at the University of Alaska. Communities throughout Alaska have also benefited through the March of Dimes clinics conducted by these same visiting professors. The savings in time and money to both programs has been great.

Needless to say March of Dimes volunteers throughout Alaska have also received excellent cooperation from the Department of Health and Social Services.

The continuation of the genetics portion of the March of Dimes' sponsored clinics is in serious jeopardy because March of Dimes annual grants, this year totaling $74,952 to the University of Alaska and to the Alaska Department of Health and Social Services, were committed to three different clinic and educational purposes before it was learned that funds from the National Genetics Diseases Act would be cut off.

The March of Dimes grant to the University of Alaska is, this year, committed mainly to the prevention of fetal alcohol syndrome, a condition whereby pregnant women who drink alcohol in excess run the risk of giving birth to seriously defective and mentally retarded children.

Another March of Dimes grant to the Department of Health and Social Services will finance an infant screening program designed to detect congenital adrenal hyperplasia, a serious and usually fatal disease if not detected and treated at birth or very shortly thereafter. This newborn screening program involves the entire State of Alaska and will be used as a model to determine whether similar screening of newborns should be undertaken nationwide. It is reported that the highest incidence of this disease in the world (1 in 500 births) occurs among the Yupik speaking Eskimos.

Funds previously committed for the March of Dimes' sponsored genetics clinics are currently committed (contracts signed) for the above and this was done before it was known that other funds, previously counted on, would not be available for the continuation of the genetics clinics which, for the past 12 years have become a very important part of the medical care services and educational services available to all Alaskans.

The passage of Senate Bill No. 737 will be a life saver in more ways than one, will prevent much suffering among Alaskans needing genetic services and will save literally hundreds of thousands of dollars in tax funds through the prevention of serious birth defects one case of which, over the lifetime of a single patient, can cost more than the entire amount of the requested appropriation.

A BILL

For an Act entitled: "An Act relating to the diagnosis, management and prevention of birth defects in children."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

The purpose of the bill is to provide clinics staffed by consultants with expertise in pediatrics, birth defects and hereditary disorders for the diagnosis, management, prevention and counseling of common and unusual problems that cause severe disabilities in children. Such clinic activities would be held in the cities of Juneau, Ketchikan, Sitka, Anchorage, Fairbanks, Bethel or other designated sites on a scheduled basis.

The Department of Health and Social Services shall arrange for the services of appropriately trained physicians to deliver such consultations, in collaboration with local physicians, that would benefit the children and their families. Such consultants may also provide information and training to those educational and social service programs that assist in the care of children with handicapping conditions.

The Department of Health and Social Services is further authorized to contract for the service of a coordinator in Alaska to organize and assist with the state-wide itinerant clinic program.

The above contractual arrangements are to include provision for personal services, travel, secretarial support, telephone charges and office expenses.

BUDGET

July 1, 1982 - June 30, 1983

Personal services for physician(s) with expertise in diagnosis and management of birth defects 1 FTE	$ 50,000
Coordinator for clinics 1 FTE	30,000
One-half secretary	10,000
Travel costs for itinerant clinics	18,300
Office rental (Anchorage) Approximately 300 square feet @ $1.5/ft^2/month	3,600
Office supplies, photocopy costs, educational material	1,400
Telephone charges for coordination (in and out of Alaska)	3,000
	$116,300
Indirect costs for contractual services @ 25%	29,075
TOTAL	$145,375

FTE = Full-time equivalent

Salary figures include costs of fringe benefits

BUDGET JUSTIFICATION

Personal Services for Physician(s): $50,000

Part-time physician at $30-40,000 per year with specialty training in birth defects and hereditary disorders is contracted with the University of Washington. This physician serves as the primary person to arrange for the visits to each city in Alaska, to offer diagnosis, management and counseling services in each clinic, to select an appropriate subspecialist in birth defects to accompany him/her to each clinic and to assure prompt consultative reports to the private physicians of each family. This physician will also assist with the coordination of care for children sent to Seattle for necessary diagnostic studies.

The remaining funds in this category are to allow for the services of subspecialists in birth defects with special skills in neuromuscular disease, hereditary eye disorders, hereditary bone disease, hereditary skin disease, congenital nervous system disorders and congenital disorders of the urinary tract. Any extra funding in this category could be used to assist with travel costs for the specialists.

Coordinator of Clinics: $30,000

This position is for a person with special training in counseling of families with birth defects. The position requires a M.S. degree in counseling, especially regarding hereditary disorders. The position will function in Anchorage and act as the coordination center for arranging patient visits, offering follow-up information, responding to family inquiries and counseling of common hereditary disorders or drug exposures during pregnancy.

The coordinator will assure that reports prepared by the consultants will be shared with the families and their private physicians.

Secretary: $10,000

Secretarial services are required to prepare the consultation reports, letters to families and submitting administrative reports. One-half time secretary should be adequate for this purpose.

Travel Costs:

Consultants in birth defects

Air fare (estimate) Seattle/Juneau/Ketchikan/Anchorage Seattle/Anchorage/Fairbanks	= $600/trip	
12 trips @ $600/trip		$ 7,200
Per diem @ $75/day (6.7 days/trip--12 trips)		6,000

Supspecialists in eye, skin, neurological, etc.	
4 trips/year @ $600/trip	2,400
(5.3 days/trip) ($75/day per diem) (4 trips)	1,600
Travel for coordinator to SE Alaska and Fairbanks once each year	
Estimated air fare @ $600	600
6.6 days per diem @ $75	500
	$18,300

Indirect Costs:

The University of Washington is currently charging 23% indirect costs for contracts of this nature.

Birth defects can be reduced, youth meeting told

By GALE METCALF
Herald Staff Writer

Although birth defect causes are mostly unknown, would-be mothers can reduce chances of bearing an infant with a major defect, Tri-City high school students were told Monday.

Those attending the Second Annual Youth Conference on Birth Defects at Pasco High School were told by Dr. Sterling Clarren and Charlene Butler of the University of Washington that causes for most birth defects can't be pinpointed.

But, steps taken by parents, particularly pregnant women, can reduce potential effects from known and perhaps unknown causes, the two said.

Clarren is assistant professor of pediatrics and director of Craniofacial and Community Clinics at UW. Ms. Butler is with the university's Division of Congential Defects.

The youth conference here was cosponsored by grants from the Hanford Environmental Health Foundation and the Mid-Columbia Chapter of the March of Dimes Birth Defects Foundation.

Dr. Clarren said 500,000 drugs or chemicals exist which little is known about in terms of effects on unborn children.

"About the only advice I can give you about drugs when you're pregnant is you shouldn't be exposing yourself to the unknown," Clarren said. "If you wouldn't give it to a baby, you probably shouldn't be taking it yourself unless you absolutely have to."

Clarren said only about six of the 500,000 drugs and organic chemicals sold by prescription and across the counter, or encountered, are absolutely known to cause birth defects. Medical specialists are suspicious of another 20 to 25, but the remainder are complete unknowns.

"About 25 percent of the birth defects are caused by genetic defects," Ms. Butler said. "The largest number of birth defects are unknown."

Alcohol now is known to cause about 10 percent of the mental retardation in birth defects, Clarren said, but until the early 1970s alcohol was still not known to be a problem.

"Is marijuana dangerous? We don't know," Clarren said. "We know very little about marijuana. We know very little about medication."

Everyone has from three to a dozen minor birth defects that are virtually not noticeable, Dr. Clarren said. A few major birth defects may occur, eventually go away and some can be cured, he said.

Ms. Butler told the students to learn as much as possible about their own genes. Quizzing older generation family members may uncover knowledge of birth defects that might help a genetic counselor. RH negative blood, for example, could cause birth defects, she said, and tests can determine if blood is negative.

The ideal age for giving birth is between 18 and 30, she told would-be mothers.

DR. STERLING CLARREN

CHARLENE BUTLER

Ms. Butler cautioned against taking medicines unless necessary, smoking, drinking alcohol, radiation directly to the stomach and exposure to infection, particularly venereal disease.

THE NATIONAL FOUNDATION-MARCH OF DIMES
REPORT OF PROGRESS UNDER MEDICAL SERVICE GRANT

University of Washington School of Medicine	Seattle	WA
Grantee Institution	City	State

Ronald C. Scott, M.D.	King
Program Director	Grantor Chapter

Calendar year covered by this Report: 1/1/81-12/31/81

1. Describe briefly the extent to which the activities you planned to initiate or continue under this grant actually were carried out during the year covered by this report. If the volume of services rendered can be expressed quantitatively, please do so, e.g. number of patients by diagnostic category, initial visits, return visits, etc. or numbers served with genetic services, prenatal care or other service.

The March of Dimes has been a driving force in initiating genetic services within the Pacific Northwest. They have initiated funding in support of diagnostic facilities to evaluate children with congenital defects, the counseling of families with genetic diseases, the diagnostic and treatment programs for children with metabolic disorders, and an educational program to the professional and lay community of the region.

The current grant has supported this program by funding part of a physicians salary and by supporting a genetic associate. The funding of these positions has allowed the above mentioned goals to be achieved in a highly organized manner and within the frameworks of an academic discipline at a major University.

The grant allowed for services to be extended to the Children's Orthopedic Hospital in Seattle and for the development of regional clinics within the Pacific Northwest. These regional clinics were established at Spokane and Tacoma, Washington and more recently at Walla Walla and Yakima. As a regional extension of genetic services, the program provides consultative services to the State of Alaska. Such services have been provided to the cities of Anchorage, Fairbanks, Juneau, Ketchikan, and Sitka on a routine and scheduled basis. Two physicians trained in Medical Genetics spend one week

every other month in the State of Alaska at the above mentioned cities. On those visits they offer diagnostic expertise to the physicians of the region who request their genetic expertise. Laboratory support in cytogenetics and metabolism remain centralized in Seattle with specimens being sent from Alaska to the appropriate laboratory. As part of the program in Alaska, an educational component is a strong contributing arm. Advanced announcements of the consultants visit are made by newspaper articles or short announcements on television programs. The visiting geneticists offer a wide ranging educational interview with one of the public newspapers or television stations in support of the birth defects and genetics program.

The strength of the program is the concept that specialize genetic and perinatal services can be centralized within a tertiary care center, but with coordination, dedication, commitment, and clinical support to a large region. It is our belief that this can be achieved at minimum expense and in an effective manner through professional commitment to the concept of regional responsibility. To this end, we believe we have been successful and have developed a model program in offering genetic services to the Pacific Northwest.

The actual number of families receiving assistance from this grant during 1981 are as follows:

I. Seattle Area

A. Children's Orthopedic Hospital Genetics Clinic: 301 families

B. University Hospital Genetics Clinic: 151 families

C. Biochemical Genetics Clinic: 118 families

D. Prenatal Diagnostic Clinic

1. University Hospital: 704

2. Swedish Hospital: 364

TOTAL 1068

II. Regional Clinics Within the State of Washington

1. Spokane Genetics Services: 169 families

   Prenatal Diagnostic Services: 83 families

   TOTAL 252

2. Tacoma Genetics Program: 66 families

   Prenatal Diagnostic Services: 50 families

   TOTAL 116

3. Walla Walla Genetics Program: 103 families

   Prenatal Diagnostic Services: 24 families

   TOTAL 127

III. Clinic Sites Within the State of Alaska

1. Anchorage

   12 clinic days: 158 families

2. Fairbanks

   3 clinic days: 22 families

3. Juneau

   3 clinic days: 32 families

4. Ketchikan

   2 clinic days: 10 families

5. Sitka

   1 clinic day: 7 families

2. Explain briefly any changes made during the year in
   (a) the kinds of services rendered under this grant;
   (b) the geographic area or population served;
   (c) the location or time schedule for these services;
   (d) the sources of referral used;
   (e) the schedule of charges, if any, for these services;
   (f) the composition of the professional staff engaged in rendering these services;

Several significant changes were made during this years grant period:

(a) Dr. Judith Hall has moved to University of British Columbia in Canada. Her loss represents a significant loss of clinical skills

that are available to our program. She represented a very dynamic and high quality force for the region.

(b) Dr. Virginia Sybert has assumed the responsibility for coordinating genetic services to the State of Alaska. One-half of her salary is funded by the State of Alaska to assist with this program. She participates in each visit to Alaska and selects an appropriate genetic specialist to assist her with these visits. We anticipate continued support from the State of Alaska for this aspect of the program.

Those individuals who served as consultants to Alaska during 1981 consist of the following:

Dr. Thomas Bird
Associate Professor
Division of Neurology

Dr. Peter Byers
Assistant Professor
Department of Medicine/Biochemistry

Dr. Judith Hall
Professor
Department of Medicine/Pediatrics

Dr. Arno Motulsky
Professor
Department of Pediatrics

Dr. Roberta Pagon
Assistant Professor
Department of Pediatrics

Dr. C. Ronald Scott
Professor
Department of Pediatrics

No visiting faculty was used during 1981.

Postdoctoral fellows in Medical Genetics participate in the clinical services and offered consultative assistance under faculty guidance as participants in the regional clinics. Participating fellows for 1981:

Dr. Susan Cassidy
Dr. Philip Chance
Dr. Robert Mueller
Dr. Jack Jung
Dr. Margot Van Allen
Dr. Jeff Murray

3. What, in your view, are the major strengths or accomplishments of your program?

The strength of the program has been the interdisciplinary nature and quality of the clinical faculty. We have been fortunate in having a well organized and centrally integrated program in which the members work well together and have been supportive of the service needs of the region. We have a sophisticated and supportive medical community that has been receptive to receiving genetic information for improving the quality of care for their patients. A significant administrative concept has been that of "in place" clinics under the direct medical supervision of local physicians who take the responsibility of supervising the regional clinics. The University personnel serve as "consultants" to the clinics. In this manner, local control for patient referral remains at the direction of the community with the University personnel only offering advice and assistance as requested.

4. What weaknesses or deficiencies do you see in your program, and what measures do you suggest for improvement?

The major problem in offering genetic services are the financial constraints that exist in offering time dependent, nonprocedure oriented medical services. With the decreasing availability of federal funds and the shifting of money into the "block-grant" concept, we once again will need strong support at the local level to assure continued support for genetic services.

C Ronald Scott
Signature of Program Director

1/25/82
Date

FEB 1 1982

C-242

THE NATIONAL FOUNDATION-MARCH OF DIMES
REPORT OF PROGRESS UNDER MEDICAL SERVICE GRANT

University of Alaska	Fairbanks	AK
Grantee Institution	City	State

Wayne W. Myers, M.D.	Northern Alaska Chapter
Program Director	Grantor Chapter

Calendar year covered by this Report: 1/1/81-12/31/81

1. Describe briefly the extent to which the activities you planned to initiate or continue under this grant actually were carried out during the year covered by this report. If the volume of services rendered can be expressed quantitatively, please do so, e.g. number of patients by diagnostic category, initial visits, return visits, etc. or numbers served with genetic services, prenatal care or other service.

The itinerant genetics and birth defects program conducted seven clinic tours providing 59 physician-days of clinic sessions and seeing 308 patients from 183 families. The number of patients seen this year increased 15% over the 267 patients seen in 1980. The latter figure similarly represented a 27% increase over the 210 patients seen in 1979.

Professional education conferences for physicians, nurses and special education teachers were conducted in conjunction with each clinic tour.

In addition, the March of Dimes grant supported the following explicitly educational activities. Dr. Louis Gluck traveled from the University of California, San Diego, to present a workshop on neonatal intensive care at the Alaska Perinatal Care Conference in Anchorage, and to present a training session for pediatricians in Fairbanks, Kathe Dobbs, R.N. and Zane Brown, M.D. of the University of Washington presented workshops in Juneau and Fairbanks. Nancy Warren of Childrens Orthopedic Hospital, Seattle, spoke on genetic counselling at the Alaska Year of Persons with Disabilities Conference in Anchorage.

2. Explain briefly any changes made during the year in

(a) The kinds of services rendered under this grant:

No substantive changes.

(b) The geographic area or population served:

Continue to serve entire state of Alaska.

(c) The location or time schedule for these services:

No change.

(d) The sources of referral used:

Both public and physician outreach has been improved since the state of Alaska hired a half-time genetics associate in Anchorage October 1, 1981. Referrals hav increased 25-30% for the last 2 clinics of the year.

(e) The schedule or charges, if any, for these services:

No charges, no changes.

(f) The composition of the professional staff engaged in rendering these services:
Dr. Virginia Sybert of Childrens Orthopedic Hospital in Seattle has been retained on half-time salary through contract with the state of Alaska to provide continuity of care. She participated in 5 of the 7 clinic tours.

3. What, in your view, are the major strengths or accomplishments of your program?

The itinerant specialist clinic program appears to be the only cost-effective approach to providing highly qualified consultants to Alaska's small and widely scattered population. The state of Alaska is now assuming financial responsibility for the program.

4. What weaknesses or deficiencies do you see in your program and what measures do you suggest for improvement?

The itinerant program is now well organized and smoothly running as we turn its support over to the state of Alaska. We may be calling for support from the National Foundation officers in addition to local chapters in this effort.

5. Any additional comments?

Without the support of the National Foundation, the development and maturation of the birth defects program in Alaska would not have been possible.

The Foundation should, I believe, count this as one of its many successes in improving the health of American families.

Signature of Program Director

28 Jan 82
Date

(original submitted to Dr Salisbury

1/30/76

ALASKA STATISTIC Jan. - Nov. 1981
(by Families)

	No. of Clinics	No. of Clinic Days	No. of Clinic Visits	
			NEW	RETURN
Anchorage	5	10	97	24
Fairbanks	2	2	10	3
Juneau	3	3	25	7
Ketchikan	2	2	8	2
Sitka	1	1	6	1
			146	37

REFERRAL SOURCE	Physicians	Self	Agency	Return
Anchorage	85	9	3	24
Fairbanks	10	1	0	3
Juneau	22	3	0	7
Ketchikan	8	0	0	2
Sitka	2	3	1	1
	127	16	4	37

DIAGNOSTIC CLASSIFICATION

GENERALLY 1 Diagnosis = 1 Family (except in cases where are multiple diagnoses per family). Does not reflect total number of patients seen.

Single Gene Disorder

Aarskog syndrome	1
Adrenal hyperplasia	1
Aniridia	1
Cleft lip/palate and periorbital edema	1
Coloboma	1
Cystinosis	1
Carrier (Duchenne muscular dystrophy)	1
Ectopia lentis	1
Ehlers-Danlos (III)	2
Friedreich's Ataxia	1
Hemophilia	1
Juvenile onset diabetes mellitus	1
Lymphedema & distichiasis	1
Marfan syndrome	3
MR, hypotonia, dysmorphic, CHD, hernia, hyperextensibility	1
Metaphyseal epiphyseal dysplasia	1
Muscular dystrophy (? type)	1
Myotonic dystrophy	1
Neurofibromatosis	5
Osteogenesis Imperfecta II	1
PKU	2
Renoglycosuria	2
Retinal disease	1
Retinitis pigmentosa	1
Sickle trait	2
Stargaardt's disease	1
Tay-Sach's screen	2
Tuberous sclerosis	1
Waardenburg	1
	40

Polygenic/Multifactorial

Asthma	1
Cleft lip/palate	1
Congenital hip dislocation	1
Constitutional short stature	9
Diabetes mellitus	1
Hypospadias	1
Mental retardation	2
Psoriasis	2
Neural tube defect	2
Seizures	3
	23

Chromosomal

Trisomy 21	3
14/21 Translocation	1
?Translocation Down syndrome	1
Turner syndrome	3
Trisomy 18	1
Triploidy	1
Ring 22	1
46XX/47XX+mar	2
47XXY	1
46XYp+	1
48XXXX	1
	16

Environmental

Mysoline during preg.	1
Radiation exposure	3
Cerebral palsy	2
In utero constraint	1
Herpes encephalitis	1
Fetal alcohol syndrome	1
Hydrocephaly	1
Metopic craniosynostosis	1
Birth anoxia	2
Ricketts	1
	14

Genetic Etiology Unclear, Not Genetic

Abnormal arm musculature	1
Amniotic band syndrome	1
Anterior placed anus	1
Aplasia cutis congenita (AD)*	1
Beckwith syndrome (AR)	1
Behavior problems	1
Bladder extrophy	1
Congenital hypothyroidism	1
Cornelia de Lange	1
Cyllosomus	1
Esotropia	1
Giant hairy nevus	1
Hemangioma	5
Holoprosencephaly	1
Klippel-Trenaunay-Weber	3
Marcus Gunn phenomenon	1
Microcephaly	2
Moebius syndrome (AD)	1
Nevus of Ota	1
Pectus excavatum	1
Poland's anomaly (AD)	1
Radial ulner synostosis	1
Tight frenulum	1
Unilateral limb reduction defect	1
Unilateral pulmonary hypoplasia	1
Urethral malformation complex	1
Cancer	1
Urticaria pigmentosa (AD)	1
	35

? Diagnosis

Achondroplasia VS Hypochondroplasia	1
Hypothyroidism	1
Leigh's encephalopathy	1
MR, R/O metabolic disease	1
Noonan VS Leopard syndrome	1
Mucopolysaccharidosis	1
Psychiatric problems	1
Tuberous sclerosis	1
Turner syndrome VS Neurofibromatosis	1
Urticaria pigmentosa	1
Urea cycle abnormality	1
X-linked mental retardation	1
	12

Normal, Condition R/O

Down syndrome	1
Klinefelter's syndrome	2
Hypothyroidism	1
Premature thelarche	1
Head growth	1
Developmental delay	1
Prader-Willi syndrome	1
Failure to thrive	1
Peutz-Jehger	1
	10

Other

Multiple miscarriages	3
Advanced maternal age	2
Infertility	1
	6

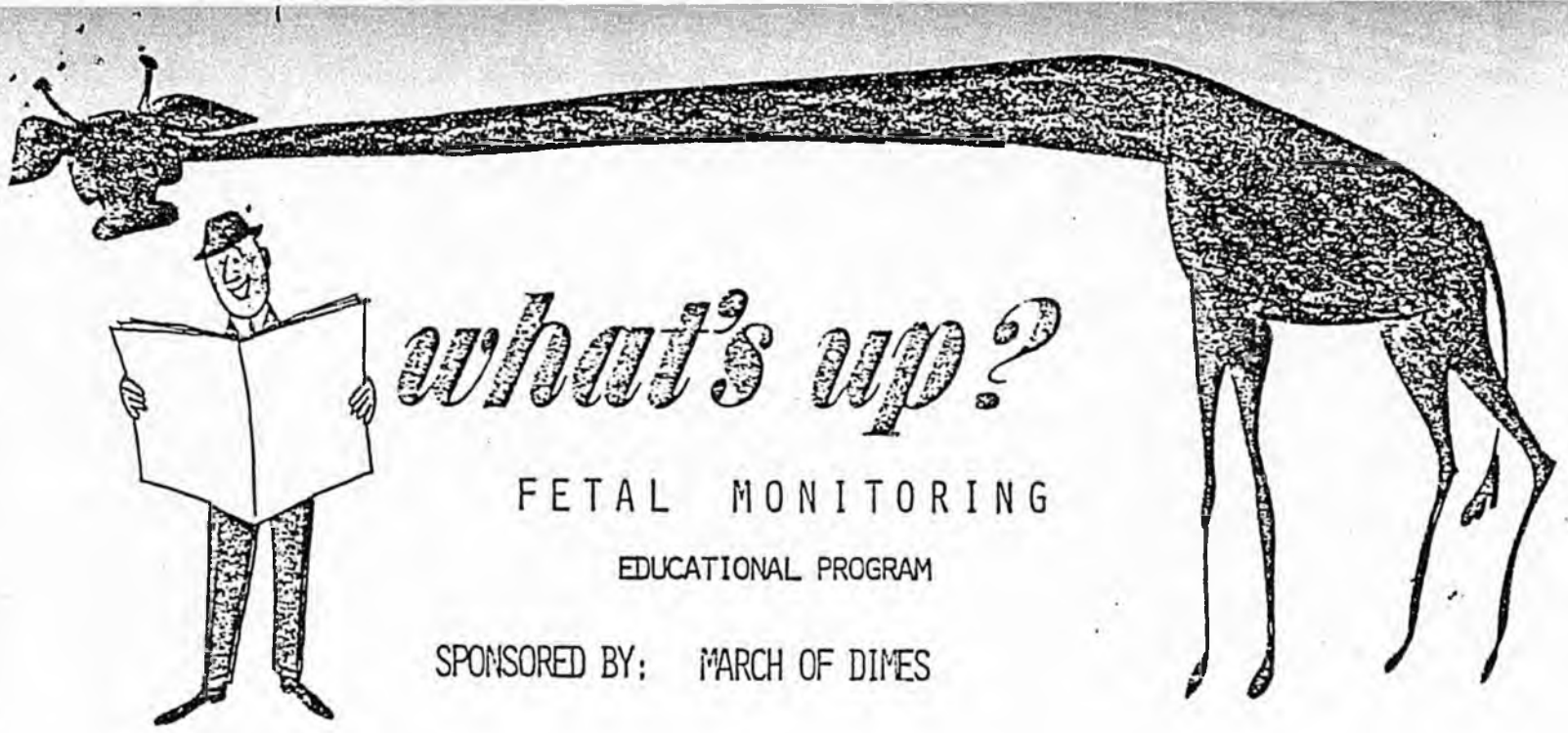
Unknowns

See page 4

* = (AD) (AR) Cases have been reported with these modes of inheritence in the literature. ? etiology in our cases above.

Unknowns

Vertebral anomalies, facial assymmetry, microophthalmia	1
MR, precocious puberty	1
Craniosynostosis, polydactyly, syndactyly, situs inversus	1
Triphalangeal thumbs, short forearms, pyloric stenosis, hypospadias	1
Anal atresia	1
Cystic kidneys, rudimentary bladder, bicornate uterus, dupl. vagina	1
Short stature and delayed puberty	1
Hernia, cryptorchidism, bilateral dislocated hips, hypospadias	1
Short stature, club foot, MR	1
Hernia, omphalocele, dysmorphic facies, scoliosis, craniosynostosis	1
Nystagmus, microcephaly, micrognathia, microphallus	1
Microcephaly, IUGR, short stature, MR, dysmorphic facies	1
Developmental delay and hypodontia	1
Absent right thumb	1
Genuvarum	1
Sensorineural hearing loss & seizures	1
Mental retardation	3
Dysmorphic facies, pulmonary stenosis	1
Short stature	2
Congenital heart block and genitourinary abnormalities	1
Sensorineural hearing loss	1
Choanal atresia and mental retardation	1
Hydranencephaly, large ears, abnormal scrotum	1
Developmental delay, hydrocephaly, dysmorphic facies	1
Dev. delay, dysmorphic, overlap of toes 2 & 3, tapering fingers	1
Dysmorphic, fixed joints, synostosis, motor delay	1
Devl delay, minor dysmorphic facies, ear abnormalities	1
	30



what's up?

FETAL MONITORING

EDUCATIONAL PROGRAM

SPONSORED BY: MARCH OF DIMES

PRESENTED BY: Kathe Dobbs, R.N. and Zane Brown, M.D.
Regional Perinatal Care Program, University of Washington

DATE: Friday, October 9, 1981 10:30 a.m. - 4:45 p.m.
Saturday, October 10, 1981 9:00 a.m. - 12:30 p.m.
Self-assessment quiz 12:30 p.m. - 1:30 p.m. (may be taken here)

PLACE: Chandler Room, Fairbanks Memorial Hospital

FEE: None TO REGISTER: Call 452-8181, ext. 503

SCHEDULE OF TOPICS:

October 9 - Introduction to Monitoring (for those new to fetal monitoring)
Premature Labor
Antepartum Fetal Assessment
Workshop A - Strip Interpretation - Antepartum Tracings
Workshop B - Strip Interpretation - Baseline and Variability Examples
Mechanics of Monitoring and Fetal Arrhythmias

October 10 - Labor and Implications for the Fetus
Workshop C - Strip Interpretation - Periodic Changes
Workshop D - Strip Interpretation - Decreasing Fetal Reserve with Periodic Changes
Strip Interpretation - Your Cases - Stump the Expert!

NOTE: Workshop portions will have two presentations: one for the beginning level, one for advanced. Please indicate which level you are planning to participate in when registering.

Physicians and nurses are invited to attend.

FMH nurses are urged to schedule time off with their Head Nurse or Supervisor.

C E A R P credit has been applied for.

March of Dimes
BIRTH DEFECTS FOUNDATION
Public Information Department / 1275 Mamaroneck Avenue, White Plains, New York, 10605 / 914-428-7100

News Release

contact: Martha Kongshaug
914-428-7100

FOR IMMEDIATE RELEASE
(mailed Feb. 25, 1982)

Expanded medical insurance coverage to include services related to genetic illnesses is being studied by the Blue Cross and Blue Shield Associations.

The one-year study is being supported by grants from the March of Dimes Birth Defects Foundation and by the Bureau of Community Health Services, Department of Health and Human Services.

Support for counseling services for inherited disorders such as Down Syndrome, sickle cell anemia, or Tay Sachs disease now comes chiefly from March of Dimes and programs administered by HHS. Those agencies are funding the study to investigate the possibility of private reimbursement that will remove financial barriers to obtaining genetic services.

The $181,968 study will focus on payments for screening and diagnostic work for a host of genetically transmitted disorders.

Coverage to include counseling services for prospective parents at risk of transmitting a genetic disease will also be investigated.

-MORE-

"Many insurance plans do not cover genetic services at all, and there is little consistency among those that do," said Dr. Arthur J. Salisbury, March of Dimes vice president for medical services.

Although most genetic illnesses are rare, collectively they have a major impact. It is estimated that 30 percent of admissions to children's hospitals are the result of genetically related disorders and that such disorders account for 40 percent of pediatric mortality. Approximately 4.8 million Americans are retarded as a result of genetically related diseases.

Insurers have been reluctant to pay for screening services or for the services of non-physician genetic counselors, according to Dr. Vincent Hutchins, Director of the Office of Maternal and Child Health, Health Services Administration. "Without these components, the victims of these illnesses will not have adequate information or explanations of options to make educated decisions about having a family," Hutchins said.

Each year, the birth of genetically handicapped children in the U.S. creates a future commitment to custodial care of more than $2 billion. Dr. Hutchins noted that "insurance coverage for screening, diagnostic and counseling services will make more money available to support scientific research into the prevention and treatment of genetic illnesses."

-MORE-

Screening of prospective parents who might be carriers of certain genetic disorders enables them to know the risks of having a handicapped child before they conceive. After conception, diagnostic tests often can determine whether a child has been affected by a genetic disorder. In some instances treatment for the disorder can begin before the child is born.

Among items to be investigated are what services could be included under a genetic services benefit, how much it would cost, and its market potential. The study will also review related administrative issues.

Though the study's immediate impact may be to affect the coverage of the Blue Cross and Blue Shield Plans, in the long run it could shape coverage provided by other insurers and federal health care programs.

# # #

MARCH OF DIMES BIRTH DEFECTS FOUNDATION STATE OF ALASKA

The entire State of Alaska is serviced by the MARCH OF DIMES BIRTH DEFECTS FOUNDATION through the four Chapters listed below together with the name and address of the Chapter Chairman.

Local community representatives of these four March of Dimes Chapters are appointed yearly for fund raising and other programs of the March of Dimes Birth Defects Foundation.

Peoples File

NORTHERN ALASKA CHAPTER

Mrs. Ardella Telfer
CHAPTER CHAIRMAN
2740 Kuskokwim
Fairbanks, Alaska 99701
TEL: (907) 452-2461

SOUTHCENTRAL ALASKA CHAPTER

Ms. Iyllamae Olsonoski
CHAPTER CHAIRMAN
1317 Crescent Avenue
Anchorage, Alaska 99504
TEL: (B) (907) 264-7412
(R) (907) 278-9177

Ms. Lora Alexander
EXECUTIVE DIRECTOR
P. O. Box 164
Anchorage, Alaska 99510
TEL: (907) 279-2622

STATE VOLUNTEER ADVISOR

Mrs. Grayce Oakley
2458 Sprucewood
Anchorage, Alaska 99504
TEL: (907) 277-7407

SOUTHEASTERN ALASKA CHAPTER

Mrs. Pat Vadman
CHAPTER CHAIRMAN
P. O. Box 410
Juneau, Alaska 99802
TEL: (907) 789-9112

STATE VOLUNTEER ADVISOR

Mrs. Venetta Hildebrand
Box 184
Douglas, Alaska 99824
TEL: (907) 364-3222

TONGASS CHAPTER, ALASKA

Mrs. Phyllis Yetka
CHAPTER CHAIRMAN
Box 928
Ward Cove, Alaska 99928
TEL: (907) 225-5146

STATE VOLUNTEER ADVISOR

Mrs. Phyllis Yetka

REGIONAL DIRECTOR

Mr. Felix A. Montes
414 Securities Building
Seattle, Washington 98101
TEL: (206) 624-5470

The areas covered by the Chapters named above correspond to the four judicial areas of Alaska with the First Judicial Area having been divided into two Chapter areas with the Wrangell Narrows as the dividing line. The two Chapters resulting are the Southeastern Alaska Chapter and the Tongass Chapter, Alaska. The Northern Alaska Chapter encompasses the Second and Fourth Judicial Division.

January, 1982

To: Charlie

From: Nancy

RE: Proposal for Birth Defects Specialist from WAMI

All reports show that this has been an excellent program in the past, amd in view of the high rate of congenital abnormalities in Alaska, it would seem that is should be continued.

zthe Department of Health and Social Services does not have the flexibility of budget to request money for this, though Dr. Dave Spence has drawn up a proposal for considerably less money than the one submitted by Dr. Meyers of the U of A.

Dr. Spence's budget is for $53,000 and will rely heavily on volunteers from the March of Dimes to make this program work. The money is for ½time genetic associate ($13,000) and the remainder to go to the University of Washington for the salary, travel and per diem of the Birth Defects specialist.

Traditionally, the Department has paid for diagnostic services for every child, and then has a sliding scale for treatment costs through the Handicapped Children's Program. This is subject to sporadic use, and the fund can be easily used up by one very ill child. Unfortunately, at the end of the last fiscal year, there was an overrun of $290,000 and consequently the BRU was cut by the legislature. The fund is empty this year, and no more children can be served, and they have been told that there will be no supplemental appropriation.

This is a good program, and there is no specialist in the state. Families will have to go outside for diagnosis and treatment with no public funds available this fiscal year. It seems like a minor appropriation and a good use of WAMI.

Would you like to submit a bill?

UNIVERSITY OF ALASKA, FAIRBANKS
Fairbanks, Alaska 99701
WAMI Medical Education Program
January 25, 1982

The Honorable Charles Parr
The Alaska Senate
Pouch V
Juneau, AK 99811

Dear Charley:

Would you please give serious consideration to supporting legislation, based on the attached draft material, to maintain and strengthen a birth defects prevention and treatment program for Alaska?

Birth defects exert lifelong impairments for affected children. Medical understanding of these conditions has enormously expanded in the past two decades. Today over 600 syndromes are recognized. Most are individually rare but in the aggregate affect at least 4 percent of all newborns--500 infants in Alaska each year.

Because of the rarity and complexity of many of these problems, their management requires the services of physicians specializing in this area. Such physicians are only found in major medical centers. No such specialists are currently practicing in Alaska.

An itinerant birth defects clinic program in Alaska was initiated by the March of Dimes in the early 70s and has been supported by MOD thru a series of annual grants to the WAMI Program. The March of Dimes is no longer able to continue this support.

The Department of Health and Social Services has provided assistance as its resouces have permitted, largely thru the use of certain Federal funds which are now disappearing.

Both the March of Dimes funds and state funds have been used to partially support a birth defects specialist position thru the University of Washington School of Medicine, travel expenses for 7 to 8 itinerant clinics per year serving Ketchikan, Juneau, Sitka, Anchorage, Fairbanks and occasionally Bethel, and a trained coordinator in Anchorage.

The attached draft authorizing bill and budget are intended to permit Department of Health and Social Services support of this program. The alternative is expensive with disruptive and recurring travel to medical centers

outside of Alaska for the children and their families. This is often at state expense. It is more cost effective to bring one or two specialists to substantial numbers of children, than to bring families to the specialists. The added benefit of education, advice and training provided by these itinerant specialists to local school, medical and nursing personnel further contribute to the day-to-day care of the children and assistance to these families.

I have initiated this modest legislative effort simply because I am convinced that it is in the best interest of the citizens of Alaska. The program which I administer anticipates no financial interest in this arrangement.

Sincerely,

Wayne W. Myers, M.D.
Director, WAMI Program

Attachment

Distribution:

Senate	House
Don Bennett	Michael Beirne
Richard Eliason	Thelma Buchholdt
Vic Fischer	Terry Martin
Jalmar Kerttula	Mike Miller
Charles Parr	Joe Montgomery
Bill Ray	Sarah J. Smith
Arliss Sturgulewski	
Robert Ziegler	

POSITION PAPER/Department of Health & Social Services

POSITION PAPER
SENATE BILL NO. 737

"An Act making a special appropriation to the Department of Health and Social Services to combat the causes and effects of birth defects."

This bill appropriates $100,000 to this Department that may be utilized over the next 5 years, for which will continue to enhance a birth defects counseling service. In the past, this program was initiated and continued for several years by the National Foundation for Prevention of Birth Defects. It is anticipated that we will have to find another source to fund this service as that voluntary organization has indicated that other priorities have emerged for their support.

The Birth Defects program provides services ranging from diagnoses or confirmation of diagnoses, management and counseling. The categories covered include genetic disorders, chromosomal disorders (e.g. Down Syndrome), environmental (e.g. fetal alcohol syndrome) and those syndromes and malformations of unknown origin. They also receive many requests for information regarding amniocentesis, sickle-cell screening, drug exposure during pregnancy, etc.

The needs for services are rapidly increasing. The March of Dimes Birth Defects Foundation estimates that 1 out of 12 babies born has a significant birth defect. In Alaska during 1981, the Department of Vital Statistics recorded approximately 9550 live births, which statistically could represent almost 800 babies with significant birth defects. This is twice the number they can see in one year. A viable contracting mechanism has been established with the University of Washington using available Federal funds in addition to Foundation money. Federal funds are not available for FY 83 or beyond. This mechanism serves four cities in Alaska every two to four months. A continuation level would require close to $50,000 per year An expansion of the frequency and geographic availability of this service would require the expenditure of some additional funds.

POSITION

This service is considered by the Department to be a much needed preventive and cost effective program.

8% children in gen hosp there because of birth defects
clinics 6 yr in Anch
" 1 " " Ekks
" 3 " " Juneau & Ketchikan

Recommended by: E.S. Rabeau

E.S. Rabeau, M.D., Director
Division of Public Health

Date: March 3, 1982

Approved by: Helen D. Beirne

Helen D. Beirne, Commissioner
Department of Health and
Social Services

Date: 3-3-82

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. Senate Bill No. 737
Title "An Act making a special appropriation to the Department of Health and
Requested by Senate HESS Date 2/10/82
Social Services to combat the causes and effects of birth defects."

II. FISCAL DETAIL
Agency Affected Department of Health and Social Services
Program Category Affected Health/Public Health
BRU, Program, Or Subprogram(s) Affected Child & Family Health
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES	0	0	0	0	0	0
200 TRAVEL	0	0	0	0	0	0
300 CONTRACTUAL	0	0	0	0	0	0
400 COMMODITIES	0	0	0	0	0	0
500 EQUIPMENT	0	0	0	0	0	0
600 LAND & STRUCTURES	0	0	0	0	0	0
700 GRANTS,CLAIMS,ETC.	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

FUNDING (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER (Specify Source)	0	0	0	0	0	0

POSITIONS

FULL TIME	0	0	0	0	0	0
PART TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

III. ANALYSIS (See Fiscal Note Preparation Instruction, Section III)

The $100,000 appropriation in this bill may be expended over a 5 year period.

IV. DATE March 3, 1982 PREPARED BY E.S. Rabeau, M.D.
AGENCY Dept. of Health & Social Services
PHONE 465-3090

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/81)

SB
747
-13

COMMITTEE REPORT

SENATE

FINANCE

2/11/82

FURTHER: None

Date: 2-12-82

Mr. President:

The Committee on HEALTH, EDUCATION & SOCIAL SERVICES has had SB 747 relating to midwifery

under consideration and (a majority of the committee) (the committee) reports it back with the following recommendations:

[X] do pass [ ] do not pass

[ ] do pass with attached amendments(s)

[X] replace with CS for _____ [ ] same title [ ] new title

and recommends _____

[X] AND attaches a "Letter of Intent" [ ] New Fiscal Note

[ ] reports it back without recommendation

[ ] referred to the _____ Committee

MEMBERS SIGNING
DO PASS

MEMBERS HAVING
OTHER RECOMMENDATIONS:

CHAIRMAN

S 60 (Rev. 12/78)

3924 E. 8th Ave #2
Anchorage, Alaska 99504
March 7, 1982

Senate and House Health, Education, and Social Services Committee
Pouch V
Juneau, Alaska 99811

Dear Sir:

I would like you to vote in favor of Senate bill #747, regarding the legelization of midwives and the establishment of a midwifery board. Homebirths and having midwives present at births is a part of our heritage. Although this practice had diminished in the recent past, it is on the rise again. I feel it is a beautiful way to bring a child into this world as opposed to being plugged into a machine and being injected with drugs at birth in a hospital.

The federal government recognizes midwives and uses them in Alaska at Elmendorf AFB, the Alaska Native Hospital, and throughout the State. With proper management midwifery can be a useful and rewarding program for our state, as it is for the federal government.

I realize that persons in the medical profession will lobby against this bill but their's are selfish -monetary- interests. Please vote as the common people in Alaska would have you represent them, in favor of midwifery in Alaska.

Sincerely,

Thomas Malone
Thomas Malone

Karen Malone
Karen Malone

cc: Charles Parr
Terry Stimson
Mike Coletta
Vic Fisher
Tim Kelly

Received by
Date 3-16-82
N.D.

Alaska State Legislature

Senator Vic Fischer · Pouch V · Juneau, Alaska 99811 · (907) 465-4954

February 16, 1982

To: Members of the Senate and interested parties

From: Senator Vic Fischer

Re: Senate Bill 747 - relating to midwifery.

SB 747 creates a mechanism for voluntary licensing of "lay midwives through a board of midwifery under the Department of Commerce and Economic Development, Division of Occupational Licensing.

Introduced by request of individual midwives, childbirth educators, and health care providers, this bill is primarily concerned with providing a degree of consumer protection and information not available under current practice.

The traditional and cultural use of midwives and the demand for midwifery service, particularly for out of hospital births, is increasing in Alaska without adequate regulation and licensing. This bill provides a method of regulating midwifery in the public interest to assure that users of midwifery services are aware of the competency levels of their health care providers.

A key element in this bill is the concept of voluntary licensing. Regulatory boards are often accused of creating a "limited entry" in their field by refusing to grant licenses. This legislation creates a board of midwifery to test, regulate and license qualified midwives and makes it unlawful for a person to represent oneself as a licensed midwife or use any designation that implies that a person is licensed or certified by the state to act as a midwife. The bill does not, however, prohibit the practice of midwifery in the state without a license.

The concept is simple: the state has a legitimate interest in assuring that consumers of midwife services have the information available to make an informed choice of health care providers but should not hinder, prevent or interfere with consumers exercise of free choice in childbirth services.

SB 747 establishes experience and education levels for licensing, permits use of certain procedures and drugs by licensed midwives, requires ongoing education and experience, provides for apprenticeship training, and it requires midwives to keep statistical records available to the public. The bill establishes standards of practice and professional conduct and subjects licensed midwives to criminal penalties or suspension for violations of the provisions for licensure.

American College of Surgeons

FOUNDED BY SURGEONS OF THE UNITED STATES AND CANADA, 1913

COMMITTEE ON TRAUMA

George M. Longenbaugh, M.D., F.A.C.S.
Chairman, Alaska State Committee
Box 377
Sitka, Alaska 99835

March 25, 1982

The Honorable Charles Parr, Chairman
Health, Education and Social Services Committee
State Capitol
Pouch V
Juneau, Ak. 99811

Dear Senator Parr,

I would like to address the Committee regarding Senate Bill #347, an act relating to midwifery.

First of all, I am a graduate of the University of Colorado School of Medicine, with surgical residency in Baltimore. I came to Alaska in 1962 and was Chief of Surgery at Public Health Service Hospital, Mt. Edgecumbe, Alaska. I have been in private practice in Sitka since 1967, as well as consultant Chief of Surgery at the Mt. Edgecumbe Public Health Service Hospital since 1971. I am currently Chief of Staff at the Sitka Community Hospital and Chief of Surgery at Sitka Community Hospital.

During my years in Alaska, although I have not practiced obstetrics, I have, as surgeon in this small community, served as consultant and as the primary physician for most Cesarean sections performed during these years. I have also been active in Emergency Medical Services, served as medical advisor for the Southwest Regional Medical Services during the last several years and currently director of American College of Surgeons, Committee on Trauma, for the State of Alaska.

I believe that Senate Bill #347 is seriously flawed and its basic concept, that of licensing midwives who have not had medical training, encourages a pattern of obstetrical care which is certainly not in the best interest of survival for mother or infant. Delivery of children is certainly a natural process, and we realize that in the vast majority of deliveries is readily accomplished without a great deal of medical intervention. However, there is a significant percentage of mothers-to-be who at some point in their pregnancy have problems either immediately with their delivery or earlier. It is to this group of obstetrical patients that the encouragement of untrained attendants would do the greatest disservice. It seems to me that there are two factors involved in the management of the obstetrical patient that are often critical to the outcome of both mother and child.

1. The experience and training of the attendant.
2. The equipment and facility available to that attendant in the event there may be an unforeseen event.

In my role as consultant to various people practicing obstetrics over the years, it ha certainly been apparent to me that the degree of training and experience is directly related to the complications encountered in the course of the delivery. I cannot belie that the attendence by an essentially untrained and minimally experienced person would have a significant influence on the presence of complications.

We here in the Sitka community have had some experience with home delivery, as at one t there was a physician here who promoted home delivery; however, the only neonatal death a full term infant to occur in this community over the span of many years happened in a sociation with a home delivery performed by a physician.

Again, I think that there is no question that the experience of the operator, including the facility and equipment available to him are factors in preventing various complicat and death in the obstetrical practice. I believe that the licensing of minimally or un trained individuals to do deliveries would be a distinct disservice to the patients, as well as the society as a whole.

I appreciate this opportunity to submit this testimony for the consideration of your committee.

Sincerely,

George H. Langenbaugh, M.D., F.A.C.S.

GHL:pb

My name is Beth Cox and have lived in Sitka for 15 years. I am also President of our Local NARSAC organization and a member of TCIA.

I urge the passage of SB 747 for one main reason. I believe childbirth is a natural physiological event and should be treated as such. This not always available in today highly technological medical society.

I believe people should be allowed to have and choose safe alternatives in childbirth.

Midwifery is here to stay. You can outlaw midwifery but, you can't make it disappear.

To formal parents don't care if a Midwife is a nurse or not. They don't care if she is trained formally or informally. They just want her to be appropriately skilled, experienced and reliable by whatever means accomplished

I ask you to kill SB so that quality care will be available no matter where you choose to give birth.

From:
Beth Cox
Box 878
Sitka, AK.
(PAGE 1 of 1)

Senator Charlie Farr

Ness Committee

Pouch V

Juneau, Alaska 99811

Senator Charlie Farr and all other legislators

Sir:

I am a mother, a mother-to-be and a childbirth educator in the Sitka area. I am in support of SB 747 "An Act Related to Midwifery". I know people in this area would like an alternative to the hospital births available. Many are forced to labor in crowded labor rooms, transfered to the one delivery room and on occasion returned to a room with a mother still in labor. How can one hope to have a good birthing and bonding experience under these conditions?

The medical community should be here to help everyone. When they refuse their services because a couple wants a home birth, they are not fulfilling their obligations.

Right now in Alaska, there is no way for the consumer to judge a midwifes ability. This bill would help do this and the way it does seems fair. Attending 20 births in Sitka would be very hard and considering most of Alaska has a population less than this area, it is very limiting. However, if a person meets the standards excepted by the liscencing committee, then I would feel they are able to handle births.

A college education does not improve your value as a midwife. It is the experience and knowledge gained through actual birthing that makes a good midwife. Some people are born with a natural ability and desire to attend births. They may

spend their lives gaining knowledge and skill in this area alone. They would be able to meet the needs of the birthing community along with nurses, CNM and doctors.

I urge you to support SB 747.

Sincerely,

[signature]

Senator Charlie Parr
HESS Committee
Pouch V
Juneau, Alaska
99811

Senator Charlie Parr and all other Legislators

Sir:

I am in support of SB 742 "An Act Related to Midwifery". I feel that pregnancy and childbirth is a natural physiological process and, as such, a state of wellness rather than disease. For that reason, I feel that safe birthing alternatives such as midwifery within birthing center and home deliveries be offered as options as well as the hospital settings.

I urge you and other legislators to support passage of this bill, so families might exercise their freedom of choice in matters relating to safe, healthy childbirth.

Sincerely,

From:
Bill Stokes
Box 1141
Sitka, AK.

For Senate HESS
PAGE 1 of 1

March 25, 1982

[illegible] Legislative Information Office
[illegible] Lake Street
[illegible], AK 99835

RE: Senate Bill 747

Dear Sir:

I am for Senate Bill 747 and would like to see it go through. We want safe alternatives in child birth and the licensing of midwives would all this because the people coming into Alaska would have a way of judging the performance of our midwives.

Sincerely,

Drusilla Kennedy Palmer
Box 1990
Sitka, AK 99835

SITKA COMMUNITY HOSPITAL
P. O. Box 500 • Sitka, Alaska 99835 • (907) 747-3241

March 25, 1982

We, the undersigned, are unalterably opposed to SB 747. We strongly endorse the position of the Alaska Nurses' Association and urge you to vote NO on the licensure of lay midwives.

If this bill passes, the state is endorsing and encouraging lay midwifery, and in effect, telling the people of the state of Alaska that the licensed individual is well qualified. Without extensive education and experience requirements and defined standards of practice this piece of legislation only creates a false sence of security for the consumer.

On next page

Cheryl Johnson RN Director of Nursing — Cheryl Johnson
Patricia Gomez RN Head Nurse — Patricia Gomez
Suzanne Fitton RN Staff nurse — Suzanne Fitton
[illegible] RN — [illegible] Stablein
Kay Keegan Campbell RN — Kay Keegan Campbell
[illegible] RN [illegible] — [illegible]
Linda K. Cook RN OR Supervisor — Linda K. Cook
Jean M. Young RN — Jean M. Young
Dorothy A. Boose RN — [illegible]
Dana Hebbel FNP — Dana A. Hebbel

cc: Senator Charles Parr, Chairman, Health, Education and Social Services
Senator Terry Stimson
Senator Mike Colletta
Senator Vic Fischer
Senator Tim Kelly
Senator Dick Eliason
Rep. Ben Grussendorf

MSG 82-00016873 PRTY 1 03/26/82 09:56:03 ORIG: LS00 IN= 0004 OUT= 0009
FROM: ELAINE TO: SUE
TARGET: LJH2 SUBJ: NAMES ON TELECOPY
PAGE 0001

THE TELECOPIED MATERIAL ON "SITKA COMMUNITY HOSPITAL" LETTERHEAD IS SIGNED BY

SHERYL JOHNSON, RN, DIRECTOR OF NURSING
PATRICIA GOMEZ, RN, HEAD NURSE
SUSANNE FILTEAU, RN, STAFF NURSE
RICHARD STAKLISTER (?), RN
PEGGY KEEGAN CAMPBELL, RN
JOANNE CLYDE, RN, INSERVICE C.S.C.H.
LINDA K. COOK, RN, O.R. SUPERVISOR
JEAN M. YOUNG, RN
DOROTHY A. DREIER, RN.
DONNA HEBBELER, FNP

I WILL XEROX THE MESSAGE AND MAIL TO EACH LEGISLATOR COPIED; HOWEVER, PLEASE GO AHEAD TO DISTRIBUTE TODAY PER REQUEST OF PEOPLE WHO BROUGHT IN THE MATERIAL THANKS.

Childbirth experiment goes well

by Peter Eisner
Associated Press

Fortaleza, Brazil — A pilot project that teaches basic health care to women in Brazil's poorest region may provide a Third World cure for the disease and death that threaten childbirth among the world's impoverished millions.

"The only pediatrician a new baby usually needs is its own mother," says Dr. Galba Araujo.

The Brazilian obstetrician has organized a network of traditional rural midwives who are taught methods that blend with traditional health care. They also learn to recognize warning signals in the few births which require a doctor's attendance.

"We've never had a woman die in childbirth," Araujo said in an interview. "The statistics show that 94 percent of the births were without complications."

With more than 8,000 births in five years, the project, supported by U.S. private money and Brazilian government funding, has also slashed the rate of infant death in one of the world's highest population growth areas.

"Underdeveloped countries have been imitating the developed countries in providing health care," Araujo said in an interview. "They have been adopting technology at high cost. But nobody can afford to pay."

The pilot project here stresses inexpensive methods which require minimal training, and also provides local training in famliy planning and birth control — a sensitive subject in this predominantly Roman Catholic country.

U.S. population specialists, based in Brazil, praise Araujo's work. With two-third of the world's people living without adequate medical care, these specialists say, the project may have major implications in the coming decades.

Araujo cited U.N. statistics which show that, if present trends continue, there will be three billion births worldwide between now and the year 2000. The statistics also indicate that one billion of those infants will die, an additional 400 million will not reach a year of age and 100 million women will die in the birth cycle.

Araujo, medical director of the Maternity Hospital in Fortaleza — an Atlantic coast city of 1.3 million 1,500 miles north of Rio de Janeiro — says the data he is gathering show at least 85 percent of pregnant women

making birth more a matter of surgery than a physiological act," said Araujo, who has sponsored international forums on health care and has lectured in the United States and elsewhere.

Araujo's project, which receives grant money from the Ceara State government, federal health officials and the Kellog Foundation of the United States, has established a series of regional and local health clinics. He and other physicians enlist the help of traditional midwives and offer them group training.

The project advocates the use of "birthing stools," either at home or in a clinic, instead of giving birth lying down. The birthing stools — which can be a simple as a wooden chair with part of the seat removed — place the mother in a squatting position so that gravity aids the birth process.

Three hundred midwives have been trained in Ceara state, learning about problems of infection and about modern preventive care. They also are taught warning signals of birth problems and can refer mothers to local "satellite clinics" for better care. The satellite clinics, in turn, can refer patients to "base hospitals" for more sophisticated help.

There are now eight satellite centers and three base hospitals. Araujo says he and the state health department plan to double the number by 1983, with eventual plans to cover the entire state.

Ceara, with a population of more than five million, is in Brazil's drought-stricken northeast poverty belt. The birth rate here is higher than the national rate of 36 per 1,000 and the infant mortality rate higher than the national rate of 109 per 1,000.

The statistics at the satellite center at Aquiras, 25 miles from Fortaleza, are markedly better. Since the clinic opened on May 1, 1977, there have been 2,359 admissions and 1,803 births. An additional 329 cases were referred to the Fortaleza center and other women received pre-and post-natal care. There were 26 infant deaths among the 1,936 births, a death rate of 12 per 1,000 — one-eighth of the national average and lower than the U.S. infant mortality rate of 15 per 1,000. The overall statistics in the Ceara project are similar, Araujo said.

The coordinator of the Aquiras Center, Dona Teresinha Pereira Lins, herself a traditional midwife, said the clinic has been able to convince reluctant local residents that the free health service works.

"I began learning (to be a midwife) from my grandmother when I was 21," she said. "When I got here, everything was different. But now, everyone is used to it and we deliver 50 to 60 babies a month."

Araujo said the northeastern project has important lessons for more developed areas of Brazil, as well as for countries like the United States.

I believe you would find these statistics to be much better than most in Alaska, even in Anchorage. Our infant statistics are comparable to methods in Alaska are known for their inaccuracy and lack of completion.

HOME BIRTH—HOW SAFE IS IT?

by Robert E. Brooks, PhD., former professor of Quantative Analysis, University of Southern California

One of the most common assumptions which doctors make when criticizing home birth is that they are much more dangerous than births in the hospital. Note that we say "assumptions" because, in fact, there is no proof at all to support such assertions.

According to Wegman (1975) the United States ranked 15th in infant mortality rates for 1973. (See Table 1)

The differences between the top six countries and the U.S. is quite substantial: the U.S. infant mortality rate is more than 50% higher than the sixth placed country, Norway. Yet this can hardly be blamed on home birth since only about 3% of births in the U.S. occur at home.

In fact in nearly all of the top twenty countries most births take place in some type of hospital or maternity home. The one exception to this fact is Holland where fully 53% of births took place at home. Huygen (1976) in his classic paper on home deliveries in Holland cited statistics showing the perinatal mortality rate for home births in 1970 to be only 6.9 per 1000 live births compared to 33.8 per 1000 for hospital deliveries. Since high-risk mothers are usually referred to hospitals for their births in Holland, one cannot conclude from these statistics that home birth is five times safer than hospital birth. On the other hand one can certainly conclude that it is possible to have a system wherein a low risk mother can have her baby at home with an extremely high chance for a safe birth.

In addition Huygen states that he has "serious doubts about the desirability and safety of hospital for normal deliveries. Home births offer important advantages from an emotional and psychological point of view. Research has made it clear that many women prefer to have their babies at home." And regarding the technology available in the hospital, "I feel that these advantages in technology at the same time carry with them the risk of unnecessary intervention."

Even though the percentage of home births in the U.S. has been small, it has experienced a rapid growth in the past few years. Statistics on the entire population of home births are not available. Some studies have been done, however, which can be used to indicate what kind of safety one can expect from home births.

Dr. Lewis Mehl's analysis of 1147 elective home births in northern California revealed the following outcomes (see Table 2).

In this study the incidence of infant mortality is less than half as much for home birth as it is for all births in California in 1973. While the total number of home births represented in this study is not large enough to statistically conclude that home birth is twice as safe as hospital birth, it is certainly indicative that the physicians' assumption that home birth is much more dangerous must be seriously questioned.

TABLE 1 - INFANT MORTALITY RATES (1973)

Country	Deaths per 1000 Live Births	% Hospital	Attendee
Sweden	9.6	100	Midwife
Finland	10.0	99.9	Doctor or Midwife
Japan	11.3	89.9	Doctor
Netherlands	11.5	47	Doctor or Midwife
Denmark	11.5	85	Midwife & Doctor
Norway	11.8*	99.4	Midwife
Switzerland	13.2*	99	Midwife
France	15.5*	97	Doctor
Canada	15.6	97	Doctor
German Democratic Repub.	16.0	98	Doctor
New Zealand	16.2*	100	Doctor
Australia	16.5*	most	Doctor
Hong Kong	16.8*	76	Midwife
England & Wales	16.9	96	Midwife
Belgium	17.0	98	Midwife & Doctor
United States	17.7	97	Doctor
Ireland	19.0	85	Midwife
Czechoslovakia	21.2	99	Nurse-midwife
German Federal Repub.	22.7	97	Midwife
Israel	22.8	100	Midwife

Sources: Wegman, M. "Annual Survey of Vital Statistics-1974 Pediatrics, 56: 960-966, December, 1975
IFGO and JCM, Maternity Care in the World, 2nd Edition, 1976

TABLE 2

	Number	Rate	All California Birth rate-1973
Total Births	1152		
Live Births	1147		
Fetal Deaths	5	4.3	10.2
Neonatal Deaths	6	5.2	10.3
Total Perinatal Deaths	11	9.5	20.3
Low Birth Weight (2501g)	15	1.3%	6.4%

Source: L. Mehl "Outcome of Elective Home Birth: A Series of 1147 Cases", Infant Health Unit, California State Department of Health, Berkeley, CA
Birth Notes, Vol. 2, No. 2, page 6

1-9-82

The study of home births was completed in August '81. Dr Ender was our professor for a research methods class that we took at Univ. of Alaska, Anch.

Participants were Anchorage residents and had a home birth within the last three years. Most of the respondents had a lay midwife attendant. Due to our sources or leads, most of these participants had birth attendants. It would be very difficult to determine the number of unattended home births.

We wanted to determine why people chose home births we gave respondents 3 selections. In descending order:

1	more control over birth	78.8
2	relaxed home setting	62.6
3	less medical intervention	51.5
4	participation of family, friends	46.5
5	economic consideration	21.2
6	anti hospital philosophy	18.2
7	difficulty finding OB care	3.0

It would appear that hospitals are not effectively meeting these peoples needs.

AL

HOMEBIRTH
FILE BABE (CREATION DATE = 08-13-81)

VAR20 RATE HOSP BIRTH

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
POOR	1.	18	18.2	32.7	32.7
UNSATISFACTORY	2.	18	18.2	32.7	65.5
UNDECIDED	3.	1	1.0	1.8	67.3
SATISFACTORY	4.	16	16.2	29.1	96.4
GREAT	5.	2	2.0	3.6	100.0
NOT APPLICABLE	8.	44	44.4	MISSING	100.0
	TOTAL	99	100.0	100.0	

MEAN	2.382	STD ERR	0.177	MEDIAN	2.028
MODE	1.000	STD DEV	1.312	VARIANCE	1.722
KURTOSIS	-1.291	SKEWNESS	0.471	RANGE	4.000
MINIMUM	1.000	MAXIMUM	5.000		

VALID CASES 55 MISSING CASES 44

Majority have had previous hospital birth, less than 1/3 were satisfied with hospital birth experience.

HOMEBIRTH
FILE BABE (CREATION DATE = 08-13-81)

Should hospitals be given a monopoly on births?

VAR24 RATE HOME BIRTH

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
SATISFACTORY	4.	8	8.1	8.1	8.1
GREAT	5.	91	91.9	91.9	100.0
	TOTAL	99	100.0	100.0	

MEAN	4.919	STD ERR	0.028	MEDIAN	4.956
MODE	5.000	STD DEV	0.274	VARIANCE	0.075
KURTOSIS	7.917	SKEWNESS	-3.124	RANGE	1.000
MINIMUM	4.000	MAXIMUM	5.000		

VALID CASES 99 MISSING CASES 0

100% satisfied with home birth experience!

HOMEBIRTH
FILE BABE (CREATION DATE = 08-13-81)

VAR25 WHO CAUGHT BABY

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
NATURO DR	2.	32	32.3	32.3	32.3
FATHER	3.	19	19.2	19.2	51.5
LAY MIDWIFE	4.	42	42.4	42.4	93.9
FRIEND	5.	2	2.0	2.0	96.0
SELF	6.	3	3.0	3.0	99.0
	9.	1	1.0	1.0	100.0
	TOTAL	99	100.0	100.0	

MEAN	3.293	STD ERR	0.119	MEDIAN	3.421
MODE	4.000	STD DEV	1.180	VARIANCE	1.393
KURTOSIS	4.393	SKEWNESS	1.271	RANGE	7.000
MINIMUM	2.000	MAXIMUM	9.000		

VALID CASES 99 MISSING CASES 0

HOMEBIRTH
FILE BABE (CREATION DATE = 08-13-81)

VAR29 MEDICAL INSURANCE

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
YES	1.	47	47.5	[redacted]	47.5
NO	2.	52	52.5	52.5	100.0
	TOTAL	99	100.0	100.0	

MEAN	1.525	STD ERR	0.050	MEDIAN	1.548
MODE	2.000	STD DEV	0.502	VARIANCE	0.252
KURTOSIS	-2.031	SKEWNESS	-0.103	RANGE	1.000
MINIMUM	1.000	MAXIMUM	2.000		
VALID CASES	99	MISSING CASES	0		

HOMEBIRTH
FILE BABE (CREATION DATE = 08-13-81)

VAR30 MEDICAID INSURANCE

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
YES	1.	13	13.1	[redacted]	13.8
NO	2.	81	81.8	86.2	100.0
MISSING	9.	5	5.1	MISSING	100.0
	TOTAL	99	100.0	100.0	

MEAN	1.862	STD ERR	0.036	MEDIAN	1.920
MODE	2.000	STD DEV	0.347	VARIANCE	0.120
KURTOSIS	2.590	SKEWNESS	-2.130	RANGE	1.000
MINIMUM	1.000	MAXIMUM	2.000		
VALID CASES	94	MISSING CASES	5		

HOMEBIRTH
FILE BABE (CREATION DATE = 08-13-81)

VAR31 INCOME AFFECTS HB

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
YES	1.	1	1.0	1.0	1.0
[redacted]	2.	98	99.0	[redacted]	100.0
	TOTAL	99	100.0	100.0	

MEAN	1.990	STD ERR	0.010	MEDIAN	1.995
MODE	2.000	STD DEV	0.101	VARIANCE	0.010
KURTOSIS	99.000	SKEWNESS	-9.950	RANGE	1.000
MINIMUM	1.000	MAXIMUM	2.000		
VALID CASES	99	MISSING CASES	0		

(1 3% had medical coverage which would have paid for a hospital birth — instead they chose to have a home birth and paid out of pocket.

for { "Normal" vaginal hospital birth costs ≈ $2,500 - 3,000
Cesarean section 4,500 - 5,000 & ↑
Homebirth 250 - 750

HOMEBIRTH

FILE BABE (CREATION DATE = 08-13-81)

VAR26 INCOME 1980

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
LESS THAN 10,000	1.	14	14.1	14.1	14.1
10,000 TO 20,000	2.	19	19.2	19.2	33.3
20,000 TO 30,000	3.	27	27.3	27.3	60.6
30,000 TO 40,000	4.	17	17.2	17.2	77.8
40,000 TO 50,000	5.	16	16.2	16.2	93.9
GREATER THAN 50,000	6.	2	2.0	2.0	96.0
	8.	2	2.0	2.0	98.0
	9.	2	2.0	2.0	100.0
	TOTAL	99	100.0	100.0	

MEAN	3.303	STD ERR	0.172	MEDIAN	3.111
MODE	3.000	STD DEV	1.711	VARIANCE	2.928
KURTOSIS	1.679	SKEWNESS	1.011	RANGE	8.000
MINIMUM	1.000	MAXIMUM	9.000		
VALID CASES	99	MISSING CASES	0		

HOMEBIRTH

FILE BABE (CREATION DATE = 08-13-81)

VAR27 COUPLE OR SINGLE INCOME

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
SINGLE INCOME	1.	5	5.1	5.1	5.1
COUPLE INCOME	2.	92	92.9	92.9	98.0
	9.	2	2.0	2.0	100.0
	TOTAL	99	100.0	100.0	

MEAN	2.091	STD ERR	0.103	MEDIAN	1.984
MODE	2.000	STD DEV	1.021	VARIANCE	1.043
KURTOSIS	42.453	SKEWNESS	6.388	RANGE	8.000
MINIMUM	1.000	MAXIMUM	9.000		
VALID CASES	99	MISSING CASES	0		

of midwives compared by 77 people that had a home birth in the Anchorage Borough within the last three (3) years.
Study completed 8-81 by Chris & AL RUSHING

Age of woman

		age
1.	21.2	( )
2.	42.4	( )
3.	28.3	( )
4.	6.1	( )
5.	2.0	( )

ALL PERCENTAGES ARE ADJUSTED FREQUENCIES

number of children

1.	35.4
2.	27.3
3.	21.2
4.	8.1
5.	6.1
6.	1.0

number of children born at home

1.	75.8
2.	17.2
3.	6.1
4.	1.0

Employment

49.5 not employed during pregnancy

33.3 employed to or thru 3RD trimester

months of prenatal care

0	3.0
1	3.0
2	1.0
3	4.0
4	6.1
5	12.1
6	17.2
7	23.2
8	14.1
9	16.2

prenatal care by

medical dr.	9.1
naturo. dr.	28.3
CNM	2.0
lay midwife	26.3
med dr & nat dr.	8.1
med dr & mid.	13.1
nat. dr & mid.	13.1

previous hosp. birth

yes	54.5
no	45.5

rate hosp birth

poor	32.7
unsat	32.7
undecided	1.8
sat is	29.1
great	3.6
not applic.	MISS.

rate from birth

poor	0
unsat	0
undecided	0
satis	8.1
great	91.9

who "caught" baby

med. dr.	0
nat. dr.	32.3
father	19.2
lay mid wife	42.4
friend	2.0
self	3.0

had medical insurance

yes	47.5
no	52.5

income affect choice of home birth

yes	1.0
no	99.0

registered birth with state

yes	74.7
no	25.3

reasons for choice of home birth (given three choices of seven)

less medical intervention	51.5	3
more control over birth	78.8	1
difficulty finding OB care	3.0	
anti hospital philosophy	18.2	
relaxed home setting	62.6	2
economic considerations	21.2	
participation of family, friends	46.5	4

Table
Neonatal and Infant Deaths of
Anchorage Residents, 1970-1979

	Neonatal Deaths/Rate		Infant Deaths/Rate		Number Live Res. Births
1970	55	17.2	74	22.5	3285
1971	36	11.6	52	16.3	3192
1972	36	11.6	51	16.4	3119
1973	39	13.5	51	17.5	2917
1974	36	11.6	46	14.8	3132
1975	13	4.0	36	11.3	3260
1976	25	6.4	47	12.0	3968*
1977	22	5.9	43	11.6	3720
1978	39	10.3	58	15.3	3825
1979	39	10.3	56	14.7	3823

* estimated

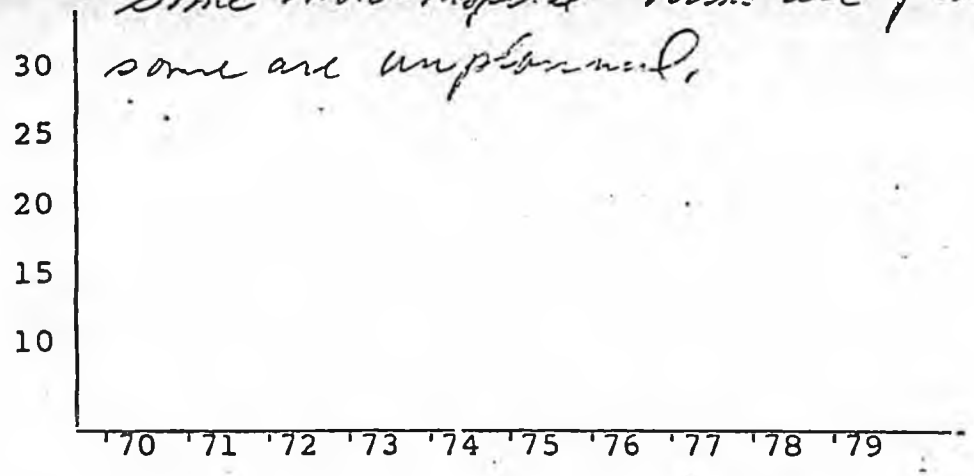
Resident neonatal and infant death rates dropped dramatically from 1970 to 1975, but have started climbing slowly gain. Because numbers are small the effect of each change may be misleading. Until 1978 local rates were below those of the nation. Since 1979 local rates (14.7) have exceeded national rates (13.6). The State Health Systems Plan recommends maintaining a neonatal mortality rate of no more than 9.0 per 1,000 live births, and an infant rate of no more than 15.0 per 1,000 live births. Further and careful review of Anchorage rates is necessary.

Table
Neonatal and Infant Mortality for Anchorage, Southcentral and Alaska, 1970-1979

	Infant Mortality Rates			Neonatal Mortality Rates		
Year	Anchorage	Southcentral	Alaska	Anchorage	Southcentral	Alaska
1970	22.5	17.2	23.4	17.2		
1971	16.3	20.3	18.3	11.6		12.6
1972	16.4	16.7	17.0	11.6		11.1
1973	17.5	21.8	19.9	13.5		13.0
1974	14.8	19.2	18.8	11.6		12.6
1975	11.3	13.7	14.3	4.0		9.4
1976	12.6 *	15.3	16.1	6.4		9.2
1977	11.6	13.9	14.8	5.9		8.2
1978	15.3		14.6	10.3		9.6
1979	14.7	147	6.1	10.3		9.1

*estimated

some non-hospital births are planned?
some are unplanned.



° Anchorage
- Southcentral
-- Alaska

Home Births and Perinatal Mortality. Growing numbers of Alaskan women are choosing to have their babies at home or at least outside of an acute setting. Table ? shows the number of Alaskan and Anchorage births which occured in a setting "other" than a hospital or clinic.

Table ____

Number and Percent of Births Occuring Outside a Medical Facility
Anchorage and Alaska 19__ - 1979

	1976		1977		1978		1979	
	#	%	#	%	#	%	#	%
Anchorage	N/A		N/A		32	1.2	75	1.8
Alaska							302	3.3

It is not clear at this time exactly how many women who intended a home birth, developed complications and actually delivered in a hospital. Indicators of the incidences of problem deliveries are minimal. However, Annual Surveys of Anchorage hospitals indicate that from 15 to 30 percent of all hospital deliveries are classified (ICD-9-CM) as "Complicacions of Pregnancy, Childbirth and Puerperium." While that classification code may include relatively minor complications, it does indicate need for medical attention beyond that which occurs during a normal delivery. In addition, some physicians estimate that about one of every four women identified as low risk throughout pregnancy, experience (maternal or fetal) complications during delivery. The inference from these data is that there is sufficient risk to mother and infant during the perinatal period to question the adviseability of home births. Features such as alternative birthing rooms and centers,

WHAT DATA ?