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*Fetal Abuse and the Psychology of Aggression*

Second, the present author (Condon, 1985) and others (Cranley, 1981; Leifer, 1977) have demonstrated the development of emotional "attachment" between most expectant parents and their unborn child during pregnancy. The term "attachment" is often used rather glibly in the literature and the reader is referred elsewhere for discussion of debate over the conceptual difficulties presented by this construct (Sluckin *et al.*, 1963). However, there is reasonable agreement that the pleasure or pain associated with the presence or absence, respectively, of the object of attachment subserves the prime function of attachment, viz., protection of the object, even in the face of threat to the self.

Ambivalence toward the fetus may arise when resentment, stemming from the losses and threats of pregnancy, coexists with feelings of attachment or affection. Some degree of ambivalence is probably ubiquitous, and which aspect of this ambivalence achieves behavioral expression will depend on a variety of conditions, including the strength of the woman's attachment to her unborn child. The case material suggests that women with less antenatal attachment are less able to derive pleasure from interaction with the unborn child in either fantasy or reality and have more difficulty subjugating their own needs to those of the fetus.

Investigation of the determinants of antenatal attachment has barely begun. In the author's study (Condon, 1985) the most powerful correlate of antenatal attachment was a spouse perceived as supportive and involved in the pregnancy. Cranley (1981) has also documented an association between maternal antenatal bonding and social support.

Antenatal attachment can potentially provide a conceptual framework for identifying women at risk of fetal abuse. It can also define a focus for therapeutic intervention in a clinical setting, thus enabling the abuse to be dealt with in the context of the psychological events of pregnancy as a whole, rather than as an isolated, deviant behavior. Finally, it could be argued that strategies aimed at reducing fetal abuse could more profitably focus on the determinants of the dysfunctional maternal-fetal relationship rather than on "education." The latter, although clearly necessary, may be insufficient for a major impact, as illustrated in cases 2 and 3 above.

The determinants for antenatal attachment are complex and include both historical factors, especially the quality of the woman's own mothering, and contemporary aspects, especially the extent to which the woman's social network supports and validates her role as mother.

It has long been known that intimacy does not lessen the likelihood of violence; rather, it appears to favor its occurrence. The symbiotic relationship between the mother and the unborn child, with all its vicissitudes of dependency and intimacy, can provide a setting in which ambivalence or hostility can be acted out as assault or maltreatment.

Grant (1979) has proposed a tripartite model of assaultive behavior which can be modified as follows to provide a framework for considering fetal abuse:

1. Violence is facilitated by the victim's being perceived as different from one's own species, race, or culture or as only vaguely defined or lacking in reality. As pregnancy progresses, the mother's concept of the fetus normally advances along a continuum from "inanimate object" through "living thing" to "human being" or "real little person" (Condon, 1985; Lumley, 1972). One would predict that the fetus would acquire more protection as its "humanness" increases, and most investigators do report a reducing consumption of alcohol in pregnant women from the first to the third trimester (Fried, 1950). A woman who retains an inanimate or very vague concept of her fetus may be at a higher risk of fetal abuse, as was evident in case 2 cited above.

2. Assault is more likely if violence is ego-syntonic. The intergenerational transmission of child abuse is well documented (Smith and Pagan, 1978) and a similar progression occurred in cases 1 and 2 cited above. During childhood, such women acquire a model for the expression of violent impulses but lack any model for care-taking or nurturance.

3. Poor impulse control clearly predisposes to assaultive behavior, and the possibility of hormonally mediated alteration in impulse control during pregnancy has been mentioned above. The patient described in case 2 resembles Lion and Penna's (1974) description of patients who, failing to experience any early warning signs of anger, suddenly explode into violent behavior.

*Fetal Abuse and Alcohol/Nicotine Use in Pregnancy*

Most studies reveal that 25% to 35% of pregnant women smoke throughout pregnancy (Kwok *et al.*, 1983; Streissguth *et al.*, 1983), and one quarter of these smoke more than 20 cigarettes per day. Between one half and two thirds of pregnant women consume some alcohol, and between 2% and 13% of all pregnant women "admit to" heavy consumption (Kwok *et al.*, 1983; Sokol, 1981). There is a strong association between alcohol and cigarette use during pregnancy.

In contrast to the voluminous literature concerned with the effects of alcohol on the fetus, almost nothing

(other than basic demographic data) is known of the characteristics of women who continue to drink or smoke heavily, nor of those who abstain. The study of the subgroup of women who abstain even when pregnancy becomes a possibility would seem potentially rewarding. Variation in intellectual awareness of the potential damage to the fetus seems unlikely to constitute a satisfactory explanation of the variation observed. Indeed, current educational programs for pregnant women have largely failed to make significant impact in terms of cigarette smoking (Kwok *et al.*, 1983) and less than expected impact on alcohol intake (Rosett and Weiner, 1981; Streissguth *et al.*, 1983). The distaste that many pregnant women acquire for alcohol, coffee, or cigarettes (Little *et al.*, 1976) must likewise be an incomplete explanation, as illustrated by the subgroup of women who abstain as a result of a mistaken idea that conception has occurred. Moreover, distaste may not equate with abstinence or even reduced intake.

#### *Fetal Abuse and the Family System*

No phenomenon of pregnancy, including fetal abuse, occurs in an interpersonal vacuum, and the unborn child can be a significant participant in family dynamics. The literature suggests that expectant fathers are a stressed group (Fein, 1976; Grossman *et al.*, 1980) and studies on child abuse suggest that, although mothers are the most frequent abusers, if time spent with the child is controlled for, fathers are more abusive (Rae-Grant, 1983).

Gelles (1975), reporting on the high prevalence of domestic violence during pregnancy, quotes a case in which the "target area" for the partner's violence shifted from his wife's face to her abdomen upon confirmation of the pregnancy. This was also the target area for the father's violence in case 2 above. The identity of the intended victim in such cases must be considered uncertain. In addition, the partner may derive vicarious gratification from the woman's fetal abuse and thereby consciously or unconsciously collude with or reinforce it.

Adams-Hillard (1985) has reviewed the possible effects of a pregnancy on wife-abuse, both increased and decreased incidences having been reported. A full understanding of the possible origins of a male partner's hostile impulses toward a fetus would require a review of the psychology of expectant fatherhood, which lies outside the scope of this paper. Only four aspects will be mentioned briefly:

1. The fetus as a rival. Some men may experience the fetus as a rival for their partner's affection or attention, especially if she is highly involved in the pregnancy or, as is common in the third trimester, their sexual relationship should cease. Pregnancy, for

the male, is lacking in biological immediacy and hence provides fewer substitute gratifications to offset the demands and sacrifices.

2. "Pregnancy envy." Recent studies of expectant couples have provided some empirical support for the notion that the man may consciously or unconsciously envy the power and creativity inherent in the female's capacity to bear a child (Liebenberg, 1974). A woman's fetal abuse, the antithesis of competent motherhood, may be gratifying to such a man and hence he may collude with it or reinforce it.

3. Psychoanalysts have suggested that the vicissitudes of a man's childhood gender identification may have been such that having a child in some way equates with a loss of masculinity; *i.e.*, involves exchanging a penis for a baby (Ross, 1979). Hence, the fetus may constitute a threat, awakening a variety of primitive anxieties, and may become the victim of retaliation.

4. Either partner may displace hostile impulses toward the other onto the fetus, as was illustrated in case 2. For example, the pregnant woman's representation of the fetus may be as "his" baby.

#### **Conclusions and Implications for Prevention/Management**

Table 1 represents an attempt to summarize the attributes characterizing the group of women at high risk of fetal abuse, based on the cases presented and the literature reviewed. In the author's experience a question along the lines: "Some pregnant women find that they get so frustrated and irritated with the pregnancy that they feel like they want to take it out on the baby. Have you ever felt like that?" is not experienced as unduly threatening if inserted into a general interview about the pregnancy and will often produce an affirmative response in the high-risk group. Education about the detrimental effects of smoking and drinking during pregnancy, although clearly necessary, will not be acted upon if there is an emotional obstacle blocking such action. The additional strategy of attempting to identify those at risk, and focusing available resources upon this group, would seem timely.

Clearly, the recognition and treatment of existing fetal abuse is a less desirable strategy than is prevention in the at-risk group, which in turn is a less optimal intervention than alleviation of the adverse social circumstances that often characterize this group.

If, as seems likely, an abused fetus is at high risk of becoming an abused child, then the identification and successful treatment of a case of fetal abuse may be synonymous with the prevention of subsequent child

TABLE I  
Characteristics Predisposing to Fetal Abuse/Protection

	Increased Risk of Fetal Abuse (Low Protection)	Decreased Risk of Fetal Abuse (High Protection)
Attachment to fetus	Low (both partners)	High (both partners)
Concept of pregnancy	Romanticized	Realistic
Concept of fetus	"Thing"/unwanted	"Person"/wanted
Stress levels	High level of "losses" and "threats" of pregnancy	Moderate-low level of "losses" and "threats"
Attitude to pregnancy	Tendency to deny, passivity by both partners	Realistic, active involvement by both partners
Pregnancy symptoms	High level of physical and emotional symptoms (anxiety and depression)	Moderate-low level of symptoms
Personality	Poor impulse control, primitive defenses (especially projection/displacement)	Mature impulse control and defensive structure
Spouse/partner	Perceives fetus as threat. Marital dysfunction	Not threatened by fetus. Stable marriage
Attitude to violence	Ego-syntonic (previous child abuse?)	Ego-dystonic
Models of caring/protection	Lacking—own parenting dysfunctional (especially mothering) Abused as a child (or fetus) herself	Present—own parents perceived as "good"
Psychological tasks of pregnancy	Either not tackled or overwhelmed by them	Appropriate achievement
Perceived family/staff attitude	Interested only in the fetus rather than her	Interested in her as a person

abuse. The treatment of such a case is a most difficult and complex problem for the consultation-liaison psychiatrist and other professionals, involving moral, ethical, and medicolegal issues. Not only is evidence of fetal abuse less available for scrutiny than is that of child abuse, but also the strategy of "removing" the endangered fetus from the high-risk situation is not feasible. In addition, attempts to protect it may come into conflict with the mother's autonomy. Management guidelines will be the subject of a separate paper, the mainstay being an approach based on "mothering the mother."

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# A Natural History of the Fetal Alcohol Syndrome

## A 10-Year Followup of 11 Patients

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In 1973, 11 children with a similar pattern of altered body development and central nervous system function, all born to chronic alcoholic women who continued to drink heavily during pregnancy, were described in detail (Jones et al., 1973; Jones and Smith, 1973). Subsequently, children with the fetal alcohol syndrome (FAS) have been identified in every racial group (Clarren and Smith, 1976) and in many countries (Denaene et al., 1977; Majewski et al., 1976; Degard et al., 1979). The teratogenicity of alcohol (the ability to induce malformations) has been confirmed in laboratory studies involving many different species of animals (Abel et al., 1983). However, the long-term outcome and the natural history of children diagnosed as having FAS have not been documented. We recently completed a follow-up evaluation of the initial 11 children diagnosed as having fetal alcohol syndrome. The purpose of this report is to set forth their present status in terms of mental development, academic performance, and physical condition, to follow their abnormally formed characteristics and their growth status across time, and to document their medical histories over the past 10 years.

The children in the present study (listed in Table 1) include the following numbers 1 through 8 are presented in the same order as the 8 children described by Jones and colleagues (1973), and numbers 9 through 11 are the 3 children described by Jones and Smith (1973). The medical histories of these children are summarized in Table 2 and their growth curves, intelligence quotient (IQ) scores are present in Figure 1.

*Patient 1* drowned in the bathtub at age 3.5. She had been adopted when she was 15 months old and was reportedly easy to manage, seldom cried, and was neither fearful nor hyperactive. She had a heart murmur which was no longer audible at 15 months. In addition to a congenital hip dislocation, which was treated surgically and casted for one year, she was treated repeatedly for ear infections and had extensive physical therapy.

*Patient 2* is a short, thin, prepubescent 10.5-year-old Native American girl who has lived in a stable adoptive home since she was 3 years old. She is in the fifth grade, attends regular classes at school that are supplemented with remedial reading. Achievement testing reveals grade level performance. She is self-sufficient, independent in urban life, and responsible for household chores and snopping. She reportedly has age-appropriate social interactions.

The features of the child's face and head have not changed significantly over the last 10 years. Her palpebral fissures (the length of the eyelids) remain short (right 2.5 cm., left 2.4 cm.), while her inner canthal distance (the distance measured between the tear ducts of the eyes) is normal at 3.0 cm. Her nose is not disproportionately short, but the frontonasal region (the region of the forehead and nose) is abnormal in that there is deficiency in width and definition of the alae nasae (the "wings" of the nose) and a "teardrop"-shaped philtrum (the groove running between the nose and upper lip). Her midface is flat while her jaw appears clinically of normal size. This disproportion has led to a mild class III malocclusion

(an underbite). Her external ears retain their mild irregular shape. The patient continues to have a low-grade heart murmur and has been diagnosed as having an atrial septal (heart) defect. The rest of her exam is normal except for a specific abnormal crease pattern of the palms of her hands which has been described as frequent in fetal alcohol syndrome (Jones et al., 1973; Tillner and Majewski 1978).

The patient had been in good health, although she has had chronic serous otitis media (middle ear congestion). Despite conscientious followup and treatment, she has a fixed 80-decibel conductive hearing loss in the left ear. She is currently undergoing standard orthodontic treatment for malocclusion with selected dental extractions and bracing.

*Patient 3* is a short, stocky, sexually mature 14-year-old Native American girl who lives with her natural mother and several brothers and sisters. She is in the seventh grade at school but receiving failing grades and not attending school regularly. Although cooperative and engaging on earlier examinations, as an adolescent this patient is suspicious, guarded, and sullen. She is also a social isolate at school. Family ties remain very strong, but the family itself is socially isolated and very poor but steadfastly refusing help. This patient refused to be seen for an adolescent medical and psychological examination although growth data were available.

*Patient 4* is a short, overweight, sexually mature 14-year-old black girl (Figure 2). She has lived in a stable adoptive home since she was 4.5 years old. She has always attended special classes for the re-

## A Natural History of the Fetal Alcohol Syndrome

Table 1. Demographic and Growth Data: Original 11 FAS Children

Patient No.	Race	Sex	Alive in 1983		Gest. Age	Birth Data			Breed	Age	Follow-Up Data		
			Child	Mom		Length	Weight	HC			Height	Weight	HC
1	Am Ind	F	-	?	40	45.0	1850	32.0	-		deceased		
2	Am Ind	F	-	-	40	44.5	2500	31	-	10.7	130.0	26.36	50
3	Am Ind	F	-	-	38	47.0	2500	31	-	14.7	143.5	45.00	not taken
4	Black	F	-	-	36	42	1600	29	-	14.2	143.7	46.93	50
5	Black	M	?	?	38	43	1673	-	-		lost to follow-up		
6	Black	M	-	-	34	38	1550	30.5	-	13.9	145.1	31.14	50.6
7	White	F	-	-	44	49.7	2345	32	-	14.4	142.5	35.57	48.5
8	White	M	-	-	37	43.2	2250	35	-	13.2	145.2	32.39	53
9	Am Ind	M	-	-	35	43	2020	29	-	10.1	119.3	19.5	47.6
10	Am Ind	F	-	?	32	36.5	1300	27	-		deceased		
11	Am Ind	F	-	-	7 mos		964	-	-	14.0	129.5	25.85	47

vanced and reads and spells at a second- to third-grade level. She is a happy, outgoing, talkative child with no apparent stranger anxiety and no inhibitions. Because of her poor judgment, she is never left alone. Although she is no longer hyperactive, she continues to have a short attention span.

The patient's facial features are similar to those described in early childhood. The palpebral fissures are short (2.2 cm, bilaterally). She has numerous eye problems including ptosis (drooping eyelids), strabismus (crossed-eyes), severe myopia (nearsightedness), and defects in the optic nerves. She has a moderate malocclusion secondary to flat midface and prominent lower jaw. She continues to have palatine pegs. Her external ears are prominent and irregularly shaped. She also has numerous minor skeletal anomalies including radio-ulnar synostosis (fusion of the bones at the elbow), brachydactyly (abnormal shortness of the fingers and toes), camptodactyly (mild contractures of the fourth and fifth digits of both hands), clinodactyly (deflection) of the third and fourth digits of the left hand, and bilateral syndactyly (webbing) of the second and third toes. A cardiac murmur (compatible with a patent ductus arteriosus) was audible until 5 years of age. Since infancy, she has been in reasonable health although she has needed careful ophthalmologic follow-up. Orthodontia with possible oral surgery is indicated but has not yet been undertaken.

*Patient 5* was a 17-month-old black male who has been lost to follow-up for 10 years.

*Patient 6* is a short, thin, 13.5-year-old black male who has lived with his natural parents and siblings his entire life. He is in the eighth grade and attends regular classes with remedial help in mathematics and English. He is quiet, well behaved, appropriate, cooperative, and no longer hyperactive.

The patient has most of the facial features of the fetal alcohol syndrome except for a normal midface which tends to make his face less typical of the syndrome. His palpebral fissures are short (2.1 cm, bilaterally) while his inner canthal distance is normal (3.3 cm.). He has the typical frontonasal features including epicanthal folds (vertical folds of skin covering the inner corners of the eyes), short nasal tip, and a smooth philtrum. Although he has no malocclusion, he has a wide mouth with irregularly shaped and poorly aligned anterior teeth with an open bite. His external ears are prominent and oddly shaped. He has mild skeletal defects including radio-ulnar synostosis (fusion) of the bones at the elbow and camptodactyly (mild contractures of the digits), and small toenails. He has been in reasonably good health although he is followed by an ophthalmologist for strabismus (crossed eyes) and has allergies. He is currently in orthodontic treatment.

*Patient 7* is a 14.5-year-old, short, microcephalic (a condition characterized by

an abnormally small head), sexually mature white female who is quiet and compliant. She has lived in a stable adoptive family since she was 6. She has attended special classes for the retarded all her life, and her academic skills are at the first- to second-grade level. Because of her poor judgment and lack of inhibition with strangers, she is never permitted to go out alone in the neighborhood.

With the exception of normal palpebral fissure size (2.6 cm, bilaterally), she has most of the facial features of the fetal alcohol syndrome. Her inner canthal distance is 2.7 cm. She has mild epicanthal folds, a smooth philtrum, and a thin upper lip. Her midface is flat and she has a protruding jaw and a moderate dental malocclusion. She has had major skeletal problems, including bilateral congenital hip dislocations and scoliosis (curvature of the spine). In addition, she has small nails on her hands and feet. Multiple hemangiomas (birthmarks) present in infancy have resolved. A systolic murmur heard in infancy also resolved prior to a full diagnostic evaluation. She has had chronic serous otitis media (middle ear congestion) and still has a mild conductive hearing loss in spite of conscientious care.

*Patient 8* is a short, thin, 13-year-old white male who lives alone with his natural father (Figure 3). Although school is becoming increasingly difficult, he attends regular classes with supplemental tutoring. Although his hyperactivity has gradually diminished, he continues to

**Table 2. Frequent Medical Problems Original 11 FAS Children**

Intraoral	8/8
Class III malocclusion 5/7, poor dentition alignment 3/8, cleft palate 2/11	
Ears	8/9
Chronic otitis media 5/9, permanent hearing loss 3/8	
Eyes	4/8
Optic nerve hypoplasia 2/8, ptosis 2/8, strabismus 4/9, severe myopia 2/8	
Cardiac	8/11
Cardiac murmur interpreted as VSD 5/11, ASD 1/11, PDA 1/11	
Skeletal	9/11
Congenital dislocated hip 3/9, progressive thoracic scoliosis 1/8, radio-ulnar synostosis 3/8, flexion contractures 1/9, bilateral hallux valgus 2/9, minor hand anomalies 6/9	
Other	
Bleech 5/11, wear sock 10/11, prolonged hospitalization after delivery 8/9, failure to thrive 6/9	
Behavioral	
Fast hyperactivity 8/9, persistent hyperactivity 1/8, attention deficit 1/8	
Environmental	
Neglect 8/9, physical abuse 2/8, suspected sexual abuse 1/8	

Note: The denominator of frequencies in the 8 column includes patients Nos. 2, 3, 4, 6, 7, 8, 9, and 11. The denominator of 9 includes Patient 10, who was included until the death at age 20 years. The denominator of 11 includes both and retains a value of zero for a patient. The denominator indicates the Patient No. 3 who had been treated for malocclusion.

have an attentional deficit. He is currently repeating seventh grade because of refusal to attend school for 3 months. Present academic functioning is 1 to 4 years below present grade level. He is friendly, uninhibited, and self-sufficient but a loner, and he manifests poor judgment.

His facial features remain typical of the fetal alcohol syndrome. His palpebral fissures are very short (1.9 cm. on the right, 2.0 cm. on the left), while his inner canthal distance is 3.7 cm. He has a unilateral strabismus and the usual midline finding of epicanthal folds, short nasal tip, a smooth philtrum, and a thin upper lip. He has a mild malocclusion. Mild skeletal abnormalities include altered palmar creases, camptodactyly, and hallux valgus (mild anomalies of fingers and toes). Since 1 year of age, he has been healthy, although he was hospitalized for a hernia repair and surgical correction of

undescended testis at the ages of 3.5 months and 6 months.

*Patient 9* is a 10.5-year-old Native American male who is extremely thin and short (Figure 4). Hyperactive to the point of destructiveness, he is also outgoing and friendly to the point of intrusiveness. He has always attended classes for the trainable mentally retarded. He cannot read or write. He has lived in a single foster home where he has received excellent care. Seizures, triggered by both high-pitched noises and hyperventilation and followed by lethargy, were first noted at 8 months. They decreased in frequency and finally stopped by 4 years. A systolic murmur thought to be secondary to a ventricular septal (near) defect also resolved by 4 years. He has had frequent viral illnesses and diarrhea as well as persistent otitis media (though his hearing is now considered normal). Dental restorative care and extractions preparatory to orthodontia have been performed. He has worn glasses since 3 years of age, is intolerant of light, and is virtually blind in the right eye.

The patient has retained the typical facial features of the fetal alcohol syndrome. He is near-sighted, has astigmatism, and has optic nerve atrophy. He has poor dental alignment, but no malocclusion. There are mild skeletal defects including radio-ulnar synostoses, camptodactyly, and small toenails. Thirteen ribs are present bilaterally (though normally there are 12 on each side).

*Patient 10* died when he was 5 days old, after multiple apneic (breathing cessation) episodes. Detailed reports of the malformations and the medical condition of this infant have appeared previously (Clatten et al. 1978, Jones and Smith 1975).

*Patient 11* is a very short, sexually mature 14-year-old Native American girl who has lived in a stable foster home since she was 6 years old. She is mentally retarded and does not speak spontaneously. She is highly distractible but not hyperactive. She is totally trusting and indiscriminate in relating to strangers. She is obedient and compliant but her judgment is too poor to permit her to remain alone.

Physical examination revealed a severely growth-deficient child in good general health. Midline features include marked epicanthal folds, a short nasal tip, a smooth philtrum, and a thin upper lip. Her midface is flat and she has a relative degree of jutting of the jawline with a re-

sulting malocclusion. Her ears are prominent and poorly formed. She has multiple mild skeletal defects and small birthmarks. A systolic heart murmur, compatible with a ventricular septal defect, resolved spontaneously by the age of 10. Her cleft palate was closed at age 3 with a single operation and she is currently undergoing orthodontic treatment.

## Discussion

Follow-up evaluation 10 years after initial diagnosis of the original 11 children with the fetal alcohol syndrome documents the long-term effects of prenatal exposure to alcohol. Although the degree to which these children are representative of all children with fetal alcohol syndrome is not known, certain generalizations regarding the natural history of the disorder have become evident. These may be helpful in planning for the future of affected individuals.

## Growth

As depicted in Figure 1, all children remained growth-deficient over time with respect to height, weight, and head circumference. Although most children initially showed some catching up in linear growth during the first 1.5 years of life, there was a relative decrease in weight and head circumference for most of the children. The failure of the head to continue growing at a normal rate after delivery may explain why some infants who are undiagnosed at birth are later diagnosed at 9 to 12 months of age.

The statistic that gives the best single description of the particular appearance of these children and adolescents with fetal alcohol syndrome is the weight-for-height age depicted in Table 3. Initially, the children were all strikingly underweight for their height, with a weight-for-height age averaging between the 5th and 10th percentile during the preschool years. However, with the onset of puberty, the females developed a relatively more normal weight-for-height age relationship.

Neither of the boys who were between 13 and 14 years of age had reached puberty, and both continued to be underweight for height. The characteristically emaciated appearance of the young child with fetal alcohol syndrome may not be a salient feature in the affected adolescent, at least for females.

## Pattern of Malformation

After 10 years, the 8 affected children for whom follow-up data are available, including 3 who have undergone pubertal

Figure 1. Growth and IQ across time in original FAS children. Height (a), weight (b), and head circumference (c) are reported in standard deviations from the mean. Girls are represented with dashed lines, boys with solid lines. Measurements from five ages were reported when available: birth and the last measurements and the measurements closest to the following ages: 1-1/2 to 2 years, 3-1/2 to 4-1/2 years, and 9 to 10 years. All available IQ scores (d) are reported from individual age-appropriate tests of general intelligence and mental development, including the Wechsler Intelligence Scale for Children-Revised, the Wechsler Preschool and Primary Test of Intelligence, the Stanford-Binet Intelligence Scale Form L-M, and the Bayley Scales of Mental Development. Note that the original Stanford-Binet Scores (1) were re-calculated because norms applicable to 1973 were published after the 1973 Lancer paper was published. The first "IQ" point for Patient 11 is circled because it was estimated from the Vineland Social Maturity Scale and clinical observation.

Figure 1a. Height in Standard Deviations From the Mean. Original FAS Children

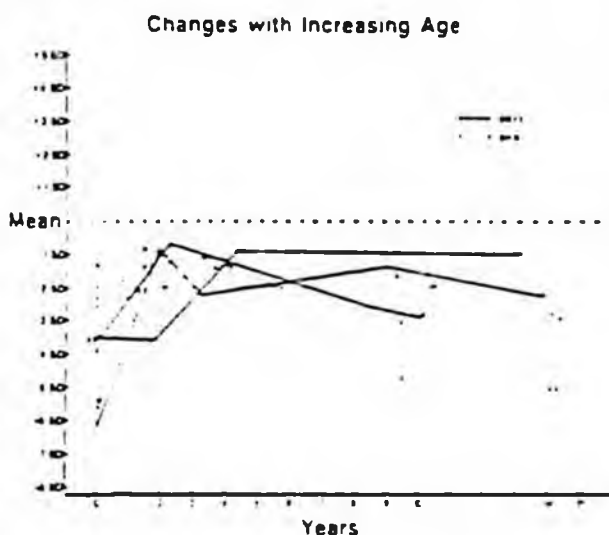


Figure 1b. Weight in Standard Deviations From the Mean. Original FAS Children

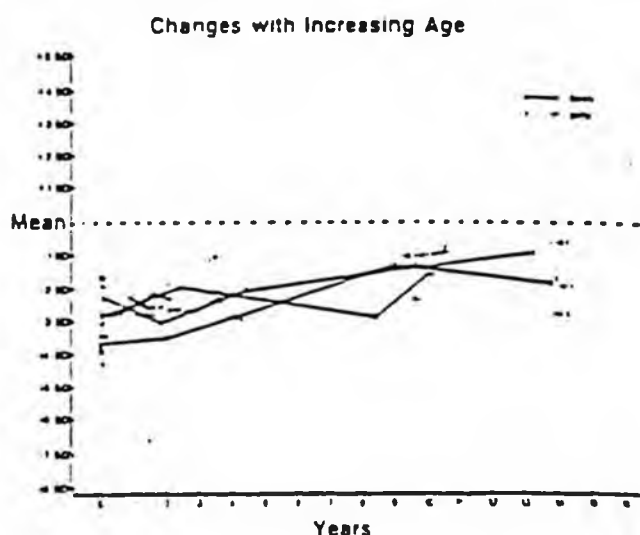


Figure 1c. Head Circumference in Standard Deviations From the Mean. Original FAS Children

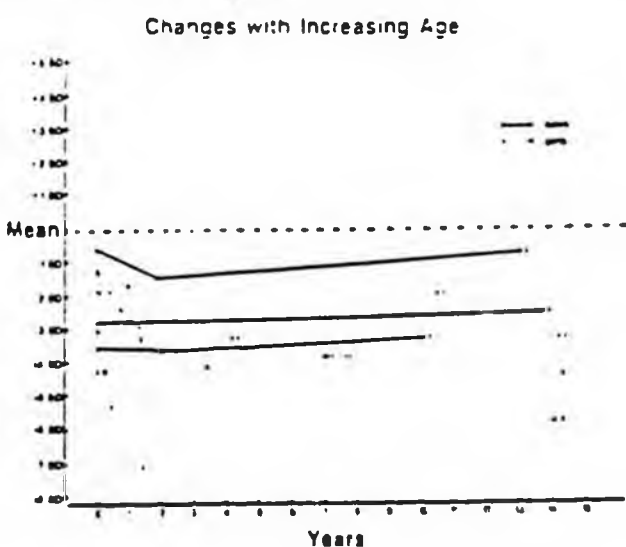


Figure 1d. Successive IQ Scores of Original FAS Children

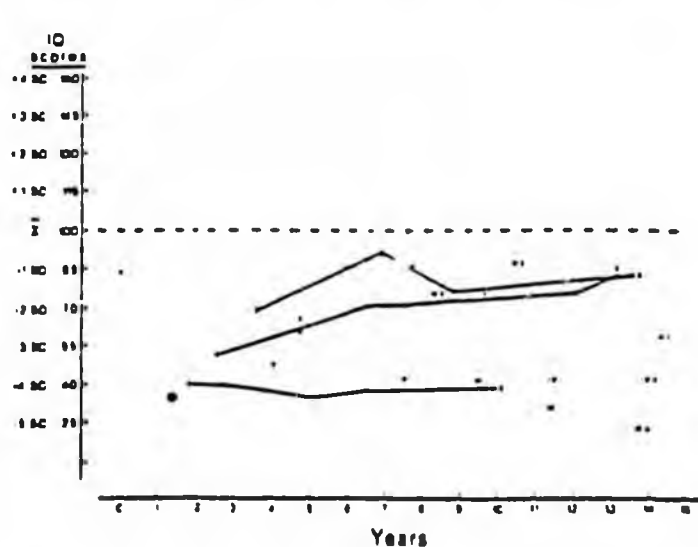


Figure 2. Patient 4 at ages (a) 3 years, 9 months, and (b,c) 14 years, 2 months.

Courtesy of Streetsmith et al.



Figure 2a



Figure 2b



Figure 2c

Note the persistence across ages of the short palpebral fissures, hypoplastic philtrum, strabismus, and ptosis; the increased growth of the nose and mandible; and the short, stocky stature often associated with puberty in girls with

Figure 3. Patient 6 at ages (a) 2 years, 6 months, and (b,c) at 12 years, 2 months.

Courtesy of Streetsmith et al.



Figure 3a



Figure 3b



Figure 3c

Note the short palpebra fissures, epicanthic folds, flat midface, hypoplastic philtrum, and thin upper vermillion border; also the short, lean-pre-pubertal stature characteristic of young adolescent boys with FAS.

Figure 4. Patient 9 photographed at (a) birth, (b) 5 years, and (c) 8 years



Figure 4a



Figure 4b



Figure 4c

Note the short palpebral fissures, epicanthal folds, short upturned nose, long and hypoplastic philtrum, thin upper lip vermilion, flat midface, hirsutism, and characteristic emaciated appearance of the pre-pubescent FAS child with minimal subcutaneous fat. (Photograph c from Streissguth et al. 1984, CIBA Foundation Monograph #105, Pitman Press, London.)

Table 3. Weight for Height Age at Three Different Ages: Original FAS Children

Patient No.	Preschool 1.5-5 years	Pre-pubertal 9-10	13-14 yrs.	Puberty 13-14 years
<b>Girls</b>				
11	7.5%	5%	—	62%*
4	15%	37%	—	85%*
7	8%	50%	—	50%*
3	5%	15%	—	82%*
2	15%	38%	—	—
<b>Boys</b>				
9	3.5%	17%	—	—
8	3.5%	10%	20%	—
6	<1%	10%	17%	—

Note: Weight age of each child was determined by noting the chronological age on the growth charts at which the child's active weight fell at the 50th percentile (growth charts from National Center for Health Statistics, NCHS).

\*Weight for height age is the percentile at which the child's active weight fell when plotted against the child's height age.

†In this table girls and boys have been re-ordered separately by severity of dysmorphism (increasing).

changes, continue to have craniofacial features similar to those previously set forth as typical of the fetal alcohol syndrome. In particular, the short palpebral tissues, smooth philtrum, and flat midface remain constant. However, the patients' noses have taken on a new contour with prominent growth of the nasal bridge and jaw. The short eye openings in the fetal alcohol syndrome were initially interpreted as being secondary to decreased growth of the eyes. Optic nerve defects as well as other anomalies affecting the eyes of five other children at this most recent followup, tend to support this interpretation and are consistent with the work of Stromland (1981). Although the patients continue to resemble each other, the changes in nose and jaw alter the overall facial appearance substantially and may explain the general failure to recognize fetal alcohol syndrome in adolescents and adults.

Heart anomalies consisting of (1) an atrial septal defect in one patient, (2) patent ductus arteriosus in one patient, and (3) systolic murmur interpreted as representing a ventricular septal defect in six patients have all resolved spontane-

nally or are considered insignificant. Congenital hip dislocation has been managed successfully with casting or splinting (two patients), while a third required hip surgery. With the exception of one patient with severe scoliosis requiring surgery, none of the other skeletal or joint anomalies has required surgery. With one exception, they have not interfered with performance.

Dysrhythmic growth of the midface and lower jaw has led to relative jutting of the jaws with malocclusion in five children, while dental malalignment was seen in all patients. Chronic ear problems required medical and surgical procedures in four children, three of whom have suffered permanent conductive hearing loss.

Since infancy, the children have all been in relatively good health. Although immunologic deficiency in children with fetal alcohol syndrome has been reported (Johnson et al., 1981), no obvious increase in the frequency of chronic or recurrent infections has been observed in these children. However, the present children were not evaluated from an immunologic standpoint.

### Performance

None of the eight children had normal intellectual development on follow-up (Table 4 and Figure 1c); four appeared to be mildly handicapped and four were seriously handicapped. The four mildly handicapped children had IQ scores in the borderline to dull-normal range, had gone through school with a combination of regular and remedial classes, and had academic achievement that was at least in line with their intellectual functioning. Two of these four had repeated one grade and were functioning at or below grade level. The remaining two were functioning several grade levels below their placement and were having increasing difficulty with school as they got older. All four of these mildly handicapped children lead relatively normal lives within their own social milieu, appearing to be independent, resourceful, and self-sufficient. Nevertheless, the discrepancy between their self-sufficient manner and their borderline to dull-normal intellectual skills may place them at risk for later social and academic problems. Further follow-up seems warranted. Two of these four children (both of whom remained with their natural families) already have social, emotional, and school attendance problems.

The remaining four children were seriously handicapped, functioning intellectu-

Table 4. Severity of Diagnosis Related to IQ and Performance: Original FAS Children

Patient No	FAS Diagnosis		Age 1983	IQ		Type of Instruction
	1976	1983		1973	1983	
**	Severe	Severe	14	30	20	Trainable mentally retarded
9	Severe	Severe	10	43	40	Trainable mentally retarded
4	Severe	Severe	14	47	48	Trainable mentally retarded
7	Severe	Mod/sev	14	60	57	Self-contained Special Ed Class
E	Mod sev	Mod sev	13	50	60	Regular Class - Special Ed
3	Moderate	(E)	(E)	66	(76)	Regular Class - Special Ed
E	Moderate	Moderate	13	68	61	Regular Class - Special Ed
2		Mod sev	10	83	68	Regular Class - Special Ed

$$\bar{X} = 56 \quad 61$$

Note: The patients were scored according to severity of diagnosis by Dr. David W. Smith in 1976 based on severity of structural cerebral malformations and growth deficiency but without knowledge of IQ scores. (E) Patients nos. 2 and 11 were not included in the 1976 follow-up. Patient no. 3 was last seen at age 14 but the last available IQ exam was from age 8. Patient 2 who had a hearing loss was also given the Leiter International Intelligence Scale; a comparable IQ score of 88 was obtained.

The 1973 IQ scores for patients E and 11 were actually obtained in 1977 and 1978 respectively. Four children (numbers 3, 4, E and 7) were given the Stanford-Binet form with IQ scores in 1973 before the 1973 norms were published. In Jones et al. (1973) their IQ scores were calculated with the old 1950 norms. In the above table their 1973 IQ scores have been recalculated using the more appropriate 1973 norms published in 1973. Leiter norms have the effect of decreasing an individual's IQ by approximately 10 points.

ally in the mildly-to-moderately retarded range. They have never attended regular classes and are progressing through classes for the mentally retarded appropriate to their level of performance. Two of these children can read and write at a primary level, while the remaining two can barely write their own names. Although these latter children were all hyperactive when younger, those who are now adolescents are no longer hyperactive. They all continue to have attentional deficits and are all friendly, outgoing, socially engaging, and uninhibited. The youngest boy (Patient 9) is a severe management problem, but the three severely handicapped adolescent girls (Patients 4, 7, and 11) are compliant and obedient. All four of these latter children need constant surveillance and show little ability to differentiate among strangers and friends, being uncritically trusting in social interchange. They all continue to need sheltered environments.

The severity of diagnosis during the preschool years was highly predictive of the children's relative ranking on IQ scores at the last follow-up (Table 4). Thus, the children who were the most severely affected in terms of early facial fea-

tures and growth deficiency had the poorest prognosis for later performance. Likewise, the children who were most mildly affected from the standpoint of growth deficiency and structural development and the best prognosis for later intellectual development.

### Environment

The degree to which postnatal environmental factors have influenced the development of these children is difficult to assess. The first 2 years of life were not ideal for seven of these children. Six of them lived intermittently with natural mothers who continued to drink, or they were in temporary custody. The seventh was hospitalized. The one child who has remained in the same stable foster home since birth is among the most retarded. The four most severely handicapped children (whose mothers were unable or unwilling to care for them) have all been in conventional stable families who have provided stimulating and loving care for at least the past 5 years. Of the four mildly handicapped children, two remain with their natural mothers, one remains with his natural father, and one has been

*Continued on page 70*

alcohol-related conditions at the time of both initial and follow-up interviews.

It is anticipated that future morbidity surveys of the United States directly related to collection of alcohol-related data will be able to use this instrument to diagnose clinically defined alcohol abuse and dependence. The demonstration of relative equivalence of method and results based on the ECA program's development of a viable standardized methodology for the epidemiologic study of psychiatric disorder has also set the stage for comparative studies of all sorts. To date, the DIS has been translated into 20 languages, and ongoing research using the DIS and ECA program methodology is being conducted on numerous special populations in the United States (e.g., diabetics, disaster victims, alcoholic patients) in addition to general population surveys in over nine countries including the Republic of China, Peru, Japan, Germany, and Canada.

Turn to page 77 for references.

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### A Natural History of the Fetal Alcohol Syndrome: A 10-Year Followup of Initial 11 Patients

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adopted in this small sample, the differential effects of these diverse environments is not obvious in terms of intellectual development, but the caretaking environment does appear important in terms of social and emotional adjustment during adolescence.

The single most differentiating characteristic in the backgrounds of the four most handicapped children (Patients 4, 7, 9 and 11) is that three of their mothers were so severely alcoholic that they had died of alcohol-related causes within 6 years of the birth of these children (Table 2).

Child neglect has been documented at least once during the early years in five of the nine children followed. Two appear to have been the victims of physical abuse (one in a natural home and one in a foster home), and one has been abused sexually (Table 2). For those who remained with their natural mothers, the first years were always tumultuous, with a supportive rela-

tive or friend being particularly important as a refuge for the infant when the mother was drinking. Although the risks of child rearing in an alcoholic milieu are well known, these children were often particularly difficult to care for during their early years because of their failure to thrive, feeding difficulties, hyperactivity, and intrusiveness. On the other hand, of the three relinquished at birth by their mothers to state custody, one died in an apparent drowning accident in an adoptive home and another spent the first 1.5 years in a hospital and then had four different foster homes in seven years before finally getting into a stable home environment at 8 years of age.

### Conclusions

Followup of these children over a 10-year period has suggested two factors that may well be helpful in predicting the ultimate prognosis for individuals with the fetal alcohol syndrome.

Of greatest predictive significance is the extent and severity of the pattern of malformation. In a previous study that included some of these children (Streissguth et al. 1978), severity of the pattern of malformation and growth deficiency was correlated with degree of intellectual impairment. In this study, the four children with the most striking craniofacial abnormalities (Patients 4, 7, 9 and 11) have the most severe degree of microcephaly (abnormal smallness of the head), the shortest stature, and the most impaired intellectual function. Three of these four infants presented in a breech position at birth, while none of the four moderately affected children did so.

The most predictive factor in the backgrounds of the four most severely handicapped children was the severity of maternal alcoholism. Three of these four mothers had died of alcohol-related causes within 6 years after the birth of the child suggesting that biological factors associated with the terminal stages of alcoholism may be involved for the most severely handicapped children. Unfortunately, the quality of the later home environment could not overcome the severity of the prenatal insult. Two of the four most severely affected children lived in the most stable foster homes suggesting that the prognosis for children with the most severe fetal alcohol syndrome depends primarily on the extent and severity of the prenatal exposure to alcohol. However, improved social and emotional development was noted in all patients when home environments stabilized. This resulted

from decreased maternal drinking, departure of the alcoholic mother, or placement of the child in a stable foster or adoptive home.

This research was originally published in *Lancet* on July 13, 1985. Turn to page 73 for references.

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### Training Professionals to Identify and Treat Pregnant Women Who Drink Heavily

Continued from page 35

aged to discuss their responses to the counselor and her techniques. By comparing this patient with others, viewers are allowed to express frustration, anger, and concern towards patients. The goal is to recognize that the interviewer's unemotional, nonjudgmental, and supportive statements allow her to maintain communication with the patient.

### Conclusion

Pregnancy is a time in a woman's life when changes in physiology and social role cause her to think and behave differently. The sense of responsibility for another life increases the mother's receptivity to assistance in overcoming problem drinking. Women are concerned about multiple health issues and will adopt a lifestyle consistent with total health. Professionals must develop new attitudes towards alcohol abuse by pregnant women. Treatment programs with pregnant women report that 60 to 80 percent of heavy drinkers reduce consumption before the third trimester.

The adverse effects of heavy drinking on fetal development have been demonstrated repeatedly in clinical, epidemiological, and experimental programs (Rosett and Weiner 1984). High blood alcohol concentrations represent a risk at all stages of pregnancy. There is no safe time for intoxication. Reduction of heavy drinking

... benefits for both mother and child. It is important to stop drinking heavily as early in pregnancy as possible, however, it is never too late. Some benefits can accrue whenever alcohol abuse ceases. Incorporation of treatment strategies into routine prenatal care represents an effective, low-cost method of preventing fetal alcohol syndrome and fetal alcohol effects. The Fetal Alcohol Education Program helps to improve the skills of health care professionals who can facilitate effectively the reduction in drinking among pregnant women. □

Turn to page 74 for references

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#### An Evaluation of the Pregnancy Health Program

Continued from page 55

... is unresponsive to treatment, is at risk herself, and is carrying an infant who is at very high risk. This type of patient, seen in all types of alcohol treatment programs, often receives extensive services without a corresponding change in her condition. The women in group 3 are typical of this prototype. All but one had at least four PHP appointments prior to de-

... and total service hours ranged from 4 to 27 without improvement. The vulnerability of the mother as well as the fetus is becoming evident. For example, a high death rate after delivery has been reported among mothers who have had FAS children (Beattie et al. 1983). The case histories of women in group 3 are consistent with a poor, possibly fatal, prognosis.

Only 10 percent of the cases in this study fit this bleak prototype. By the end of PHP contact, most mothers (86 percent) were judged by independent raters to have improved. This result underscores the importance of identifying women who drink too much and providing effective education and treatment for them before their problem becomes chronic.

Pregnancy is a time when most women seem to decrease their drinking easily (Hook 1978, Larsson 1983, Little et al. 1976) and generally respond well to treatment (Larsson 1983, Rosen et al. 1980), at least in the short run. The data from this study support these findings.

#### Conclusion

We suggest that pregnancy is an ideal time to intervene in heavy drinking. We have outlined a simple method of screening that will identify those patients at the first prenatal visit. We have also presented evidence that if a heavy drinker receives education, and treatment if needed, she is likely to experience a significant decrease in alcohol consumption beyond that normally expected. Finally, we have reported that women who are identified and treated early have healthier babies.

Prevention of fetal alcohol effects requires intervention in maternal alcohol use at all levels of drinking, from regular use to the most severe alcoholic drinking. But prevention efforts must start earlier and continue longer if they are to be

maximally effective. True primary prevention requires women to decrease their drinking before conception. And resolution of any alcohol problem should endure after delivery so that decrease in drinking that occurs during pregnancy is the beginning of a long-term recovery that will benefit both mother and child. □

Turn to page 75 for references

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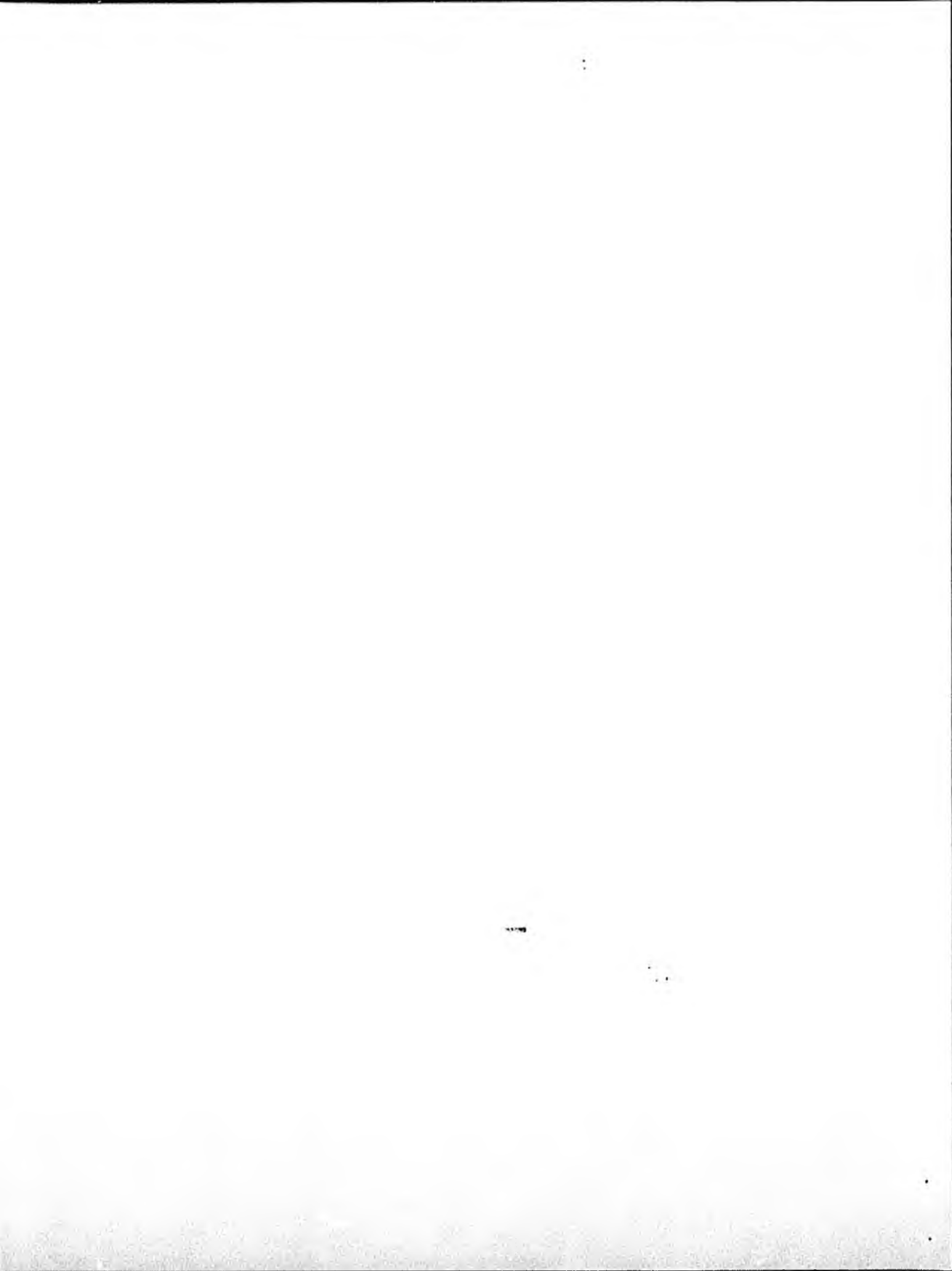
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*This infant is a low birth weight baby. State programs aim to increase awareness that maternal alcohol use can result in low birth weight and deleterious fetal effects.*

project were to encourage women of childbearing age to avoid alcohol and unnecessary drugs during pregnancy; to urge women with drinking problems to seek and accept treatment; to influence health, social service, and education professionals to provide education on alcohol and drug effects to all patients, clients, and students prior to and during pregnancy; and to intervene with high-risk women (Yancosek 1982).

#### Target Groups

The education of women is vital regardless of the intensity of their drinking, to permit them the opportunity to make informed decisions about alcohol consumption during pregnancy. Becky Beardsley of the Nebraska LCAD Fetal Alcohol Syndrome Prevention Project has distinguished three subgroups of women as target audiences for information and inter-

vention: high-risk, moderate, and low-risk (Table 1). Each of the cells in Table 1 describes a level of risk based on the drinking and/or pregnancy status of the individual. The low-risk cell, for example, describes the person neither currently drinking nor pregnant. Reinforcing the decision not to consume alcohol if pregnant is the thrust of prevention for the low-risk group. Public information efforts, school health education, and health professions curricula are also strategies for reaching women considered at low risk (Beardsley et al. 1985).

#### Program Structure

The Nebraska LCAD Fetal Alcohol Syndrome Prevention Project utilizes a program framework based on primary, secondary, and tertiary prevention modalities for each stage of the maternal-child health continuum (i.e., preconception, prenatal, intrapartum, and postnatal) (Table 2). Primary prevention encompasses activities that target low- and moderate-risk women. These efforts can include teacher training for junior and senior high school teachers, public information and education, and professional education for health and human service workers. Pri-

mary prevention may also entail curriculum development and consultation with curriculum developers associated with educational institutions.

Secondary prevention consists of professional training and consultation with health and human service workers. Training includes information and individual consultation on the identification of high-risk (alcohol- and drug-abusing) women, especially pregnant women, and intervention counseling techniques. Trained personnel may directly assist physicians and other health professionals in directing intervention efforts. Tertiary prevention consists of providing referral information and guidance for alcohol-abusing women and affected children. It might also include a support group for women with FAS/FAE children as well as legislative activities (Beardsley et al. 1985). The program components just identified will be discussed further in the article.

Caregivers in the intrapartum and postnatal periods may need to be reminded of secondary and tertiary prevention. Even a woman who has been drinking during pregnancy should stop doing so to protect her baby from further alcohol-related birth risk during the remainder of the pregnancy

**Table 2. Target Groups of Women in Childbearing Years**

		PREGNANT	
		Yes	No
Drinking	Yes	<p><b>High Risk</b>  <i>Secondary prevention</i> (intervention aimed at alcohol/drug abstinence during course of pregnancy.  <i>Tertiary prevention</i> (referral and support group) to minimize adjustment difficulty.</p>	<p>Appropriate referral would be made to existing agency.</p>
	No	<p><b>Moderate Risk</b>                      Since these women are currently pregnant, not using alcohol/drugs, <i>primary prevention</i> efforts aimed at reinforcing that as well as skill to maintain.</p>	<p><b>Low Risk</b>  <i>Primary prevention</i> efforts at reinforcing a choice of alcohol/drug-free lifestyle while pregnant if woman chooses to become pregnant</p>

Health also conducted a statewide telephone survey of 300 randomly selected women of childbearing age. Only minimal costs, for computer time, were incurred (Nystrom 1983). The Pennsylvania Project for Prevention of Fetal Alcohol and Drug Effects used questionnaires mailed or directly administered to randomly selected women (Yancosek 1982).

In order to determine the extent and the nature of the problem and to obtain a base of information upon which a prevention program could be developed, Maine commissioned a study. The four objectives of the study were:

- To determine the state-of-the-art of the State and national level;
- To identify effective education and prevention strategies and activities;
- To develop a proposal for a long-term prevention model program; and
- To identify constituencies with the duties, responsibilities, or interest in prevention strategies (Mullen and Anderson 1985).

Existing statistics may also be useful in estimating the extent of the problem, although data about the incidence and prevalence of FAS/FAE are often flawed because of misdiagnoses. Information on demographic factors, births, infant deaths, fetal deaths, rate of alcoholism, number of women admitted for treatment, and other data is generally available through the State's division of statistics or a health planning agency. Such information should assist in understanding the effectiveness of current educational efforts and in identifying sources of information and advice related to the effects of drinking alcohol during pregnancy.

#### Professional Education

Many State FAS/FAE prevention programs have strongly emphasized professional education of physicians and other health care providers. Education of professionals is most effective when directed at both medical and nonmedical personnel concerned with the health and welfare of women and children. The overall goals of such education efforts are to increase knowledge of alcohol-related birth defects, to stimulate awareness and interest in the problem and prevention efforts, and to activate preventive and therapeutic behaviors such as:

- Patient or client education;
- History taking concerning alcohol and drug use;
- Diagnosis of maternal drinking and other drug problems;
- Intervention and and referral for alcoholism and drug treatment; and
- Diagnosis of FAS and other prenatal drug effects in children.

Many State programs have "kicked off" their professional education for physicians and other health professionals with a symposium, a workshop, or a conference. A forum that includes a local pediatrician, an alcohol/drug women's counselor, a family therapist with expertise in the areas of women's alcoholism and FAS/FAE prevention and, if possible, nationally recognized researchers in the field offers a valuable opportunity for introducing the many dimensions of this problem. Typically, physicians prefer to receive information from other physicians in the same specialty.

More extensive training sessions might be held at local hospitals, nursing schools,

medical assistant training programs, and conferences sponsored by related organizations. Inservice sessions can be provided to Women, Infant, and Children (WIC) nutritionists, public school nurses, public school teachers, drug/alcohol counselors, Head Start staff, welfare case-workers, and others concerned with maternal and child health.

As part of the New York State Division of Alcoholism and Alcohol Abuse (NYSDAAA) campaign in 1980, FAS information packets were mailed to 1,000 obstetricians and gynecologists. The packets contained a reprint from a prestigious medical journal describing FAS, an outline of the criteria for the diagnosis of alcoholism, photographs of FAS cases, patient brochures, posters in English and Spanish on drinking while pregnant, a patient alcohol and health self-test, a referral list for problem drinkers, a referral list for affected children, and patient pamphlets on alcohol abuse. In addition to mailing out the information packets, NYSDAAA-sponsored medical conferences and grand rounds around the State on FAS and alcohol-related birth defects. Over three-fourths of the physicians who reported receiving and reading the NYSDAAA FAS information packet considered the items useful. However, data on physicians' intervention efforts suggest that additional efforts are needed to motivate and assist many obstetricians and gynecologists with implementing a system for screening their patients routinely for problem drinking and to identify and refer those who are in need of special treatment for alcohol abuse (Russell et al. 1983).

#### Referral and Support Services

Once health and other professionals have received training about the problem of alcohol-related birth defects, they may need assistance in counseling, referring, and treating women and children. The Nebraska LCAD Fetal Alcohol Syndrome Prevention Program, for example, has responded to requests for assistance with designing screening and risk assessment tools. The services of qualified program staff have also been made available to assist with intervention and with counseling alcohol-abusing pregnant women. Referral information is provided to professionals who have identified either a woman abusing alcohol/drugs or affected children. A resource center providing up-to-date materials and information (e.g., audiovisuals, books) is also a service of inestimable value to persons in the field.

Offering consultation services to health professions educators interested in updating their curricula to include FAS/FAE prevention information is another support service provided by the Nebraska project. Some schools may want to include presentations by project staff as well (Beardsley et al. 1985). Nursing schools appear especially receptive and play a key role in disseminating current FAS/FAE information to health professionals.

To ensure that information is accessible, the North Carolina project operates a 24-hour telephone information service available to anyone with a question about FAS or about alcohol consumption during pregnancy. An answering machine records messages received when staff is not available to answer the hotline.

#### Community Education

Reaching the general public, especially women of childbearing age, with information about alcohol-related birth defects is a major thrust of most FAS/FAE prevention programs. Such public education campaigns should not be limited to women of childbearing age; informed mothers, friends, spouses may also serve as informal educators. Print materials, community education programs, and mass media are complementary and reinforcing modes of communication that reach a broad cross-section of the community.

Posters and pamphlets are the most common print materials developed and distributed by FAS/FAE prevention programs. Many States have received permission from existing programs to adapt materials and messages that have proved effective. The article in this issue on disseminating information (see page 54) suggests appropriate messages for women and physicians. Some excellent locations for placing such materials are doctors' offices, pharmacies, laboratories where pregnancy tests and premarital and pregnancy blood tests are taken, marriage license bureaus, social service agencies, church bulletins, maternity clothing stores, children's clothing stores, shopping mall displays, State liquor stores, supermarkets, family planning services, health clubs, WIC nutrition programs, laundromats, prepared childbirth classes, YWCAs, other women's clubs, beauty shops, and many other places frequented by women (Yancosek 1982).

Presentations that provide more detailed information through the use of speakers and audiovisuals are effective mechanisms for increasing awareness. Such programs

can be offered to the membership of existing organizations, clubs, and groups such as childbirth education classes, LaLeche, PTAs, and YWCAs. All presentations should emphasize the positive aspects of healthy pregnancies rather than the negative aspects of birth defects. (Information about films, pamphlets, and other materials may be obtained from the National Clearinghouse for Alcohol Information.) Some communities have established a speaker's bureau composed of experts on various aspects of FAS/FAE who have indicated an interest in making presentations on the subject.

Newspapers, radio, television, and magazines are also useful channels for communicating information about alcohol-related birth defects. In 1982, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) developed radio and TV public service announcements and distributed them nationwide to county drug and alcohol programs and radio and television stations. Newspaper sample articles and detailed talk show interview scripts were also distributed. Some of these materials are still available for distribution by contacting NIAAA. These and similar locally developed materials are the ingredients for a mass media campaign that might be conducted over a 3-month period every year or every other year. The Christmas-Hanukkah season and Mother's Day are particularly appropriate times for such campaigns.

#### School Programs

Drinking frequency and amount remains at alarmingly high rates among high school women as does the incidence of teenage pregnancy. To ensure that information on alcohol-related birth defects reaches teenagers before alcohol is a problem, it should be incorporated at all levels of education under the heading of preventing developmental disabilities. The Nebraska alcohol-and-drug school curriculum, as well as others in the Nation, includes junior and senior high school units on alcohol, drugs, and pregnancy. Most States, however, do not include such information in the elementary school curriculum. In school systems where alcohol-related birth defects are not addressed, the prevention program might encourage the department of education to develop such a component.

The Maine prevention program worked with four area institutions for higher learning. Activities included 10 FAS/FAE presentations; public service announcements through college radio stations and

newspapers; and visual and narrative materials placed in health centers, dormitories, sororities, and fraternities. All human service programs sponsored by these colleges agreed to integrate information about FAS/FAE into their course materials (Mullen and Anderson 1985).

During the 1985-86 fiscal year, Pennsylvania will implement a comprehensive program aimed at increasing awareness among youth about the harmful effects of alcohol consumption during pregnancy. This initiative will include regional workshops for relevant school personnel, the development of a five-unit curriculum for grades 9-12, and a video training tape on screening and interviewing techniques for obstetricians, gynecologists, and nurses.

#### Conclusion

This discussion has provided an overview of the core activities of an FAS/FAE prevention program. As mentioned earlier, once training and inservices have been provided, a prevention program should continue to provide ongoing services as an information and referral source. Periodic training is, of course, necessary to reach newly identified providers. Those projects that emphasize the health of the mother as well as the fetus will have a full agenda.

Here is a sampling of activities for those interested in pursuing additional prevention strategies:

- Provision of technical assistance to the State Department of Education curriculum development task force and membership on the Department's task force on chemical dependency and special education;
- Recruitment, training, and deployment of a core group of physicians interested in the prevention and treatment of FAS/FAE to provide training to their colleagues through hospital departmental staff meetings, regional and State medical association meetings, etc.;
- Collaboration with the Developmental Disabilities Council to identify groups/agencies with the capacity to support effectively families who are experiencing the trauma of having a disabled child;
- Establishment of a diagnosis registry for FAS/FAE.

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Turn to page 76 for references.

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X.

## ALCOHOL RELATED BIRTH DEFECTS: IMPLICATIONS FOR EDUCATION

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### ABSTRACT

This article emerges from a larger study of preventive approaches for Alcohol Related Birth Defects (ARBD) prepared for the New York State Department of Education. The author contends that in addition to clearly identifiable Fetal Alcohol Syndrome children, there is a continuum of impairment to the offspring of drinking mothers that is dose related and produces serious behavioral/learning deficits. The continuum includes young people of normal intelligence who perform below expected levels and find school adjustment difficult. School and community agencies need to conduct studies to determine the nature and extent of impairment and the kind of interventive and preventive action that should be instituted. To that end, this article gives information on the background and nature of ARBD and some suggestions to guide development of programs.

Alcohol is a teratogen. Animal and human studies of maternal use of alcohol during pregnancy suggest a continuum of fetal impairment ranging from severe mental retardation and growth abnormalities, what is commonly called the Fetal Alcohol Syndrome (FAS) to lesser physical and mental defects.

Estimates of prevalence of Alcohol Related Birth Defects (ARBD) range from one in every seven to eight hundred births for the full syndrome to three to five in a thousand births for partial FAS effect. Attempts to determine the number of "normal" children suffering from milder forms of impairment lack precision, but the figure might be as high as one case in every 150 births. Whatever the count, ARBD joins Down's Syndrome and Spina Bifida as leading causes of birth defects.

### IMPLICATIONS FOR EDUCATION

Quite obviously, there already exists sufficient information on ARBD to warrant full prevention programs in all schools and special interventive programs for youths identified as FAS children. To meet problems associated with

lesser alcohol-related birth defects, communities need to initiate or foster studies analyzing the extent and nature of developmental impairment. There appear to be children sitting in classrooms who are considered normal in intelligence, but are achieving at levels well below the expectations of parents and educators. The profile of such a child would approximate the following description.

1. Scores normally or above on intelligence tests.
2. Does not achieve or work effectively.
3. Tends to be sultry, hyperactive, impulsive.
4. Has attention deficit disorders.
5. May show some of the facial/physical irregularities common to FAS children.
6. Falls behind other children in terms of intellectual development.

Using a more sophisticated or precise profile, schools, local hospitals (pediatricians and nurses), clinics, and other interested agents might want to study children with those characteristics and those without to compare statistically the incidence and nature of maternal drinking. Those directing the study might then reverse the study by seeking out a specified number of non-drinking or light-drinking mothers, a sample of moderate drinkers, and a group of chronic users and compare data. Findings from both studies could then be viewed against data emerging in the literature. If a positive relationship between maternal drinking and poor learning performance emerged from the study, the school involved would have supporting data for implementation of prevention and intervention programs.

As an aid to school-directed action, some ideas basic to ARBD are listed.

1. Increased drinking rates in America over the past three decades, particularly by women, appear to have produced higher incidence of alcohol related birth defects.
2. Alcoholism produces consciously tragic consequences for the individual involved. Maternal alcoholism brings tragedy to the unborn, the innocent.
3. What is often called "social drinking" may actually be rather heavy and steady use of alcohol with negative consequences for the offspring of maternal drinkers.
4. Chronic maternal drinking before and during pregnancy results in morphologic problems for offspring. The first six to eight weeks of gestation are most critical for fetal development. Abstinence or very limited use of alcohol during that period should be the rule. Mothers should also avoid use of alcohol if the child is to be breast fed.
5. Data suggests that abstinence for the greater part of a year prior to conception may be necessary for the alcoholic mother who wishes to minimize risk of ARBD.

6. Approximately one-third of the offspring of chronic alcoholic mothers have full FAS effects. Seventy-five per cent have partial effect. Impairment appears to be dose related. Use of cigarettes, caffeine, and other drugs as well as poor nutritional habits increase the risk of damage to offspring.
7. Most attention has been given to children with full or partial FAS impairments. It is conceivable that the more significant problem for education is the larger number of unidentified children suffering alcohol-related behavioral and learning disorders and resultant school or learning difficulties.
8. Small quantities of alcohol can produce reduced birth weight and behavioral problems in offspring. Perhaps 30 to 40 per cent of prospective mothers believe that moderate, occasional, or "special occasion" heavy drinking during pregnancy is safe.
9. Pregnant women tend to drink less during pregnancy, particularly during the first trimester. The decrease is directly proportional to the amount of alcohol consumed prior to pregnancy. Chronic drinkers continue to drink more heavily than moderate users. Binge drinking (five drinks or more on an occasion) increases in heavy drinkers even though overall consumption may be reduced.
10. Though studies of paternal drinking are not conclusive, there is some evidence that drinking by fathers may be related to impairment in offspring. More study is needed.
11. Schools have the largest concentrated community of prospective parents. These young people ought to be assessing information for themselves and helping to educate their peers and elders.
12. Schools have the plant, equipment, educators, and on-going health oriented programs as resource bases for effective prevention programs.
13. Teaching about ARBD and the effects of teratogenic agents generally may have effective motivating value for youngsters in school-based health education programs.
14. Schools could broaden educational efforts by incorporating ARBD modules in various continuing education programs.
15. Schools should take the lead in attempts to foster unified community action programs which would tie together the efforts and resources of the university, community and school.
16. Alcohol-related birth defects cut across racial, class and environmental factors. Maternal drinking before and during pregnancy needs no help in producing obvious and subtle developmental problems for children.

It is encouraging to note television and radio programming aimed at problems associated with maternal drinking. It is discouraging to report that family clinics often do not collect data on the drinking habits of the prospective mothers they serve or that they make little use of the data once in hand. Obstetricians are

reluctant to question too strenuously the use patterns of patients. Consequently, follow-up of a "normal" child born of a drinking mother gets lost in the transfer from maternity ward to family doctor or pediatrician.

School administrators are generally aware of fetal alcohol problems but there is minimal transfer of that awareness to the implications of those problems for child development and school programming. Efforts by the author to locate schools with significant prevention/intervention programs went unrewarded. School officials turn away from suggestions that they spearhead, encourage, or involve themselves in studies designed to analyze the consequences of maternal drinking for education. They are interested, but only at the cognitive level. Hopefully, data emerging from childhood studies being conducted at pediatric centers and emphasis through the media will move school officials to bolder activity.

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# How Alcohol Affects the Developing Fetus

*Some observations about the normal and abnormal physiology of the pregnant woman who drinks. These reflections make it clear why we should all read the Holy Bible more carefully.*

by CORTEZ F. ENLOE, JR., M.D.

When Dr. Iber wrote in the January-February 1971 issue of *Nutrition Today* that "In Alcoholism, The Liver Sets the Pace," he helped us understand why drinking more than a moderate amount of alcohol causes the beverage to escape the detoxifying system of the liver and reach the developing fetus. The fetal alcohol syndrome or FAS, as it has since come to be known, had not been recognized at the time of Dr. Iber's report. There can be little doubt, however, that as he pointed out, the rate at which the liver can spare the body the damage of alcohol is "a linear function of time." He provided us with the clue to the fact that once alcohol consumption reaches a stage in which the alcohol blood level in the portal circulatory system between the digestive tract and the liver exceeds the capacity of the liver to detoxify it, trouble is sure to occur. The excess alcohol passes on into the general circulation and the person becomes drunk. And drunkenness

is a primary cause of crime, of automobile accidents, of fatal crashes by private airplanes, and, now it seems, it may also be a principal cause of mental retardation and birth defects by making the fetus drunk. This then is reason enough to look at the pathologic physiology in the pregnant woman who drinks.

At first blush one could easily be suspected of trivializing a serious matter when they observe that the pregnant woman who craves the psychologic release of a cocktail would do well to eat while she drinks. There is sound medical reasoning behind this advice because by eating as she sips, she slows the absorption of alcohol, or ethyl alcohol, or to be exact, ethanol, to use the contraction, from her stomach into the portal circulatory system. The slower the absorption rate, the better the chance that the liver will be able to break down the alcohol and keep it out of the general circulation.

As Dr. Iber pointed out, the moment one takes a drink, the alcohol that first reaches the stomach is quickly absorbed. However, if one then nibbles a bit of cheese or a mini-frankfurter hors d'oeuvre absorption is slowed. And the greasier the tidbit the better, because the presence of fat slows absorption of alcohol through gastric mucosa. By these willful acts—sipping drinks slowly and eating all the while—the liver, which has only a limited capacity to detoxify and metabolize any agent, is given an opportunity to reduce alcohol from the stomach into innocuous acetaldehyde and acetic acid, and these two substances subsequently break down into carbon dioxide and water. This chain of events is clearly established. It is only part of the

routine activity of the liver, a large, busy factory alive with metabolic chemical reactions that break down nutrients and other chemicals absorbed from the stomach and intestine into less complex units so the body can use or dispose of them.

## PORTAL PROTECTION

This emphasizes the virtues of the portal system because through its vessels everything that leaves the stomach or the small intestine must first go to the liver before it can pass into the body's general circulatory system. However, as Dr. Iber pointed out, the trouble is that the liver's capacity is limited and inflexible. As he told us, in the case of alcohol, the liver can handle about ten milliliters an hour. Or, to put it another way, it means that it will take the liver of the average person from five to six hours to fully oxidize the alcohol in four ounces of whiskey or two and one half pints of beer. This is why three drinks at lunch puts President Carter's mythical executive off his beat for the afternoon. This can only be avoided if one were to spread their alcohol intake of such drinks evenly over four hours' time, an unlikely event because then they would get little or no kick from drink at all.

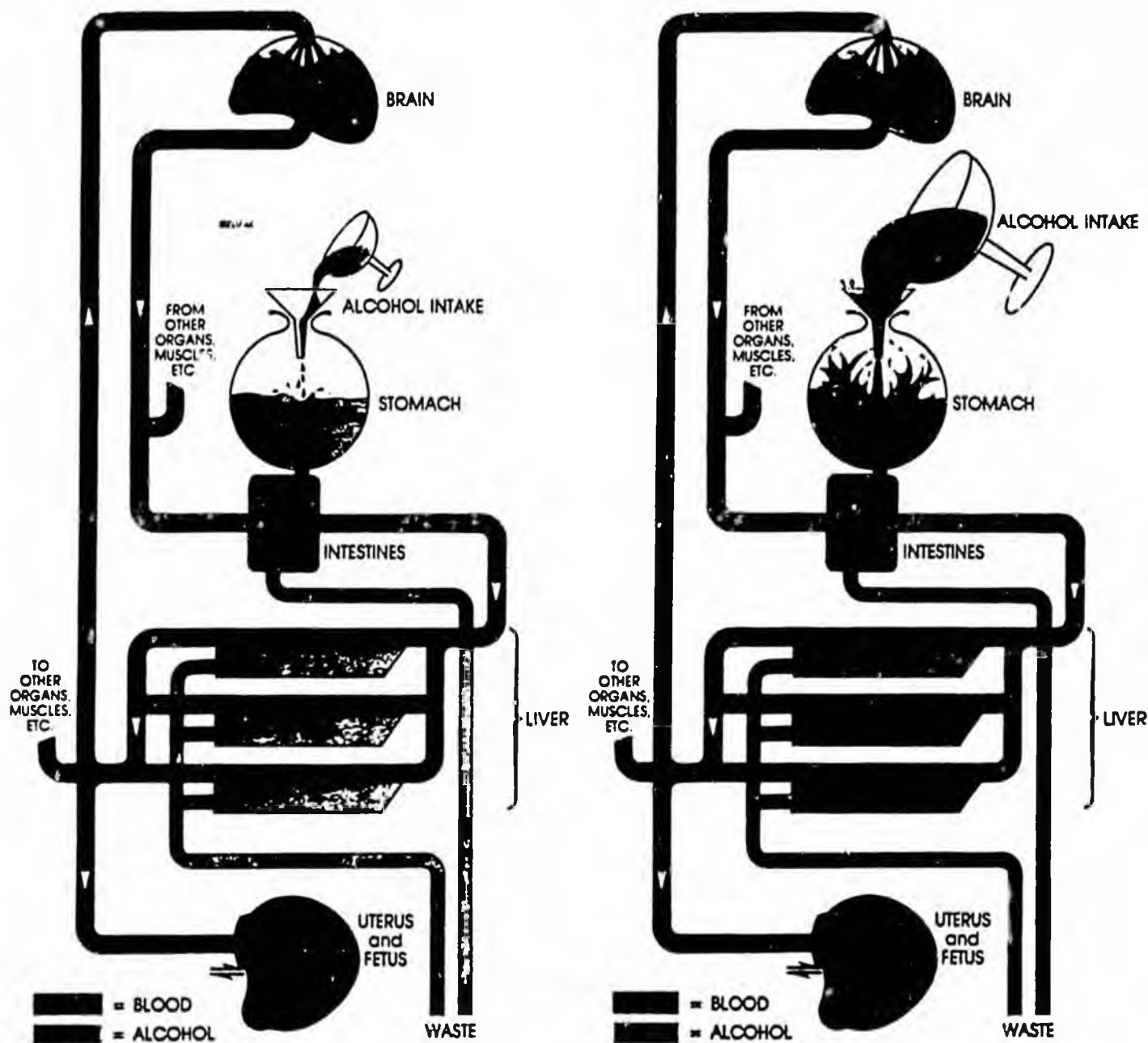
The trouble begins when the liver receives more alcohol than it can handle. It simply lets the excess pass into the general circulation and picks out that which it can detoxify at its leisurely pace as it passes back through the liver. Thus it permits the host to enjoy the intoxicating pleasures of alcohol until the organ has time to pick it up and reduce it to carbon dioxide and water. If the amount is such that the transfer of acetaldehyde exceeds



Dr. Enloe is the editor of *Nutrition Today* magazine.

Low rate of alcohol intake. The liver is able to "filter" the mother's blood, removing the alcohol before it can enter her circulatory system and affect her brain and the fetus.

High rate of alcohol intake. The threshold of the liver's ability to treat the continuing high level of alcohol in the blood is surpassed. As the blood enters the mother's circulatory system it continues to carry alcohol with it, suffusing her brain and the fetus with this toxic substance.



Schematic diagrams showing the threshold characteristic of the liver's ability to metabolize alcohol carried in the blood. When the threshold is exceeded—when the liver cannot cope—the alcohol carried through the mother's circulatory system suffuses her brain and the fetus.

female sex hormone over a period of time, then suddenly withdraw it, and it will be observed that the ovaries have ceased to produce their normal amounts of estrogen.

This habit of a cell to lose its basic function when that function is distorted or replaced by external factors, is one of the dangers of giving excessive amounts of cortisone to the person who still has a functioning adrenal cortex that manu-

factures the same hormone.

It is reasonable, therefore, to suspect when the cells of the developing fetal reticulum are bathed with desiccating alcohol they soon adapt to that state wherein the abnormal becomes to them the normal. This might be called the phenomenon of the wisdom of the cell.

The fact that the brain in both the adult and the developing baby has a rich supply of blood means that a majority of

the alcohol-laden blood soon reaches the most easily damaged area. In the case of the fetus, we have known for some time that the alcohol in the blood of the mother easily crosses the barrier from the decidua (the temporary lining that forms in the mother's uterus to hold the placenta of the baby in place) into the placenta and thus heads for the organ that has the highest coefficient of affinity for alcohol of any organ in the body.

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*The World's Most Widely Read Nutrition Journal*

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ALCOHOL AND PREGNANCY

## Characteristic Anatomical Defects that are Signs of the Fetal Alcohol Syndrome

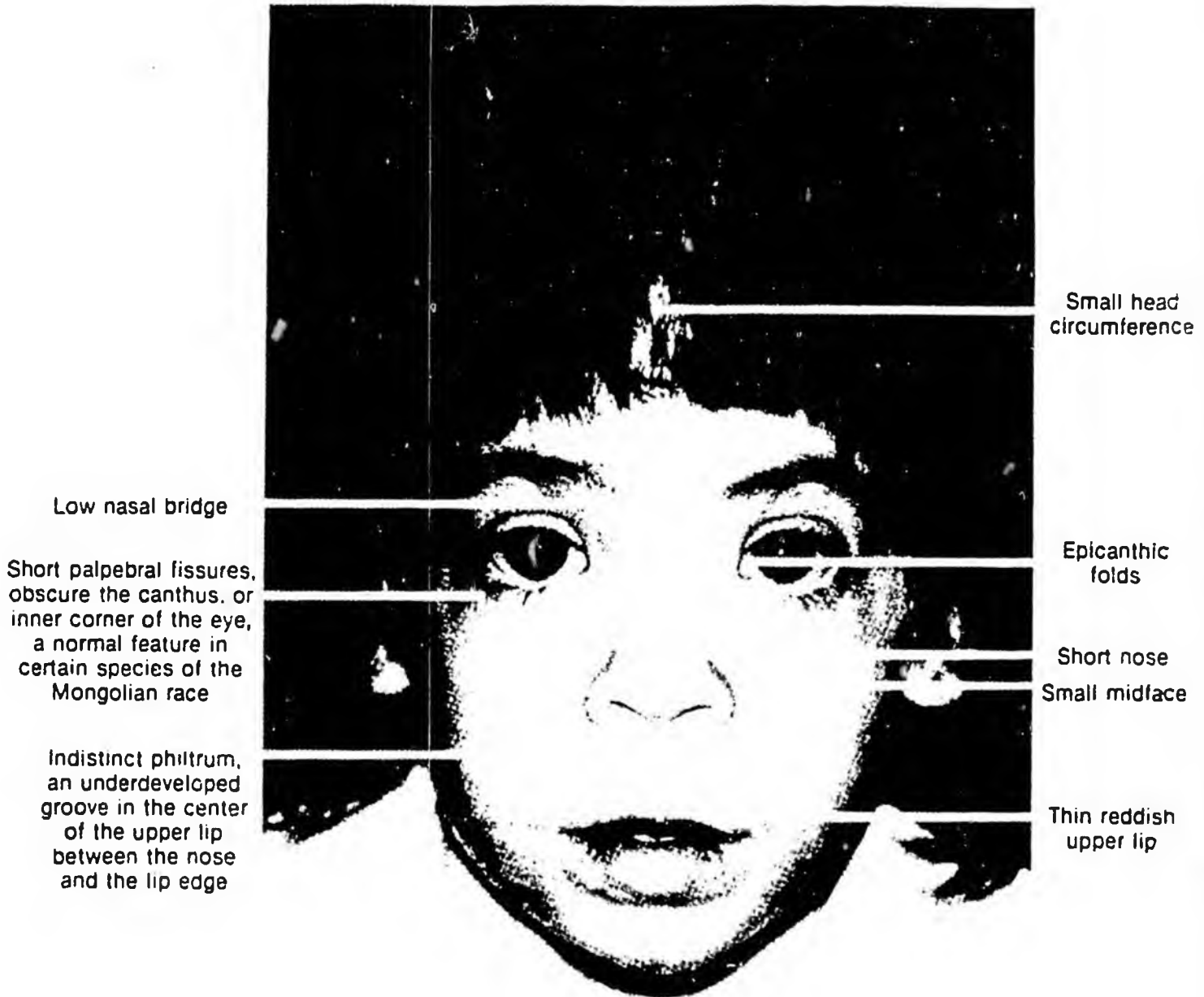


PHOTO COURTESY NLM

*Epicanthus is a characteristic of the eye where a vertical fold of skin extends from the root of the nose to the inner termination of the eyebrow, sometimes covering the inner canthus. Its presence is normal in certain of the Mongolian races but a telling deformity in FAS.*



The Fetal Alcohol Syndrome is not always looked for nor is every physician and nurse familiar with its telltale manifestations. Hence, these figures are only estimates. The actual figures may be higher than we think.



0.4

1.1

2.6

**RURAL TOWN**  
Low Alcoholism Rate

**SMALL CITY**  
Moderate Alcoholism Rate

**METROPOLITAN AREA**  
High Alcoholism Rate

Figure 2. Incidence of the full fetal alcohol syndrome for each 1,000 live births in America

### EFFECTS OF FAS

FAS in its most exquisite, full-blown development is revealed in a child by numerous defects in cranio-facial development, in prenatal and postnatal growth, and mental insufficiency. None of these defects correct themselves as the child grows older. Table 1 lists these major features.

This is the type of infant that is frequently born to women who, careful interrogation reveals, admit to having five or more drinks a day (i.e., 60 grams or more of alcohol) throughout pregnancy.

In twins born to alcoholic women some curious inconsistencies have been noticed. For example, three pairs of fraternal twins (those from separate eggs) have been observed in which one twin exhibited all of the physical deformities of the syndrome while the other twin was apparently normal. We do not know whether the second twin showed decreased mental acuity in later life. This suggests that the genetic susceptibility may be important. Otherwise at the present state of our knowledge this inconsistency defies explanation.

The only known affected identical twins, which is to say those from one egg, were equally deformed.

We do not yet know how prevalent the FAS is in America (fig. 2). The main reason is that recognition of the existence of the syndrome is so new that not all physicians have had time to become experienced in recognizing its signs and symptoms. In Seattle, where the syndrome was first defined, and pediatricians have been alert for the longest time, it is estimated that approximately

one child is born with FAS in each nine hundred live births. Similar observations in New York City indicate that the incidence is one in each four hundred births. The data suggests that FAS occurs about as frequently as the trisomy 21 Down's Syndrome. Given the fact that it most

usually causes mental impairment, the prevalence of FAS may make it the most common birth defect of which we are currently aware. For example, of over eighteen women in Brooklyn, New York, who were identified as having been heavy drinkers during pregnancy, twelve

FEATURE	MANIFESTATION	PERCENTAGE
	Present in 99% of patients	99% of patients
Brain Injury	Clear mental retardation	
Intellectual	Too small head (microcephaly)	Poor coordination
Neurological	Irritable in infancy	Hypotonia
Behavioral		Hyperactive in childhood
Growth Impairment		
Prenatal	Significant reduction in weight and height	
Postnatal	Significant reduction in weight and height	Disproportionately decreased fat stores
Facial Characteristics		
Head circumference	Too small	
Eyes	Short palpebral fissure	
Nose	Hypoplastic philtrum	Short upturned
Maxilla		Hypoplastic
Mouth	Thinned upper vermillion	Micrognathia or prognathia in adolescence
	Retrognathia in infancy	

PHOTO COURTESY D. A. SMITH M.D.



A characteristic feature of FAS is a smaller head circumference (sketch) than usual (outline)

children born each year with an anatomical and mental deformity and that twelve hundred such babies enter Canadian society each year.

Like all other substances that cause the birth of physically and mentally abnormal offspring, the effect of alcohol is varied by a combination of genetic susceptibility, maternal nutrition or malnutrition, and the intensity of the insult to which the fetus is subjected. As has been said earlier, with only one or two exceptions the advanced syndrome appears to occur only in mothers who consume a reasonably large amount of alcohol daily throughout pregnancy or who, from time to time, go on binges of extreme consumption. The mean intake of

seventy-two grams of ethyl alcohol daily for those mothers in whom this intake can be measured reveals just how heavily they do drink. In some other studies, the complete syndrome has been noted in those who have four or five drinks a day and average at least forty-five drinks a month. These data should be no comfort to the woman who may have three or four drinks in one evening while she is pregnant and then no more for a day or two, because no data yet exists that indicates a safe level of alcohol consumption during pregnancy. It is quite clear from the animal data measuring impaired learning, and in laboratory species that have been observed, that injury occurs even when lesser amounts of alcohol are consumed than those needed to produce the anatomical deformities of the head and face.

The syndrome in its full blown form has major elements that are easily observed and can be set forth in the accompanying figures and charts. To meet these requirements there must be present elements of brain injury traceable to deficiency in intellectual and neurological growth. These are clearly apparent at age one and thereafter, but are not perceptible in the first year of life. Even at birth, however, it is easy to see that the child with FAS is too small, is not long enough, nor does it weigh enough for an estimated gestational age.

The circumference of its head is even smaller than it should be for the reduced size. These are impairments that remain throughout life. There is no such thing as the FAS child catching up.



This is a teaching aid article. Price and delivery dates are available on request. For institutions and anti-alcohol programs, bulk prices will be available at a discount. Ordering information will be ready by January 1, for delivery after February 1.

Figure three shows a weight and height graph for the syndrome with data obtained during the first year of life in several of these children. In contrast to most other forms of low birth weight and height there is no postnatal catch-up growth. These infants are repeatedly evaluated for failure to thrive and at all times in subsequent growth they remain more than 2SD below the average, with weight usually being more severely impaired. The impaired adipose tissue deposits results in these children remaining skinny. Most studies of the reasons for the impaired size is a prenatal insult to cell proliferation leading to diminished numbers of fetal cells.

The best known symptoms of FAS are the abnormal features one can observe in the face (table 1). They are best understood by postulating that the brain and the part of the face dependent upon a brain of normal size just did not develop adequately to fill out the face. The eyes are too close together. There is the fold that covers the inner corner of each eye, a phenomenon that is normal in

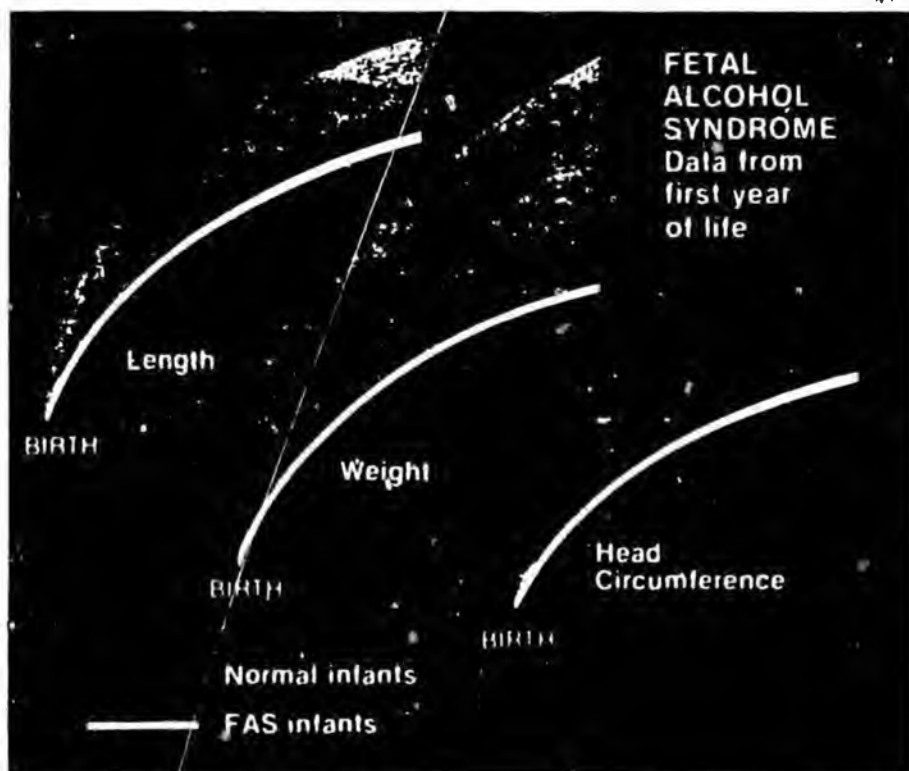
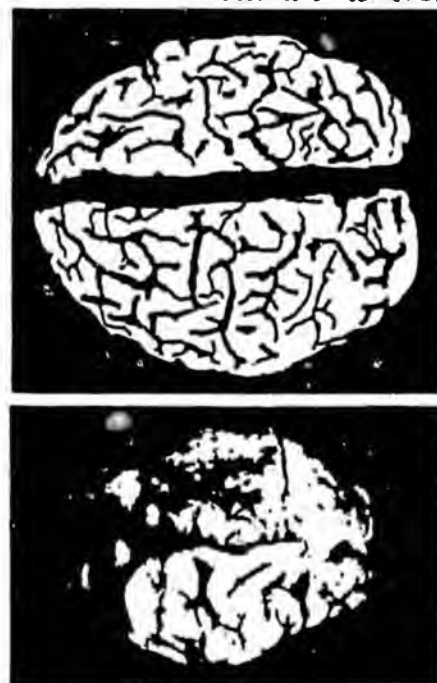


Figure 3. Growth Chart

NY 2

PHOTO COURTESY S. K. CLARREN M.D.



Compare the size of the brain of a normal newborn infant with that of an infant with FAS who died five days after birth (lower specimen). The affected brain exhibits a gyral pattern obscured by a leptomenigeal neuroglial heterotopia.

It's true that what a mother-to-be eats and drinks affects her baby. That's why pregnant women are advised not to drink alcohol because it can cause a BIRTH DEFECT called FETAL ALCOHOL SYNDROME (FAS). With FAS the baby is growth retarded, mentally retarded, has facial deformities and many other physical problems.

**BUT THE FATHER'S DRINKING ALSO AFFECTS HIS CHILDREN:**

It affects his ability to father children.

It increases the chance of other birth defects in his children.

His babies have low birthweight.

The father's support of the mother during the pregnancy is the most important action a man can do to have a healthy baby.

- \* Make an agreement that neither you nor the mother-to-be will drink alcohol, smoke cigarettes, marijuana or use any drugs during the pregnancy. This agreement makes it easier for a woman to maintain a healthy life style.
- \* Encourage regular prenatal care, and go with her to the checkups.
- \* See to it she eats a balanced diet, and takes prenatal vitamins and iron if prescribed.
- \* Remind her not to take any medicine during the pregnancy unless told to by her doctor.

**IT'S YOUR BABY TOO!!!**

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Having a healthy baby was once thought to be the woman's responsibility.....

Drinking is harmful all through the pregnancy. It is especially harmful to the baby during the first three months, a time when many women do not know they are pregnant.

FAS is a totally preventable birth defect which only YOU can prevent.

# FETAL ALCOHOL SYNDROME



Fetal Alcohol Syndrome (FAS) is a birth defect caused by a woman drinking during her pregnancy.

44-50% of women who drink heavily during pregnancy will have children with FAS.

11% of women who drink moderately during pregnancy will have children with FAS.

Alcohol passes freely through the placenta to the baby. The baby's blood alcohol level is the same as the mother's. The baby drinks with the mother - drink for drink.

No amount of alcohol during pregnancy is safe for the baby.

Children with FAS have:

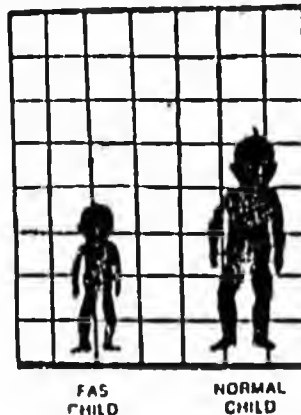
1. Abnormal, Deformed Facial Features

- \* small, widely spaced eye openings
- \* small head
- \* short, upturned nose
- \* indistinct or no groove between the nose and upper lip
- \* thin upper lip
- \* flat midface
- \* small jaw



2. Growth Retardation

- \* at birth they are smaller than normal children in weight, length and/or head circumference
- \* FAS children do not "catch-up", they will always be below normal



3. Poor Brain Development

- \* mental retardation
- \* small, incompletely formed brain
- \* developmental delays
- \* learning disabilities
- \* poor fine and gross motor coordination
- \* seizures



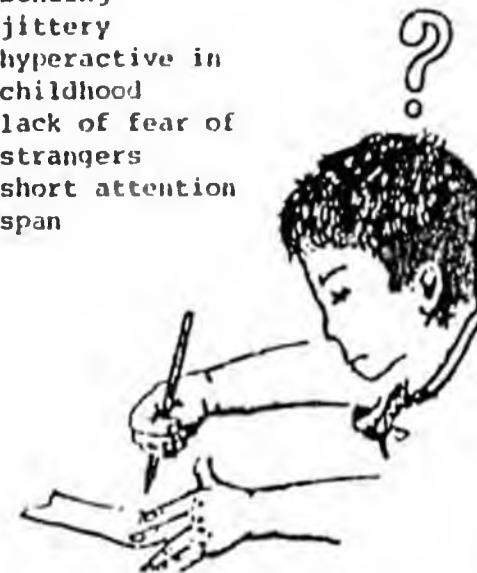
4. Physical Deformities

- \* heart defects needing surgery
- \* vision and hearing defects
- \* kidney defects
- \* abnormal liver functioning
- \* cleft lip or cleft palate
- \* joints (fingers, toes, hips, elbows, knees, etc.) that do not work right
- \* immune deficiencies - are sickly children
- \* failure to thrive



5. Behavior Problems

- \* irritable in infancy
- \* poor mother-child bonding
- \* jittery
- \* hyperactive in childhood
- \* lack of fear of strangers
- \* short attention span



Telegram



1988 MAR -2 PM 8:01

MAR 3 1988  
RECEIVED  
C

GEORGIA NATIONAL LANGUAGES CENTER  
SERVICES UNIT  
J. END

RECEIVED  
MAR 3 1988  
SERVICES UNIT  
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# **CORRECTION**

**THIS DOCUMENT  
HAS BEEN REPHOTOGRAPHED  
TO ASSURE LEGIBILITY**



Telegram

1988 MAR -2 PM 8:01

08009 NL ANCHORAGE AK 132 03-01 315P AST

PMS

SENATOR MITCH LADD

JUNEAU AK

302



WE ASK THAT YOU SHARE THE FOLLOWING COMMENTS IN SUPPORT OF SCR 36 REGARDING ~~FETAL ALCOHOL SYNDROME AWARENESS WEEK~~ WITH THE MEMBERS OF YOUR COMMITTEE AT YOUR MARCH AND PUBLIC HEARING.

THE ALASKA COUNCIL ON PREVENTION OF ALCOHOL AND DRUG ABUSE STRONGLY SUPPORTS SCR 36 WHICH WOULD PROCLAIM FETAL ALCOHOL SYNDROME AWARENESS WEEK IN ALASKA. FAS IS ONE OF THE PRIMARY, PREVENTABLE CAUSES OF MENTAL RETARDATION IN OUR STATE. PUBLIC AWARENESS OF THE PREVENTABILITY OF THIS DISEASE IS THE BEST METHOD OF REDUCING ITS INCIDENCE. THE DATES OF FETAL ALCOHOL SYNDROME AWARENESS WEEK IN ALASKA (MAY 8-14) COINCIDE WITH THE NATIONAL DATES. IT IS FITTING THAT ALASKA, WHICH HAS ONE OF THE HIGHEST FAS RATES, JOIN THE REST OF THE UNITED STATES IN BRINGING ATTENTION TO THIS PREVENTABLE DISEASE.

BETTE D'AMORE, EXECUTIVE DIRECTOR

ALASKA COUNCIL ON PREVENTION OF ALCOHOL AND DRUG ABUSE, INC.

5-1439B  
Hein  
3/16/88

Original sponsors: Binkley, Hensley,  
Zharoff, et al.

1 IN THE SENATE BY THE STATE AFFAIRS COMMITTEE  
2 CS FOR SENATE CONCURRENT RESOLUTION NO. 35 (State Affairs)  
3 IN THE LEGISLATURE OF THE STATE OF ALASKA  
4 FIFTEENTH LEGISLATURE - SECOND SESSION

5 Relating to Alcohol-Related Birth De-  
6 fects Awareness Week.

7 BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF ALASKA:

8 WHEREAS fetal alcohol syndrome is the number two cause in the United  
9 States of birth defects accompanied by mental retardation, and the only  
10 preventable one; and

11 WHEREAS fetal alcohol syndrome can result in serious health problems,  
12 such as heart defects, growth deficiencies associated with mental retarda-  
13 tion, and developmental disabilities that retard a child's ability to walk  
14 and speak; and

15 WHEREAS pregnant women who consume alcohol also risk having babies  
16 with a series of other health problems, called fetal alcohol effects, which  
17 include developmental delays, learning disabilities, and increased irri-  
18 tability and hyperactivity; and

19 WHEREAS alcohol-related birth defects have only recently been dis-  
20 covered to be a major health problem, and many questions regarding them  
21 remain unanswered; and

22 WHEREAS the latest research shows that children with fetal alcohol  
23 syndrome and fetal alcohol effects are unable to live totally independent  
24 lives; and

25 WHEREAS the research has also shown that additional children of a  
26 woman who has previously given birth to a child with an alcohol-related  
27 birth defect will be born with alcohol-related birth defects in successive-  
28 ly severe degrees if the woman continues to drink during pregnancy; and

29 WHEREAS, without exception, mothers of infants born with fetal alcohol

1 syndrome consumed alcohol during pregnancy; and

2 WHEREAS alcohol-related birth defects can be prevented if pregnant  
3 women and women who plan to become pregnant abstain from alcohol consump-  
4 tion; and

5 WHEREAS the Surgeon General has issued an advisory that pregnant women  
6 and women who plan to become pregnant should not consume alcohol;

7 BE IT RESOLVED that the Alaska State Legislature respectfully requests  
8 the Governor to proclaim May 8 - 14, 1988, Alcohol-Related Birth Defects  
9 Awareness Week, and to request that schools, health care organizations and  
10 practitioners, and other public and private agencies and individuals ob-  
11 serve the week with appropriate activities.

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SCR

47

SENATE COMMITTEE REPORT

FIRST COMMITTEE OF REFERRAL

Date of 4-7-88 5-DAY NOTICE  
IN ACCORDANCE WITH UNIFORM RULE 23

FURTHER: HESS  
FINANCE

\*\*FISCAL NOTE(S) ATTACHED  \*\*  
IN ACCORDANCE WITH AS 24.08.035  
(see below)

2/11/88  
Mr. President:

DATE TURNED INTO OFFICE 4-19-88

State Affairs Committee considered SCR 47

operation of Pioneers' Homes

and recommended:

- replace with CS \_\_\_\_\_  same title
- attached amendment(s) and  new title
- do pass
- do not pass
- no recommendation
- individual recommendations
- further referral to \_\_\_\_\_
- letter of intent adopted and attached

\*\* Committee  attached or  adopted fiscal note(s)  
 zero  fiscal impact

MEMBERS SIGNING DO PASS

OTHER RECOMMENDATIONS

[Signature]

[Signature]

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

W. Hendry - No Rec.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

[Signature]  
Chairman signature and recommendation

Committee Backup Attached

STATE OF ALASKA  
1988 LEGISLATIVE SESSION

BILL VERSION: SCR 47  
PUBLISH DATE: 2-11-88

FISCAL NOTE

REQUEST:

Revision Date: \_\_\_\_\_  
Title: Relating to the operation  
of Pioneers' Homes  
Sponsor: Kerttula  
Requestor: \_\_\_\_\_

Agency Affected: \_\_\_\_\_  
BRU: \_\_\_\_\_  
Components: \_\_\_\_\_

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-

CAPITAL						
---------	--	--	--	--	--	--

REVENUE						
---------	--	--	--	--	--	--

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS : (Attach a separate page if necessary)

Prepared by: Senate State Affairs Committee Phone: 465-4522  
Division: \_\_\_\_\_ Date: \_\_\_\_\_  
Approved by ~~COMMITTEE~~ Senator Mitch Abood Date: 4-13-88  
Agency: Senate State Affairs Committee

Distribution (by preparer):  
Legislative Finance  
Legislative Sponsor  
Requestor  
Office of Management and Budget  
Impacted Agency(ies)

## Nursing home faces loss of license over patient deaths

A corporately owned Mountain View, Calif., nursing home is facing the possible loss of its license after state health inspectors turned up evidence suggesting that poor nursing care contributed to the deaths of five patients at the facility during the past seven months.

In November, Julia Sanitarium also was fined \$226,850 for 22 violations of health care rules.

One death involves the demise of a woman for whom an ambulance allegedly was not summoned for 45 minutes after the patient first exhibited symptoms of heart failure. In a second death, for 26 minutes staff allegedly delayed calling paramedics to assist a woman dying of

### Three deaths involved patients who expired after developing numerous serious bedsores.

pneumonia. The three other deaths involved patients who expired after developing numerous serious bedsores.

The nursing home is owned by Beverly Enterprises of Pasadena, Calif., the same corporation that owns Beverly Manor convalescent hospital in Los Gatos, which health officials fined \$233,000 this fall for four patient deaths.

A state health official said California nursing home regulators in San Jose plan to recommend that the home's Medicaid and Medicare contracts be canceled. Mary Louise Mock, administrator of the California Dept. of Health Services' licensing office in San Jose, said her office already was taking steps to revoke the license of Beverly Manor in Los Gatos.

AMONG THOSE whose deaths are under investigation is Edith Hyde Sears, 81, of Santa Barbara. She died June 14 at Kaiser Hospital in Santa Clara after experiencing a heart attack at Julia Nursing home on June 1 described her condition as "alert, coherent, and oriented." On June 12, notes indicated she had vomited by 8:15 p.m. and began calling for nurses. Seventy-five minutes later, she reported chest pains and shortness of breath. When her physician was contacted, he ordered her transferred to an acute-care hospital. Ten minutes after her arrival she experienced cardiac arrest and died two days later.

Investigator Karen White reported, "More than 45 minutes passed from the time the patient exhibited classic symptoms of acute myocardial infarction until the ambulance was called."

THE WOMAN'S DEATH, health officials claimed, occurred as a direct, proximate cause of inadequate care. That poor care was a contributing factor in four other deaths, reports indicated.

A second incident involved 63-year-old Virginia Glismeyer of Santa Cruz, who died May 10 of pneumonia at Kaiser Hospital in Santa Clara after showing signs of lung problems from May 1 to May 9 while at the nursing home.

White reported, "The facility staff failed to inform the attending [staff] physician of [high] temperatures in a patient with a known history of pneumonia, failed to report green oral secretions and the development of two decubitus ulcers [bed sores]."

Moreover, White indicated that 26 minutes had passed before paramedics were called after the patient's physician

Continued on facing page

## Ants found on patients led to citations by regulators

Continued from facing page  
was notified that she was ill.

The three deaths allegedly related to bedsores involved nursing staff who failed to properly treat the sores or to notify the patients' physicians of changes in their conditions.

THOSE PATIENTS were Nettie Gill, 85, of San Jose, who died Sept. 25 at Julia; Elmer Neville, 83, of Campbell, who died Oct. 20 at another nursing home where he had been transferred; and Charles Kemmerer, 72, who died Sept. 25 at Kaiser Hospital in Santa Clara.

A state investigator said the nursing home accepts a lot of terminal patients,

### A nursing home spokeswoman claimed that citations involved incidents that had occurred before management changes were put in place.

but that none of the three was in this category.

Alleged problems at the facility were uncovered when health officials sent a seven-member investigative team into the sanitarium in October, after acquiring from anonymous sources a 31-item list of complaints. On the team were nurses, one of them with acute care experience, as well as a pharmacist and two auditors. The team spent two weeks at the home.

AMONG THE ALLEGED events that triggered citations was one involving an 85-year-old female patient who was discovered with ants all over her body. Another citation sprang from an incident in which a nursing employe alleged he suctioned ants from a breathing tube inserted in a 29-year-old comatose patient.

The facility also was fined for three incidents in which nurses reportedly calculated medicine dosages incorrectly and administered up to 7½ times the maximum amount of morphine prescribed for a patient. Fortunately, the high dose was not a fatal level.

Julia also was cited for:

- Neglecting to provide a wheelchair and oxygen as prescribed by a physician for a 22-year-old female auto crash victim.

- Failing to train staff promptly on safety procedures after a car accident victim fell 2½ feet from a lift while being moved from a whirlpool bath.

- Neglecting to report a high temperature, rash, and odorous throat secretions in a spinal-cord-injured patient.

- Neglecting to notify physicians when four patients lost six to 19 pounds each within a 30-day period.

A SPOKESWOMAN for Beverly Enterprises acknowledged that the quality of the homes' care had deteriorated during a period when the management of the home was supervised from Rockville, Md.

Diane McCarthy, director of communications for Beverly's western headquarters in Fresno, emphasized that actions connected with deaths had occurred before management tightened controls on the facility July 1 and provided more expert help for the staff of the facility. She said the company had uncovered shortcomings and had transferred supervisory control to Beverly's Fresno Western Division.

Continued on next page

SCR-47

# No more nursing homes for big chain

## State cracks down on Beverly Enterprises for its many violations

by Alex Tizon  
Times East bureau

Beverly Enterprises, the nation's largest nursing-home chain — recently under fire for having several substandard facilities in the area — will not be allowed to buy any more nursing homes in Washington, according to a state official.

The Pasadena, Calif., company has compiled too long a list of problems in its short history in the state, said Mike Wills, director of rates and licensing for adult services at the Department of Social and Health Services.

"They've acquired too many homes too fast, and we're not going to let them buy any more," Wills said.

Nearly all of Beverly's 33 nursing homes in Washington were purchased in the past three years. In the past eight months, seven of those homes have been fined or threatened with disciplinary action because of substandard conditions.

Fines levied against Beverly-owned nursing homes — totaling \$6,600 since last summer — account for more than half of the total fines levied against all nursing homes in the state in that period.

In the latest development, Renton Terrace Nursing Center in Renton was cited last week for deficiencies in food preparation and nursing care. Violations included serving residents poor-quality food, inadequate staff hygiene and allowing residents to sit in urine-drenched wheelchairs.

The center has until Sept. 26 to correct the problems or risk losing its Medicare and Medicaid certification. That would, in effect, close it down, since most of its 147 residents receive Medicare or Medicaid.

Bellevue Terrace Nursing Center in Bellevue — which, with 235 beds, is one of the state's largest nursing homes — faces the same risk. That center was purchased by Beverly Enterprises in 1985.

An order to stop admitting new patients was imposed last month on the Bellevue center after a routine DSHS inspection turned up a long list of violations, including negligent patient care, inadequate documentation of drug dispensing, unsanitary kitchens and bathrooms and the presence of cockroaches.

DSHS officials completed a second inspection of Bellevue Terrace yesterday to see if the center had corrected the deficiencies. The results are to be announced later this week.

Frank Occhuto, Bellevue Ter-

ma, Sunny Haven Co Center in Sunny-side, Terrace Nursing Center, Vernon and Lilac City cent Center in Spokane. Wills said he is cor Beverly-owned nursing have not been cited w cies may soon follow evaluations, because under the same manag "I'm wondering at ers," Wills said. "How are going to come reports? Part of m that I don't know. n

ident levue order ts will r have l with andard st Con-Moines, n Taco

Please see BEVERLY on A 10.

# State cracks down

## BEVERLY

continued from Page 1

race administrator, said the latest inspection went smoothly, with DSHS officials acknowledging "significant progress" in correcting deficiencies.

Occhiuto said he is confident the state will not strip the Bellevue center of its Medicare and Medicaid certification, and that the order to stop admitting new patients will be lifted within a month.

Other Beverly-owned nursing homes that in the past year have been fined or threatened with disciplinary action for substandard conditions are Olympic Crest Convalescent Center near Des Moines, Sherwood Nursing Center in Taco-

ma, Sunny Haven Convalescent Center in Sunnyside, Evergreen Terrace Nursing Center in Mount Vernon and Lilac City Convalescent Center in Spokane.

Wills said he is concerned the Beverly-owned nursing homes that have not been cited with deficiencies may soon follow with poor evaluations, because they are all under the same management.

"I'm wondering about the others," Wills said. "How many more are going to come in with bad reports? Part of my concern is that I don't know how wide and

how deep the problem is."

But if nationwide reports are an indication, Wills said, the problem is indeed wide and deep.

"Beverly nursing homes have had serious problems in California, they've been banned in Maine, they've had serious problems in Michigan. . . They've had problems all over."

Beverly Enterprises operates about 1,200 nursing-home facilities in the United States and is the nation's largest nursing-home chain. The company owns more than 10 percent of the nearly 300

nursing homes in Washington state alone, offering about 4,000 beds statewide.

Beverly spokeswoman Diane McCarthy said the company is having problems in Washington because it purchased too many homes in a short period and it could not upgrade all of them at the same time. McCarthy said many of the deficiencies now being cited were inherited.

"We made a lot of acquisitions too quickly, and many of the facilities needed a tremendous amount of attention," McCarthy

said. "We weren't completely aware of how bad the problems were when we bought some of them."

Wills said he doesn't buy McCarthy's contention that deficiencies were inherited. He said Bellevue Terrace, Renton Terrace, Sherwood Terrace and Olympic Crest nursing homes met all standards in the two years preceding Beverly's purchase of them.

Wills said new regulations enabling DSHS to levy stiffer fines may force Beverly Enterprises to spend more time and money keep-

ing up its facilities.

The new regulations, which went into effect in the middle of August, empower DSHS officials to levy fines of up to \$3,000 a day for any one violation. The department could triple that figure if the violation is repeated within a year. The old laws allowed only fines of up to \$1,000 per violation.

But Wills said that despite the more stringent penalties, "I'm not going to feel real confident about Beverly Enterprises until they take full responsibility and blame for what they're doing."

# THE DOWN

# Renton nursing home violates state, federal laws

By DAVID DANELSKI  
Staff Reporter

A Renton nursing home has been cited for violating state and federal laws for not properly caring for its patients.

The facility, Renton Terrace Nursing Center, 80 S.W. Second St., is owned by Beverly Enterprises, which has faced disciplinary action at seven other nursing homes it owns in the state.

The Renton facility did not meet "dietary services" conditions required for state licensing and federal certification for the Medicaid and Medicare programs, said Mike Wills, director of the state nursing home licensing division.

Food-related problems at the 147-bed facility included diabetic patients who were served improper diets, an unsanitary kitchen, poor

hygiene of kitchen staff, poor quality of food and food storage methods that could allow spoilage, said Sharon Morrison, the division's nursing home survey manager.

Moreover, a 102-page state report, she said, based on inspections done Aug. 4 to 7, said that urine puddles were observed under the chairs of three patients in the dining room and that another patient sat in a urine-soaked wheelchair in a hallway.

"The dining room smelled of urine," Morrison said.

These reports add to the troubles of Beverly Enterprises, the nation's largest nursing care company, which owns 1,200 nursing homes.

Of the company's 33 homes in Washington, the Renton facility is the eighth to face disciplinary action in the 14 months. Since July 1986, seven homes owned by Bev-

erly in the state have been fined \$6,800, a lion's share of all fines — \$11,075 — levied against nursing homes in the state.

Morrison said the Renton nursing home must correct its deficiencies by Sept. 26 or the state will recommend that to federal government that it be shut down. Also at that point, she said, the state will decide what fines, if any, will be levied against the nursing home.

Diane McCarthy, spokeswoman for Beverly Enterprises, said Monday that the nursing home is correcting its problems.

"Most of the issues were dietary," said McCarthy, interviewed by telephone from Beverly's Sacramento, Calif., office. "We put people and systems in to ensure the necessary corrections are made."

Additionally, the corporation hired a new vice president to over-

see its Washington facilities and increased its staff of consultants in the state from three to seven.

Asked about the conditions, McCarthy replied that the company had staffing problems brought on by rapid growth.

"We made a number of acquisitions that took more energy than we anticipated," she said. Problems, she added, have been compounded by a shortage of nurses and nursing aides.

Wills said the Beverly started buying nursing homes in the state in 1981 and had a relatively few problems through 1985. But that changed when the company purchased more homes in the last year and half.

"I think they over-extended themselves," Wills said. "They just can't manage all of those homes."

"When you have eight homes with all those deficiencies, all of them may be flawed. That's the concern."

Morrison said 70 percent of residents interviewed randomly at Renton Terrace complained that they don't like the food because it was bland and over-cooked.

Inspectors revealed that diabetic patients and those requiring purced food not given proper diets, Morrison said. Diabetics, for example, were fed potatoes one day which put their caloric intake over their daily limit.

"If these patients are on insulin, it makes a difference," Morrison said. "It creates a problem."

As for poor food quality, she said, residents were served grade B potatoes that were bruised and frost damaged. Additionally, residents were served chicken burned on the

outside and undercooked on the inside.

Poor sanitary conditions in the kitchen include soiled water left in a mixing bowl; dirty carts used to bring to residents food in their rooms; a dishwasher that did not remove food stuck on plates and utensils; a dirty meat chiller, floors, walls, floors and ceiling that were not cleaned; food debris that had accumulated around the perimeter of the floor; spilled food in a storage room; and dried blood from meat on the floor of a walk-in cooler.

Kitchen workers would often handle food with their hands when utensils should have been used, Morrison said.

Additionally, leftover food was not dated to be either frozen or discarded.

## Strike against drug firm unresolved

By BRUCE ROMMEL  
Staff Reporter

A strike against Northwestern Drug Co. of Auburn remained unresolved Monday when federal labor officials were unable to count more than half the ballots in a decertification election to determine whether the Teamsters will continue to represent company employees.



## Fire . . .

Continued from page A1

steep slope just behind the home of Charles and Rikki Birge.

"I was kind of surprised," Braeden said. "There wasn't any neighbors anywhere around. Just me."

He yelled for his mother to call 911, grabbed a garden hose from in front of the Birge home, and went around back and began hosing down the house and tall dried grass nearby.

"I was barefoot at the time," he said. "I hosed the area down, then my feet started getting hot, and I saw I was standing on some hot coals."

He also saw a good example of the effect of the summer drought

Wayne Kier, shift commander for District 44, later said Braeden's action was "the main factor" in preventing the spread of the fire in the home. The district will recognize Braeden's actions with a commendation, said Fire Chief Bob Tankersly.

The apparent cause of the fire was children playing with matches.

Braeden, who will be a senior this fall at Auburn High School, said after graduation he plans on going to college to seek a degree in architecture.

## Correction

# Problems in nursing home chain alarm state

## As violations mount, Beverly promises that care will improve

By Pete McConnell  
PI Reporter

Clarence B. Leen, an 85-year-old man with degenerative arthritis, developed bed sores on his spine, right foot and left elbow in the 14 months he spent at a Los Gatos, Calif., nursing home owned by Beverly Enterprises.

He eventually developed pneumonia and died Aug. 13, 1985, 12 days after he was moved to a hospital.

For Beverly, the nation's largest nursing home chain and 36th largest employer, the death was one of nine that California officials attributed to poor care in Beverly-owned facilities that year.

And while no deaths have been

linked to deficiencies in Beverly nursing homes in Washington, the state Department of Social and Health Services is troubled by the company's checkered track record here.

Beverly's nursing homes have run up a disproportionate number of problems in Washington, according to state inspection records.

Washington has 298 nursing homes in this state and Beverly owns 33 of them — 11 percent.

Yet 26 percent of the homes in the state threatened with losing their Medicaid contracts because of various deficiencies were Beverly homes, according to state records from July 1986 to July 1987.

And since July 1986, facilities owned by Beverly have been fined

Name	Facilities	Beds
Beverly Enterprises Pasadena, Calif.	33	4,002
Hillhaven Corp. Tacoma Wash.	11	1,330
Pleasant Valley Camarillo, Calif.	9	869
Regency Care Centers Issaquah, Wash.	8	769
Quad C Convalescent Centers Tacoma, Wash.	7	563
Washington state total	298	28,997

SOURCE: State Department of Social and Health Services, 1987.

\$6,800 because of deficiencies. The fines, assessed primarily because of inadequate patient care and unsanitary conditions, are more than half the total. \$11,075 levied

against all nursing homes in the state during the same period, the records reveal.

"Is it a trend? I don't know," said Mike Wills, director of the

state nursing home division under the Department of Social and Health Services. "But it looks pretty scary to me."

In California, authorities cited Beverly for 60 health and safety violations and alleged that deficiencies in care led to the deaths of nine elderly patients who were in Beverly homes in 1985.

Beverly officials have denied that poor care caused the deaths of the patients. Contending that the charges could not be proven, Beverly officials nevertheless entered into a strict compliance agreement with the state and kept the controversy out of the courts.

Admitting they have paid a price for rapid expansion, Beverly officials this year started a major restructuring program that included reducing the number of homes the firm buys each year and placing greater emphasis on providing quality care.

"We have a lot going on and I think there will be steady pro-

gress," said Beverly spokeswoman Diane McCarthy.

The nursing home chain established a strong presence in the state when it bought 30 homes from 1984 through 1986. (It so five homes this year.)

But the homes started to run into compliance problems last year, according to state inspection records.

The records for homes bought by Beverly show:

■ Bellevue Terrace Nursing Center in Bellevue was banned by the state last month from accepting new patients. State officials discovered that the acting administrator at the time of the survey was operating without a license since November 1986. Other problems included dirty bedpans, linens, utensils and the presence of cock roaches.

The home has until tomorrow to correct the deficiencies or face

See BEVERLY Page D4

inspection. One patient had feces on his long johns and was covered with flies. An order to ban new patients was lifted in December when the home came into compliance.

"It appears to me the track record has gotten substantially worse under Beverly's management," Wills said. "Olympic Crest, Sherwood Terrace and Bellevue Terrace did not have bad surveys in the immediate years they were under a different administration."

Because of the large number of patients who receive Medicaid, the state can virtually close down a nursing home by transferring its Medicaid patients to another facility.

Beverly officials said a series of changes are in the works to help improve the company's image.

The chain recently opened a training center for nurses' aides in Vancouver, Wash., and other centers are tentatively planned in the Seattle, Tacoma-Olympia and Pasco areas, said Janis E. Tietjen, Beverly's new vice president in charge of Washington operations.

The aides will receive special training in nursing care and won't be allowed to work in Beverly homes until they complete the two- to three-week program. Moreover, the training center is designed to attract new applicants during a time of a critical nursing shortage.

Also, Beverly has established its own quarterly inspection program to help identify and correct deficiencies in nursing homes before the state intervenes. The company has made key personnel changes in the corporate structure in this state and has added more consultants to help develop care plans.

Nationally, the company that was founded as a partnership in 1963 has opened a training center in Atlanta in a move to provide better care, said Beverly spokeswoman McCarthy.

But for some critics, Beverly's change in direction typifies a company that reacts to potential disaster rather than having the foresight to prevent it.

"We felt we were getting a franchise-quality operation — not very bad homes and not very good homes but very predictable," said Wills.

"We knew they had deep pockets and would at least bring some standardization here. I thought it would work out.

"I'm encouraged by the fact that they are hemmed in and won't acquire any more facilities. Now they will be forced to manage them. But I will believe it when I see it."

McCarthy denied that the company is suffering from a corporate-wide nursing care problem.

"A good facility is only as good as the management we have in that facility," she said. "The company's priority is to provide quality patient care first. There are times when you are going to have an excellent person in an administrative position, and times when that person isn't able to do the job."

Tietjen's job is to ensure that Beverly homes attract and keep quality employees.

She also has ordered that each Beverly nursing home have resident and family councils. The family councils, composed of patients' relatives, would monitor nursing home activities and be allowed to take their concerns to top corporate management.

Nevertheless, the publicity surrounding Beverly has prompted some states, including Washing-

patients in the state were due to neth River a  
their was not to any substandard agreement "wi

# Maine nixes Beverly expansion; chain pulls out

Health officials in Maine recommended that Beverly Enterprises Inc. not be allowed to purchase two homes in that state, following a finding that the company "was not fit, willing, and able" to operate the homes in accordance with Maine health laws.

The Maine recommendation was based on a 600-page review of the health care record at nursing homes owned by Beverly in seven states, recently released in response to a request from *American Medical News*.

The survey conducted by the Maine Dept. of Human Services Division of Project Review covered five states in which there were nursing homes operated by Beverly's Heritage Division, which was managing a number of homes in New England. The survey also covered Texas and Colorado, where Beverly has large concentrations of nursing homes. Analysts examined health care records for Beverly homes for 1985 and 1986.

After the recommendation, Beverly decided to pull out of the Maine market entirely.

The survey found that the Commonwealth of Massachusetts in 1985 prohibited Beverly from expanding operations in its state until June, 1986, because of patient care problems at five Massachusetts homes in 1984 and 1985. The problems have since been corrected, but Beverly has been able to obtain only provisional licenses to operate seven Massachusetts facilities the corporation purchased in 1985, the analysts said.

Officials from the Massachusetts Dept. of Public Health told Maine officials that the commonwealth also temporarily stopped Medicaid payments to one of Beverly's Massachusetts homes and banned new admissions to another.

IN PENNSYLVANIA, where Beverly managed 39 nursing facilities, one was cited more than 20 times for having an inadequate nursing staff in 1985 and 1986, the analysis said. Staffing problems jeopardized the Fayette Health Center license, Maine officials reported, and the nursing home was granted only a provisional operating license. A second Beverly facility in Pennsylvania also sustained repeated citations for staffing and physical plant problems, Maine analysts said.

In Connecticut, where Beverly operated five homes, each facility was cited at least four times in 1985 and 1986 for failing to meet nursing standards, the analysis said. Those standards, said Maine officials, ensure that nursing home operators provide enough "nursing personnel to meet the patients' needs." During 1985 and 1986, four out of the five Connecticut nursing homes were cited for infection control violations.

Maryland health officials provided data showing that each of Beverly's six nursing homes in the state were cited four to 23 times during 1985 and 1986. Sixty-one of the violations involved inadequate staffing of the facilities. Two of Beverly's Maryland nursing homes were found to have problems with infection control because cockroaches were observed at nursing stations and in utility rooms, the Maine analysts found.

New Hampshire health officials told the Maine analysts that inadequate staffing and problems with infection control and the physical plant were discovered in inspections at two facilities Beverly managed in the state from 1985 to 1986.

BEVERLY ENTERPRISES had 139 nursing homes equipped with 15,440 beds in Texas. Nurse staffing, physical plant deficiencies, and inadequate infection control proved to be problems in 34 of Beverly's Texas facilities, the Maine analysts found. Twenty-four times in 1985 and 1986, Texas Beverly homes had government funds withheld for health violations. Eight homes lost contracts to operate as Medicaid facilities, Texas health officials reported to the Maine analysts.

Beverly controlled 692 beds in Colorado. In 1985, Colorado Dept. of Health officials granted licenses for Beverly to operate three nursing homes near Denver only when the corporation agreed to provide adequate nursing staff for its Colorado facilities, according to the Maine survey. The corporation also agreed to pay the Colorado health department for any additional monitoring that would be required to ensure that the company operated its nursing homes in Colorado safely, Maine analysts found.

Maine officials concluded, "Because of the nature and widespread frequency of violations of federal and state regulations at Beverly Enterprises' existing facilities, and said violations presenting an unacceptable risk to patients," the company was "not fit, willing, and able to provide

the proposed services in conformity with the standards of care as required" by Maine health laws.

Robert Van Tuyle, chairman of the board of Beverly Enterprises, said his company's operations throughout the United States had been affected by a lack of qualified nursing home staff. "Staffing is proving to be a serious problem," said Van Tuyle.

BUT VAN TUYLE accused Maine health analysts of manipulating statistics on Beverly's performance to make the chain look bad. He complained that the Maine analysts had merely tallied the alleged health care deficiencies of Beverly facilities without comparing these tallies with similar statistics for other nursing homes in the same states.

"They do not have comparable data," Van Tuyle said.

Commenting on specific allegations about Beverly's health care record, Maryland, Van Tuyle said, "Any facility can be cited . . . if the intent is to cite. We deal with several hundred regulations [of inspections and health personnel]. It is impossible to have them all in tune at the same time."

Further comment about specific allegations, however, was "pointless," Van Tuyle said. "You seem as a group to be committed to negative journalism. . . long as you're emphasizing the negative comments are inappropriate."

Van Tuyle said, however, that many of the problems cited by health officials reporting to the Maine analysts had since been corrected. —Phyllis Gapp

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## AMA backs

*Continued from preceding page*  
nce." At the same time, the Association has "an equally serious interest" in insuring that medical and policy decisions adequately protect the public from eventable exposure to the human immunodeficiency virus (HIV).

Because the AMA is "vitaly concerned" that the public be fully informed about the modes of transmission of AIDS, the AMA brief pointed to the "extensive medical information currently available on the non-transmission of AIDS based on casual contact."

Reviewing research findings on the non-transmissibility of HIV in various settings, the AMA brief noted that medical and public health authorities have concluded that the "wholesale segregation of AIDS patients is entirely unjustified."

Noting that attorneys for the school board had argued that Chalk might transmit opportunistic infections to his students, the brief said "there is no evi-

see him" speaking and signing.

In other school cases, where the risk of transmission might be greater, courts have granted injunctions ordering that children be admitted to regular classrooms on the grounds that the transmission risk is negligible, the AMA noted.

"Numerous and extensive studies have been conducted to determine whether there is any appreciable risk of transmission through casual contact in school, the workplace, and at home," the AMA wrote. "After intensive study and blood testing of the subjects, not a single case of transmission of the AIDS virus, much less development of the actual disease, has been documented. The probability of harm, therefore, is not substantial." Accordingly, the brief concluded, Chalk is "qualified to resume his teaching position because he poses an insufficient risk of transmission to his students."

—Sari Staver

## Nursing home chain drops operations in five states

Beverly Enterprises Inc., the nation's largest nursing home chain, has withdrawn its operations from five states since January of this year. In two of these states, the 120,000-bed nursing home chain acted after encountering opposition based on charges that the chain has a poor record of patient care.

"We are making no effort to operate in Maine, and we have withdrawn from Wyoming, Montana, Colorado, and New Mexico, although we had pending plans to expand there," said Robert Van Tuyle, chairman of the board of Beverly Enterprises.

Van Tuyle denied any connection between Beverly's actions and charges of

poor patient care that have plagued the chain in some states. However, Beverly encountered opposition in both Maine and Montana before its decision to curtail its activities in those states.

The company is currently barred from expanding operations in California. Since May, 1986, the California Dept. of Health Services has refused to grant operating licenses to the chain's new enterprises, citing allegations of patient care problems at existing Beverly-owned nursing homes in the state (AMN, July 25, 1986).

IN MAINE, Beverly had proposed to purchase and operate Marchalin Nursing Home in Milbridge and Market Square

rsing Home in South Paris. However, nine health officials recommended against allowing these sales. Beverly officials responded by requesting a hearing on the decision. But the company withdrew that petition in March, after Maine officials produced a 600-page analysis of the health care record of Beverly Enterprises nursing homes in seven states. Last month, when Beverly's management contract for the Marchalin facility expired, the company ceased its operations in Maine.

Beverly also had obtained state permission to start construction on a nursing home in Helena, Mont. But two nonprofit nursing homes appealed the state's decision, arguing that Beverly should not be allowed to expand in Montana because the corporation had a poor patient care record in other states. The Court of the Fifth Judicial District of the State of Montana, in Boulder, ordered the state to

reconsider its decision. Soon afterward, Beverly withdrew an application to construct the new nursing home in Helena and sold two other nursing homes it had owned in the state. Both of these facilities had a good record of patient care, according to Montana health officials.

Health officials in Wyoming confirmed that Beverly ceased operations in the

sold to HMU Management, said Charlie Simineo, survey coordinator for the Wyoming Dept. of Health's section on licensing and certification. Officials in Wyoming said that Beverly has had no patient care problems in the state.

In January, 1987, Beverly sold four nursing homes in New Mexico. The corporation had suffered staffing problems at

able for comment.

Van Tuyle told AMN that the decision to curtail operations in all five states came because the corporation had been unable to acquire at least 1,000 nursing home beds per state.

"Unless we get 1,000 beds, we find it impossible to operate in a particular state. We no longer operate in a number of states because of the inability to get what we consider an adequate number of facilities," he said.

He added that the corporation had been unable to find nursing homes it could purchase. "People wouldn't sell to us," Van Tuyle said, adding that there was no connection between this unwillingness to sell and controversy surrounding Beverly's health care record. "People were just looking for the best price."

—Phyllis Gapen

Gapen is a free-lance writer based in Houston.

### In two of the states, Beverly withdrew after facing opposition.

state last month. Abandoning Wyoming operations meant giving up a management contract at a nursing home in Wyoming's central ranching district and giving up certificates obtained to construct three new long-term-care facilities in the western region of the state. Construction was halted on a planned facility in Evans-ton, and the partially built facility was

two of these facilities, which were located near rural Indian reservations and far from a concentrated pool of labor, said Sue Morris, a spokeswoman for the state's Dept. of Health and Environment. But the corporation apparently did not encounter any opposition to its expansion in New Mexico.

Colorado health officials were unavail-



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## Nursing home chain pays big fine, avoids sanctions

Beverly Enterprises, the largest nursing home chain in the nation, paid \$600,000 in fines Oct. 16 to ward off California Dept. of Health sanctions brought against the chain because of alleged negligence leading to the deaths of nine patients at three of its homes.

Faced with November administrative hearings to revoke the licenses of Beverly Manor in Los Gatos, Julia Convalescent

Reform law aided authorities.—page 57

Hospital in Mountain View, and Beverly Manor in Santa Cruz, the giant nursing home company agreed to stiff terms that allow the existing homes to continue operating and seven others to open.

Under the terms of the agreement, the licenses of the three Northern California nursing homes were revoked, but the three facilities are allowed to operate for

the next four years on probation.

In a pyrrhic victory for Beverly, state officials agreed to grant provisional licenses to seven new Beverly facilities, which had been held up pending the outcome of the administrative hearing, but stipulated that the Pasadena-based corporation would license no new nursing homes for the next 14 months.

That provision prevents the corporation from taking on new business in the state, but allows the company to begin operating three new nursing homes it had built in the state and four others it had purchased but had been unable to license after making a \$20-million investment.

The price of the settlement included a stipulation that all of Beverly's California skilled nursing facilities, which serve bedridden patients, will be monitored during

*Continued on page 56*

# Nursing home chain pays big fine, avoids sanctions

*Continued from page 3*  
the next 26 months to determine whether they equal or exceed the average state-wide performance record of similar, non-Beverly facilities. If Beverly fails to perform as well as other operators, the probationary licenses of Julia, Beverly Manor in Los Gatos, and Beverly Manor in Santa Cruz will be revoked, and the provisional licenses granted to its seven new homes will expire.

Kenneth Kizer, MD, state health director, said the settlement should send a clear signal to other nursing homes that poor quality care will not be tolerated by his department. He added that the fine paid by Beverly was the largest ever levied against a nursing home operator in California.

The corporation, which collects \$1 billion a year in revenues from the operations of more than 1,200 nursing homes in 46 states, agreed to pay 75 cents on the dollar for \$885,400 in fines levied against the three troubled Northern California nursing homes and five others in the Los Angeles area.

BEVERLY'S PRESIDENT, David Banks, said the corporation settled because "we decided that it made more sense to try to work hand-in-hand with the state than go through this procedure [the administrative hearing to revoke licenses]. Tempers had gotten out of line on both sides, and that does not make for us moving ahead. We felt that it was better to work with them than against."

Banks added, "We felt that it was more important to give attention to patient care than to worry about fighting our adversaries. We don't think we should be in an

adversarial role with any state, and so we decided to settle."

Banks said his firm admitted no wrongdoing as part of the settlement, and other company officials have denied that the corporation neglected patients at its Northern California homes. Beverly officials also have insisted that state officials could not prove their case against Julia, Beverly Manor in Los Gatos, and Julia Convalescent.

But Paul Keller, chief of field operations for the state health department, said, "There was never any doubt on anybody's mind on the state's side that we couldn't go to an administrative hearing and prove up our revocation actions against these three Beverly facilities. We were not negotiating from a position of weakness."

Keller said that the state's decision to settle was partly motivated by a shortage of nursing homes in Northern California and in other communities where Beverly had built new but unlicensed facilities.

ONE OF THE concessions Beverly made to state health officials was the payment of \$7,500 in fines for operating three of its new facilities — Summerfield Convalescent Hospital in Santa Rosa, Healdsburg Convalescent Hospital in Healdsburg, and Ukiah Convalescent Hospital in Ukiah — without a license. The health department recently had sued the corporation for operating these newly purchased facilities without first obtaining licenses, but Beverly had contended it was merely "managing" the homes for the previous owner while the sales trans-

action was being completed.

Beverly has agreed to turn over future proposed management contracts to state health officials before taking over operations at any other California nursing homes. The provision is important because the corporation acts as a manager of many nursing homes, in addition to those it owns.

Beverly also promised to "provide all resources, including staffing and supplies, to assure that patient care does not fall below the [health department's] standards and to implement business practices and budgetary practices that do not impede this goal" in its California homes.

—Phyllis Capen

Capen is a free-lance writer based in Houston.

## Fine settlement involves other Beverly homes

When the nation's largest nursing home operator, Beverly Enterprises Inc., settled, for \$600,000, nearly \$900,000 in fines against its California homes recently, the glare of public scrutiny was on three of its northern California homes. But Beverly facilities in other parts of the state also were involved in the settlement.

In Los Angeles, Beverly Manor Convalescent Hospital in Panorama City was fined \$5,000 for allegedly permitting a patient's thigh to be broken while untrained employees were changing linen on the bedfast woman's special bed in September, 1986. The home also received a \$10,000 fine for an incident involving an elderly patient who allegedly was struck in the face by an orderly in October, 1985.

The chain received a \$25,000 fine for allegedly allowing an unattended, retarded patient with a history of seizures to drown in a bathtub at Lynwood Care Center last December.

A \$5,000 fine was levied for alleged failure to treat a urinary tract infection or give sufficient insulin to a diabetic patient who fell into a coma after an eight-day stay at Beverly Manor Convalescent Hospital in Glendale in October, 1985.

At Beverly Manor in West Covina, the corporation incurred a \$10,000 fine in March, 1985, for allegedly failing to monitor and treat a woman who developed a bed sore that extended to the bone. When hospitalized, the woman was treated for blood poisoning arising from the infected skin ulcer. She died nine days after the home discharged her to the hospital.

In the \$600,000 settlement, Beverly paid 75% of each of the Los Angeles fines, some \$48,750. The total fines were \$65,000 from that region.

David Banks, president of Beverly Enterprises, declined to comment on the fines being paid in Los Angeles.



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# Beverly faced earlier probe of California operations

Beverly Enterprises, which has agreed to pay heavy penalties in order to resolve a string of problems with the California Dept. of Health Services, has been in trouble with the state of California before.

Twelve years ago, Beverly was the object of a headline-making investigation prompted by the deaths of nine patients in four nursing homes. The nursing home chain's operations were probed first by the *Sacramento Bee* and then by California's health department and at least five other agencies.

But those inquiries fizzled out — an outcome far different from that of the latest clash between the state and the Beverly chain. Observers say that Califor-

nia's 1985 nursing home reform act, which created special inspection teams, may have made the difference between investigations that went nowhere 12 years ago and the record settlement just negotiated by state health officials.

IN 1973, Pasadena-based Beverly Enterprises operated 63 California nursing homes and was experiencing a fiscal crisis. Until that time, the worst criticisms of Beverly had come from regulators who gave the company mixed reviews for the care it provided to the large population of elderly poor in its care. Some thought the chain did an average job compared to the independently owned homes in the state. Other regulators who talked to John

Berthelson, an investigative reporter for the *Sacramento Bee*, said they saw the company's operations as "spotty."

But Berthelson's investigative series painted a more negative portrait of the Beverly chain. The taxpayers who footed the bills for California nursing home patients in the 1970s were shocked by allegations that patients in Beverly-owned homes were suffering because of short staffing, rapid turnover of nurse's aides, and malfunctioning equipment, and that aggressive, mentally ill patients were mixed with the frail elderly. Among the accusations made in 1973 were that there had been three suspicious patient deaths in a Beverly-owned home in Azusa, two at a home the company owned in Mo-

desto, three at a facility in Carmichael, and one at a Beverly-owned facility in Los Gatos.

One charge brought against the chain was that a man who was unable to swallow had strangled after a nurse at a Beverly home poured water down his throat, and a suction machine malfunctioned. That death occurred at Beverly Manor of Los Gatos, the same home state officials last year fined some \$246,000 for violations involving the deaths of three elderly patients whose bedsores were allegedly treated inadequately.

The deaths at the Azusa facility, Edgewood Convalescent Center, were allegedly caused by food poisoning, a charge later disputed by the Food and Drug Administration, which found that staff at the facility had prepared the food properly. This home was still owned by Beverly in August, 1985, when it was fined \$10,000 for failing to ensure that a patient who had allegedly been sexually abused was seen by a physician until four days after the incident.

IN 1973, a northern California sheriff came forward with an allegation that a patient had been beaten to death at Beverly's Carmichael home. This accusation prompted Berthelson's investigative series and a round of official investigations, including a criminal investigation of deaths at the Carmichael facility. But in 1974, Chief Deputy District Attorney Geoffrey Burroughs held a press conference to announce that there was insufficient evidence on which to base criminal charges against the home. At the press conference, Burroughs angrily urged other state agencies to continue the investigation he had begun.

Burroughs did not delve into why the evidence at his disposal was inadequate to support criminal charges. However, officials from the California Attorney General's Office recently explained that, prior to 1985, the state often had great difficulty proving its cases against nursing homes. The reason: Poorly trained inspectors often failed to gather sufficiently detailed information.

This problem was addressed in June, 1974, in a state health department draft report titled "Proposed Methodology for the Identification and Prevention of Unusual Occurrences in Skilled Nursing Facilities." Prompted by the allegations concerning the Beverly-owned homes, this 1974 report was critical of the state's mechanisms for regulation of nursing homes and included a series of recommendations. Among them was a proposal to add registered nurses to the inspection teams that were expected to document instances of abuse and neglect. Another was that nursing homes be required to report unusual occurrences to the state department of health within 24 hours. Yet another recommendation was that the performance of corporately owned nursing home chains should be measured against that of independently operated facilities.

But that 1974 report was never published. It became public only recently, when a copy was obtained by AMN.

One of two investigators who produced the report recently told AMN that the report was "squashed." The former investigator said, "It was disgusting. I wasn't privy to any discussions of the report at higher levels [in the state health department] but it was clear they didn't want to do anything. Nobody wanted to come out front because the findings made the department of health look bad." This investigator also claimed that the nursing home industry influenced the decision to suppress the report.

NONE OF THE recommendations in the 1974 draft report were acted upon at the time, and the report disappeared

Continued on next page

## Beverly faced earlier probe

Continued from preceding page  
from view. Current administrators in California's Dept. of Health Services were unaware that the report had ever been produced.

A decade passed before the California Health Facilities Commission did — as had been recommended in the 1974 report — compare the Beverly chain with independently owned facilities in California.

The commission found that, among the homes Beverly was then operating in the state, more homes had received Class A citations (for life-threatening conditions) than among facilities outside of the control of big corporations. In 1983, 11% of Beverly homes were said to pose threats to life, compared to 7% of other non-corporate homes.

In the mid-1980s, the climate of opinion toward the nursing home industry in California had begun to change. Growing awareness of problems in the industry led to the passage of reform legislation in 1985. Among the provisions of this new legislation: Nursing homes must report unusual occurrences to the state department of health within 24 hours, as was originally recommended in the 1974 report.

The 1985 legislation also creates special investigative teams that include not only a registered nurse but also an auditor trained to spot Medicaid fraud and any pharmacy, dietary, or medical consultant who may also be needed. Whereas planned inspections were the norm before the reform legislation was enacted, the special teams are allowed to make surprise inspections at homes in the state. Directed by supervisors with two-to-three years of experience inspecting nursing homes, the teams have unlimited time to inspect the facilities they enter. When they find evidence that a patient has died from neglect or abuse, a medical consultant is called in to review medical records.

Regulators may now also fine facilities up to \$25,000 per incident for instances of abuse and neglect, compared to penalties up to \$5,000 before the legislation was enacted. Under the new legislation, nursing home operators are also subject to heavy fines for negligent care that leads to patient deaths, falsification of medical records, or repeated violations of health rules.

OBSERVERS INITIALLY questioned whether the state would be able to collect the full fines it levied against nursing homes, pointing out that another nursing home chain operating in California had, in 1984, been negotiating to pay 20 cents on the dollar for some \$75,000 in fines and, in 1985, had settled another \$65,000 in fines for 55 cents on the dollar.

But Paul Keller, chief of field operations for California's health department, pointed out that the state was recently able to settle some \$885,000 in fines against Beverly for 75 cents on the dollar. One key reason the state is now able to crack down on operators charged with nursing home abuses, he said, is that its accusations are now well-documented. And that is thanks to the special investigative teams.

Said Keller, "The teams develop documentation of the problems — physical evidence, testimony, photos, declarations, whatever it takes to build the best possible case."

Said the investigator who helped to write the long-suppressed 1974 report on California's nursing home industry: "Naturally if you have people who are trained medically, they're going to be looking at how the care is actually rendered, and that will provide evidence in a case."

—Phyllis Capen

Capen is a Houston-based freelance writer.

State refuses licenses

## Chain's expansion plans stymied

Expansion of the nation's largest nursing home chain has come to a standstill in California in the wake of state action to close three of the chain's 93 nursing homes in that state. In two of these homes, negligent care allegedly led to nine patient deaths, and the state now contends that the chain cannot be relied upon to meet health standards either in homes it already operates or in the facilities it had planned to open.

With revenues of more than \$1 billion a year, Beverly Enterprises of Pasadena, Calif., controls more than 100,000 nursing home beds nationwide, and the expansion-minded company has been eyeing California's 10.7% population of persons older than 65 as a prime source of new business for the next decade.

Thus Beverly Enterprises recently built two nursing homes in California and purchased four more, and had plans to open a home health agency branch office in the state soon.

But these plans have been grinding to a halt since May — when, as AMN has learned exclusively, the regional

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### Exclusive

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offices of the California Dept. of Health Services (CDHS) began refusing to grant operating licenses to the chain's new enterprises.

The reason for the CDHS decisions: allegations of serious patient-care problems at three Beverly-owned nursing homes in Northern California.

BASED ON THESE allegations, Attorney General John K. Van de Kamp recently initiated action to revoke the licenses of Beverly Manor of Los Gatos, Julia Convalescent Hospital in Mountain View, and Beverly Manor in Santa Cruz, all owned by Beverly. If Van de Kamp prevails in administrative proceedings before the State Dept. of Health Services, each of the homes also will be suspended from the state Medicaid program, and offi-

*Continued on page 35*

## State seeks license revocation of fourth nursing home

The state of California, which currently is seeking to revoke the licenses of three nursing homes belonging to Beverly Enterprises of Pasadena, also is seeking revocation of the license of a fourth nursing home in the state — West Park Convalescent Hospital in San Jose.

West Park's owner is ARA Enterprises Inc. of Philadelphia, the third largest nursing home chain in the country, with some 31,000 beds. Last year, ARA was barred from licensing any more nursing homes in California until May of this year. Before signing agreements to manage any more homes, ARA also was required to obtain approval from state health officials.

ARA is now under fire from the attorney general's office for allegedly understaffing ARA West Park, failing to maintain equipment in working order, and failing to provide adequate patient care

to patients at the 166-bed skilled nursing facility.

In the accusation filed against ARA, California Attorney General John K. Van de Kamp cites instances of patient neglect dating from February, 1983, to July, 1984, which involved problems ranging from failing to isolate a patient with a staphylococcus infection to failing to give medication for a heart condition.

State health officials also contend that patients at West Park were not properly groomed. During an inspection in September, 1984, 21 people allegedly were discovered in bed at 3 p.m., 31 patients had long or dirty fingernails, 13 people had sharp toenails, and eight people had excessive facial hair.

Cathy Daigle, a spokesman for ARA in Houston, Texas, said the company "obviously doesn't like" the state's pending

revocation action against West Park and indicated that ARA will fight the revocation proceeding. She said that ARA had corrected problems uncovered at West Park and that the company would "continue to run the facility, ensuring we have proper care."

West Park "is now running well, and from our perspective we cannot understand the state's action to revoke the license," Daigle said.

In other action involving the West Park facility, federal health officials recently decertified the nursing home, as well as a second Northern California nursing home owned by ARA, Cypress Convalescent Hospital in Pleasant Hill. Daigle said that the company has gone to court to force the federal government to reinstate Medicare and Medicaid payments to the West Park nursing home.

## Nursing home chain's expansion stymied

Continued from page 1  
cials who administered and managed the facilities may be barred from California's nursing home industry.

But it is of perhaps even greater import for the giant nursing home chain that the CDHS has begun to balk at licensing new Beverly Enterprises facilities. A total of seven Beverly facilities are stalled or about to be stalled because of the CDHS. In May and June, the CDHS denied licenses for Beverly to operate the Ukiah Convalescent Hospital in Ukiah, Summerfield Convalescent Hospital in Santa Rosa, Healdsburg Convalescent Center in Healdsburg, and Palm Terrace Health Care Center in Laguna Hills, all of which Beverly recently acquired; a new home health agency branch office in San Jose; and one nursing home Beverly has just

built, Rancho Mirage near San Bernardino. And in Ridgecrest, Calif., Beverly has completed a new 99-bed skilled nursing facility, but there is "every indication the state health agency will deny an application for licensure," said Paul Keller, chief of the field operations branch of the CHSD licensing division.

Diane McCarthy, a spokesperson for Beverly Enterprises, questioned the methods regulators are using against the chain. "Obviously it is not something we feel is equitable," McCarthy said. It is not proper for the state to hold up licensure of Beverly's new facilities pending a decision on whether to revoke the licenses of three others, she explained.

But Hank Schoenlein, a CDHS official who supervises health facilities in a vast region of Northern California, countered that health watchdogs are "following a policy whereby the licensee applying for additional acquisitions of facilities is going to have to demonstrate its ability to comply with California health laws and regulations."

As a result, when an applicant for a California license has had a license revoked or is threatened with loss of a license, Schoenlein said, that applicant is going to have problems obtaining licenses to operate other nursing homes. "We are looking at the compliance record of already existing licensed facilities" operated by the applicant, he said. "Where we have pending revocation actions, an applicant is going to have a very difficult time getting a license because the ability to comply with laws and regulations has not been demonstrated."

Schoenlein went on to say, "What we've seen in the South Bay area causes us serious concern. These actions are being taken due to the serious violations of the health and safety code and department regulations governing skilled nursing facilities run by Beverly. Because of these violations the department has determined that Beverly has not provided satisfactory evidence of its ability to comply with the statutes and regulations of the state of California related to the operation of skilled nursing facilities."

**THE MOST SERIOUS** violations alleged against Beverly involve the deaths of nine patients, four at Beverly Manor of Los Gatos and five at Julia Convalescent Hospital (AMN, Jan. 17, 1986).

In Los Gatos, one patient, identified as Margaret R., died from shock on July 8, 1985. She died in a hospital where she was being treated for infected decubitus ulcers on her right hip, right leg, left thigh, left buttock, and tailbone. Nursing notes indicate that the nursing home did not tell her physician about several of the sores for weeks. When the physician ordered draining ulcers to be cultured for infective organisms, nursing home staff failed to follow through. Attorney General Van de Kamp's accusation against the

facility states.

Deficiencies in care at the Los Gatos facility also allegedly led to the death, on July 10, 1985, of William Bronson, a San Jose man who suffered from congestive heart failure. Although he coughed up bloody sputum for three days, nursing home staff allegedly failed to report his condition to a physician. When he experienced a sudden drop in blood pressure, increased pulse rate, and labored breathing, nurses allegedly waited 22 minutes to transfer him to a hospital next to the nursing home.

Another patient, Clarence L., died Aug. 13, 1985, almost 14 months after being admitted to Los Gatos because of severe degenerative arthritis. The 120-pound man subsequently developed bedsores on his spine, right foot, and left elbow and an open sore on his penis. The accusation filed by the attorney general contends that the facility repeatedly failed to develop a plan to adequately treat these sores and that the man developed a 101 degree (F) temperature on Aug. 1, 1985, and had to be transferred to a hospital. Diagnosed with "possibly urinary source of pneumonia," he died 12 days later.

**HARRIET M.**, admitted to Los Gatos June 19, 1985, with fragile but unbroken skin, suffered from diabetes mellitus, hypertension, peripheral vascular insufficiency, and senile dementia, and had experienced a cerebral vascular accident. State officials contend that the woman developed a sore on her heel that progressed to a 5-cm X 5-cm necrotic ulcer before her physician was notified. Moreover, the attorney general alleged, Los Gatos staff failed to monitor the woman's blood sugar for the entire month of July, 1985.

Harriet M. died Aug. 12, 1985, in an acute care hospital to which she was transferred upon becoming weak and unresponsive. Documents filed by the attorney general attribute her death to gram-negative sepsis, "with acute pyelonephritis and decubitus ulcers listed as portals of entry."

At Julia Convalescent Hospital, the attorney general contends, a patient waited 45 minutes after exhibiting symptoms of heart failure before staff called an ambulance. Another negligent death allegedly resulted when staff for 26 minutes failed to call paramedics to assist a woman dying of pneumonia. The three other deaths involved patients who had developed numerous, serious bedsores.

The attorney general also is attempting to revoke the license of Beverly Manor in Santa Cruz, which was given \$65,000 in fines in June; the nursing home was given a class A citation for an incident that threatened the life of a patient, state health officials said and McCarthy confirmed.

The attorney general also reportedly is considering whether to attempt to revoke

the license of another Bay Area nursing home owned by Beverly — the Beverly Manor Convalescent Hospital in Live Oak, which in June received 11 citations and \$67,000 in fines for care that allegedly led to the death of a 93-year-old woman.

**BEVERLY ENTERPRISES** is taking the position that problems at the facilities that are the object of the attorney general's action already have been corrected, and that as a result, the state no longer has grounds for the revocation proceedings.

"At this point in time we're delivering excellent patient care," McCarthy said. "Revoking a license in an existing operation is supposed to be for the purpose of protecting any patients that might have harm come to them as a result of being in the home. On follow-up surveys, state inspectors have to be able to say that people are in jeopardy. On follow-up surveys (at Beverly homes of which the licenses are now threatened) we have done very, very well. Technically, (the state) should not be allowed to consider revoking our licenses."

But San Francisco Deputy State Attorney General Jan Sherwood said, "The law doesn't say, 'If you clean up your act, all is forgiven.'" A violator, she said, "is still subject to a penalty for having violated the law."

Sherwood also noted, "The fact that Beverly cleaned up problems is some evidence of its ability to correct a problem, but the health department has some concern about Beverly's ability to prevent the problem from happening in the first place. It's the responsibility of the licensee to always run a clean nursing home."

**BEVERLY OFFICIALS** have vowed to go to court, if necessary, to fight license revocations at their California facilities, and they have engaged the prestigious San Francisco law firm of Pillsbury, Madison, and Sutro to plead their cause. The corporation "is working on doing everything we can to see to it that" that no revocations are imposed, McCarthy said.

However, should Beverly lose its licenses to operate in Los Gatos, Mountain View, and Santa Cruz, a four-tiered appeals process remains open to the company. In California, the decision of an independent hearing officer sitting in an administrative revocation proceeding before the CDHS may be appealed to the department's director.

Beyond that, decisions of the health department also may be appealed to a California superior court, and beyond that to the California Court of Appeals. The state's Supreme Court is the final arbiter, but it hears appeals only if it chooses to do so.

—Phyllis Capen

Capen is a free-lance writer living in Houston.

# State stiffens stance on nursing homes

Armed with tough new laws giving regulators greater powers, California is moving more aggressively in its battle against nursing home abuse and neglect.

The state's new tactics include inspecting homes without prior warning and levying fines up to \$25,000 per incident. The state has already forced the closure of two facilities since the spring, when the state legislature passed landmark nursing home reform legislation.

Penalties up to \$5,000 per incident and planned inspections were the norm before California Governor George Deukmejian signed a package of nursing home reform bills giving regulators authority to levy heavy fines for negligent care that leads to patient deaths, falsification of

medical records, or repeated violations of health rules.

As a result of the new laws, the California State Dept. of Health Services has recently levied the largest fines in its history — including a record \$197,000 fine against Beverly Manor of Los Gatos, a home owned by Beverly Enterprises, Inc., of Pasadena, Calif. That sum is almost \$35,000 more than all fines levied against 82 of the California homes operated by Beverly Enterprises in 1981 and 1982.

But some observers question whether the state will be able to exercise the full measure of its new powers. Nursing home operators and reformers alike warn that the state may never collect the full fines it levies against nursing homes.

HISTORICALLY, CALIFORNIA has had difficulty collecting the full fines assessed against nursing homes accused of violations. One reason is that nursing home operators have the right to appeal decisions of the Dept. of Health Services — first to a hearing officer and then to the courts — and most do.

In addition, it has often been difficult for the state to prove the charges it makes against nursing homes. "There are often mitigating factors on the side of the facility," said Susan Bertken, an attorney for the Dept. of Health Services. "Nursing home inspectors sometimes fail to substantiate their cases. Maybe the evaluator was lax in writing up the citation."

Given the small size of the fines Cali-

fornia used to impose on nursing homes — a mere \$4,000, for example, on a charge of negligence that cost a patient a leg — there was little point in the state's pursuing these cases to the trial stage. "It takes very little time for us to spend more on legal fees and attorneys' time than we are going to get back in penalties," Bertken said.

Thus, traditionally, the state has been willing to offer a lesser fine to a nursing home rather than go to court. "I can't remember a citation going all the way to trial," Bertken said.

UNDER CALIFORNIA'S new law, specially trained inspection teams are uncov-  
*Continued on page 43*

# California acts to combat nursing home abuses

*Continued from page 3*

ering abuses that carry higher fines than in the past, and this may provide greater incentives for the state to take its nursing home cases to court.

The pattern thus far, however, is that the state continues to be willing to settle out of court — but it may be collecting a greater percentage of its fines than it previously obtained.

For example, ARA Living Centers, the Houston-based owner of a national chain of nursing homes, received some \$65,000 in fines for a wide variety of incidents that allegedly occurred in nursing homes it owned or managed in California from 1980 to 1984. Recently ARA settled these fines by paying 55 cents on the dollar, or \$35,695.

But in 1984, said Santa Rosa, Calif., personal injury lawyer Patrick Grattan, ARA was negotiating to settle \$75,000 in fines against troubled California homes for 20 cents on the dollar, with an admission that the fines were justified.

Viewed from an historical perspective, therefore, the recent ARA settlement is "quite high," Bertken said.

Even more telling were regulators' curbs on ARA's expansion in California. The state will not allow the chain to license any more facilities in California until next May and is insisting that it gain approval from state officials before signing any more contracts to manage nursing

homes in the state.

Moreover, the state revoked the license of Driftwood Convalescent Center of Santa Rosa, formerly operated by ARA, which incurred fines of considerably more than \$10,000 in 1983 and 1984 for alleged violations that included failure to give patients medications that had been ordered for them; walls smeared with feces; patients left lying in their own wastes; linen shortages that forced patients to lie on torn, wrinkled plastic sheets; and failure to obtain and record patients' vital signs.

The state placed the license of ARA's Driftwood Convalescent Center in Torrance on probation for two years because of problems allegedly found at the home between 1980 and 1983. In one instance, the facility allegedly failed to provide appropriate care for a patient who lost 20 pounds in an 18-day period in 1980 when as few as two nurse assistants were caring for 75 patients at night.

Finally, the state dismissed with prejudice actions to lift the licenses of Good Hope Convalescent Hospital, which ARA no longer manages, and the former Laurelwood Convalescent Center in Los Angeles. Under ARA's management in 1982, Good Hope officials allegedly failed to notify a physician that an orderly had struck a blind patient so hard that blood began to flow from the man's ear. Problems at Laurelwood, now called Prestige

Convalescent Hospital, involved a patient who allegedly sustained third-degree burns when a heat pack was used incorrectly, as well as the rapid decline of a patient with an open, pus-filled decubitus ulcer on her right foot, whose temperature was not monitored for a week.

**BY NO MEANS** all observers are happy with the way the state is enforcing the new laws, however.

Watchdog groups critical of the Dept. of Health Services contend that the state is not doing enough to collect the stiff fines levied under the new nursing home law.

For example, critics report that nursing homes in a five-county area of northern California, where the state is aggressively enforcing the new law, have been fined more than \$1 million since the new law took effect, on charges of neglect that allegedly led to the deaths of 10 patients and the prostitution, rape, and brain damage of three others. Yet these nursing homes have so far paid less than \$30,000 of the fines levied against them.

Meanwhile, spokesmen for the nursing home industry contend that the Dept. of Health Services is levying excessive fines in response to the intense pressure it has been under from its critics.

"This is a testing time in California with these reform actions," said Kathy Daigle, an executive with ARA, which recently

reorganized its division responsible for the operation of nursing homes. "The Dept. of Health Services feels the need to prove it is taking a more aggressive stand with nursing homes."

She said that, before the new legislation, only 5% of all fines levied against nursing homes were on charges of negligence leading to patient deaths — the category for which the highest fines are assessed. These severe penalties are more common now, she said. "But they have been inappropriately placed at the higher level."

She predicted that, because the fines are now too high, they will be lowered by the courts if the nursing homes are forced to take them to trial.

**DAIGLE ALSO** criticized the process whereby health department officials in charge of licensing and inspection also act as hearing officers when fines are initially appealed. That process represents a conflict of interest, in which an official is both "the collector of fines and the trier of facts," she said — adding that, prior to 1985, only 30-40% of fines appealed to hearing officers were reduced or dismissed.

—Phyllis Gapen

*Phyllis Gapen is a free-lance writer who divides her time between Washington, D.C., and Houston.*

# **California officials continue crackdown on health violations in nursing homes**

*Two proprietary chains cited by state  
defend overall quality of care offered*

Three nursing homes in northern California racked up record fines in recent weeks as the state's health department continued its crackdown on facilities rendering poor quality care.

Since August, three homes operated by Beverly Enterprises and ARA Services Inc. have been hit with more than \$250,000 in fines in the Golden State. California health officials have cited them for health code violations that allegedly contributed to the deaths of five elderly patients.

The two chains are the largest nursing home companies in the United States, with control over more than 10% of the country's long-term care beds.

A Los Gatos home owned by the 100,000-bed Pasadena-based Beverly Enterprises has just been slapped with the largest fine ever imposed by the state on a California convalescent center. The \$197,000 fine imposed on Beverly Manor Convalescent Hospital, a 73-bed facility south of San Francisco, was issued by the California Dept. of Health Services, which penalized the home for inadequate care by issuing 10 citations against it late last month. Two of the citations were \$25,000 "AA" violations for life-threatening conditions, the most severe the department can issue.

Penalties came in the wake of the

deaths of three nursing home patients in July and August: 65-year-old William Bronson and two unnamed patients, one an 84-year-old man and the other an 80-year-old woman.

COUNTING these latest violations, the home has been hit with 12 citations totaling \$233,000 in fines since Aug. 8.

Beverly's competitor, ARA Services Inc., which controls more than 32,000 beds in 12 states, also received heavy fines in August.

ARA's recent troubles stem from problems at Skyline Convalescent Hospital in San Jose and at Driftwood Convalescent Hospital in Salinas, the community that houses California's famed Cannery Row.

Western Medical Enterprises, ARA's West Coast division, incurred a total of \$20,000 in Class "A" fines at the facilities because two of its elderly charges died allegedly when nurses failed to respond properly to emergencies.

Driftwood, a 99-bed facility, was fined \$10,000 Aug. 6 for the death of an unnamed 82-year-old man. State health officials allege that the man died of a heart attack Aug. 6 after a nurse discovered him on a bathroom floor. Although an ambulance was called, proper cardiopul-

*Continued on page 28*

# California continues crackdown on nursing homes

Continued from page 2

monary resuscitation techniques allegedly were not implemented rapidly enough to save the man's life, and he died at a local hospital to which he eventually was transferred.

Skyline, a 227-bed facility, was issued a Class "A" citation and a \$10,000 fine for the death of an unnamed 85-year-old woman Jan. 15. The state alleges that the woman was not attended properly by a physician even though she suffered from a blood clot that lodged in her leg. State investigators said that although the nursing home contacted a physician when the woman was found cold and mottled, she went without a physician's care for more than eight hours before being transferred to a hospital where she died.

**PROBLEMS CITED** at Beverly Manor in Los Gatos are so serious, said the state Dept. of Health Services director, Kenneth McCarthy, that the home could lose its license as its certification for federal health care programs. Kluge's investigative team already has recommended that the federal government suspend Medicare and Medicaid agreements with the home.

Violations involve deficiencies in care that allegedly led to the July 10 death of William Bronson, a San Jose man who suffered from congestive heart failure and was being given oxygen to sustain his life. State investigators said that the elderly man coughed up bloody sputum July 5, 6, and 7, but a nurse failed to report the bloody nature of the liquid when a physician was contacted.

On July 10 at 1:30 p.m., Bronson experienced a sharp drop in blood pressure, an increase in pulse rate, and labored breathing, but nurses waited 22 minutes to transfer him to a hospital next door. He died at 2:35 p.m.

The state alleged in its citation that "a direct proximate cause of the death of the patient" was the failure of the nursing home staff to recognize the severity of Bronson's condition and to act immediately to transfer him to a hospital.

"The patient's diagnosis (of congestive heart failure) does not excuse inadequate nursing care," the citation said.

In response to the citations, ARA's manager of public relations, Cathy Rubenstone, said the company "holds in each of these cases that we provided adequate care." ARA has the option of protesting the fines the state has imposed, and Rubenstone suggested that the company might do so. "We routinely contest fines," she said in an interview.

ON AUG. 8, the Beverly home received "AA" and "A" citations related to the death of an unnamed 80-year-old woman who allegedly died of blood poisoning that resulted from infection in numerous large bed sores.

Although the staff of the home diligently logged the progress of the sores over two weeks into large, festering wounds,

the state charged that no one had notified the woman's physician or adequately treated the sores.

Among other "A" citations that brought the home a total of \$197,000 in fines last August were the alleged failures:

- Prevent the development of bedsores on the skin of a woman with diabetes who had to be transferred to an acute care hospital Aug. 5; monitor her blood sugar weekly as ordered by her physician; and notify the physician promptly of changes in her condition.

- Re-evaluate the plan of care for an amputee whose weight dropped from 92 to 76 pounds from Feb. 26 to June 21.

- Notify a physician about a patient with a pacemaker whose daily pulse rate varied wildly.

- Rectify a situation wherein a nurse-call device was beyond the reach of a 99-year-old blind patient with so much mucus in her mouth that her breathing was impaired.

- Prevent the development of skin ulcers in a paraplegic woman as well as provide the special bed and mattress her physician ordered to prevent sores from forming, and deal with her diminishing appetite.

- Review patient care plans.
- Provide prescribed therapeutic diets.
- Assist patients in eating.
- Provide proper skin care for incontinent patients.

- Notify physicians promptly of changes in the condition of their patients.

A SPOKESWOMAN for Beverly, Diane

McCarthy, said the corporation "is not concerned because of citations or fines. We're the largest operator of nursing homes in the country and we didn't get that way by offering anything but excellent quality of care in general. Our primary concern now is to get in there and make sure nothing like this ever happens again."

Carla Framiglio, supervisor in the San Jose licensing office of the state Dept. of Health Services, said Beverly Manor had brought in a number of consultants and undertaken a complete reassessment of the conditions of every patient since the state undertook its investigation.

"Most of the home's quite ill patients have now been discharged to other Beverly facilities or to acute care hospitals," said the state health department's district

administrator, Mary Louise Mock.

Framiglio and Mock work out of the health department's San Jose licensing office, an entity that acts as an overseer for nursing homes in Santa Clara, Santa Cruz, Monterey, and San Benito counties. Since the first of the year, the office has levied more than \$1 million in fines and recommended the closure of several facilities. Two additional ARA facilities near San Jose are facing the loss of their licenses because of the actions of the office. They are ARA-Westpark in San Jose and Driftwood Convalescent Center in Santa Rosa.

In 1983, Driftwood was cited for 83 non-life-threatening conditions. In 1983 and 1984, 39 complaints against ARA-Westpark resulted in the issuance of two Class "A" and 11 Class "B" citations. Three of the citations were for insuffi-

ciently staffing Westpark with nurses, one was for failing to notify a physician of a change in the condition of a patient, and another was for failing to implement adequate infection control procedures.

Corporately owned nursing homes are not the only facilities under fire in California. Bethany Convalescent Hospital in San Jose, one of a small group of homes run by the National Benevolent Assn. Health Services Corp., was fined \$15,000 recently in incidents involving patient deaths (AMN, Sept. 6, 1985). Northlake Convalescent Hospital in San Jose, owned by Youmans Convalescent Hospitals Inc., was cited for the deaths of two elderly women patients from dehydration and untreated urinary tract infections. That facility has been closed, as have several others.

**IN COMPARING** Beverly Manor to Northlake, Framiglio said, "The findings of our investigation indicate that the nursing care situation was far worse than it was in our investigation at Northlake Convalescent Hospital."

Framiglio made no comparisons among such chain-operated homes and the recently cited Brommer Manor in Santa Cruz, a facility fined \$3,000 and given an "A" citation Aug. 9 because of alleged rough handling of a patient.

At the 38-bed Brommer facility, an elderly woman allegedly sustained a bruised knee, a cut eyebrow, and a broken arm while a nurse's aid was turning her to change a dressing.

The citation marked the third Class "A" penalty issued against Brommer since the beginning of the year. On May 29, the

facility was fined \$10,000 after a woman patient fell and broke her hip for the fifth time in five months. State investigator Beverly Craig said, "There was no plan of care to prevent the patient from falling [even] after all of the [other] documented falls."

Brommer also was fined \$1,000 Feb. 14 after a woman patient sustained a fractured leg when a nurse's aide was putting her to bed. The patient allegedly told investigator Barbara Johnson that the aide had dragged her to the bed even though she had protested, and that her leg was broken when it became entangled in a side rail on the bed.

—Phyllis Gapen  
*Gapen is a Washington, D.C.-based free-lance writer specializing in medical and health topics.*

# Wrongful death suit is filed against nursing-home operator

by Jim Simon  
Times staff reporter

Beverly Enterprises, under fire from politicians and state social service officials for violations at several of its nursing homes around the state, now has legal problems to add to its woes.

A wrongful death suit has been filed against Beverly in Pierce County Superior Court in connection with an 89-year-old woman who, attorneys allege, died from injuries sustained at a Tacoma nursing home owned by the company.

The suit alleges that Florence Gamache died from improper care she received at the Sherwood Terrace Nursing Center.

According to the lawsuit, Gamache suffered a broken leg and bruises on her head, face, arms and neck while under Sherwood's care on June 14. Two weeks later, while still under treatment from those injuries, she developed pneumonia and died.

Sean Briggs, the attorney who filed the suit on behalf of Gamache's family, said Sherwood officials never offered an explanation of what caused the death.

"The family entrusted her to Beverly Enterprises for care, and now they're left without an explanation for why she died," said Briggs.

Briggs said Gamache lived at

Sherwood for several years. She had been bedridden for some time because of a stroke and a broken hip, he said.

Beverly officials were unavailable for comment on the lawsuit. The state House Health Committee was scheduled to hold a hearing today in Olympia to discuss problems at the 33 homes owned by Beverly in Washington. The committee chairman, Rep. Dennis Braddock of Bellingham, has warned Beverly to improve its operations or face the threat of a state takeover.

Sherwood is one of eight facilities owned by Beverly — the largest nursing-home operator in the nation and the state — that have been cited by state Department of Social and Health Service inspectors for improper practices this year. Several of those homes have been barred from accepting new patients.

Gamache's death was investigated by the state Medicaid Fraud Unit and Tacoma police, according to Curtis Edwards of the fraud unit.

Edwards said nursing-home inspectors referred the Gamache case to his office because of possible patient abuse or criminal violations.

He said Sherwood officials claimed Gamache was injured when she fell while being moved by a nursing-home employee. But Edwards said the bruises on Ga-

mache's face did not appear consistent with a fall.

However, Tacoma police say they are no longer investigating the death.

"We found no evidence of criminal intent to inflict bodily harm," said Chris Taylor, Tacoma police spokesman. He added that police responsibility under state law doesn't extend to investigating possible neglect.

Sherwood was cited twice in June by DSHS investigators for improperly transferring Gamache from her bed to her wheelchair, said Rodney Atkins of the nursing-home complaint division.

Atkins said Gamache's care plan called for the woman to be transferred with the help of two nurses aides, but only one aide was used on at least two occasions. Inspectors found Gamache suffered "skin tears," bruises on her forehead and a thigh problem that was later diagnosed as a fracture.

But Atkins said DSHS investigators do not have evidence directly linking the injuries cited in the lawsuit to the two incidents where Gamache was improperly transferred.

Last February, the DSHS nursing-home division put a temporary ban on admission of new patients at Sherwood and fined the home \$600 because of sanitation violations. The ban was later lifted after those problems were corrected.

# Judge recommends revoking nursing home license

A California administrative law judge has recommended revoking the license of a corporately owned nursing home in San Jose for allegedly understaffing the facility, providing inadequate care, and failing to maintain medical equipment in working order during a period in 1983 and 1984.

In a hearing before the state's Dept. of Health Services, administrative law judge Ruth S. Astle advised health officials to revoke the license of the former West Park Convalescent Hospital, a home owned by Western Medical Enterprises, a division of ARA Services Inc. of Philadelphia, the nation's third largest nursing home chain.

But in her decision, which is not binding on the health department, Astle also took into account improvements ARA had made at the home since the February, 1983, to July, 1984, period and recommended that the revocation action be stayed.

Mary Louise Mock, a district administrator for the health department, said nursing home regulators now were weighing whether to accept the judge's recommendation or to simply revoke the license of the 166-bed facility.

A decision from health officials is expected before the end of the year, said Cathy Daigle, a spokesman for ARA Living Centers.

The patient care problems that prompted health officials to seek revocation of the home's license ranged from failing to note the signs of a diabetic crisis to neglecting to isolate a patient with a *Staphylococcus* infection. They also included broken bed rails, urine odors, poor recordkeeping, and failure to help patients with meals.

Since then, Astle said, the chain has fired an "incompetent" nurse at the facility, hired a new administrator, increased formerly inadequate staffing, and taken steps to ensure that the physical plant is operating properly. The name of the

nursing home also has been changed to Winchester Living Center.

Daigle, who is based in Houston, said that Astle "had made a personal visit to the facility" where she found that "the new administrator at the facility had taken care of any problems that exist. We are hopeful that when the Dept. of Health reviews her findings it will concur with her decision and that we will continue operating the facility. We think that things are going very well there."

ARA'S CLOSE CORPORATE competitor in California, Beverly Enterprises, also is weighing the future of one of its nursing homes in Northern California.

Beverly Manor Convalescent Hospital in Los Altos, a 152-bed facility serving bedridden patients, was fined \$33,800 in

November and given one class A and two class B citations.

A citation filed by the California Dept. of Health Services alleges that an 89-year-old man with a history of falls sustained an injury in an accident at the home in October and will have to have his left eye removed as a result.

Inspectors cited this facility because the man allegedly had not been afforded procedures that would have prevented him from falling from his bed or wheelchair.

The facility was fined \$30,000 because of allegedly poor care that led to the injury and \$800 for failing to report the man's injury to health officials.

Charges that a demented 87-year-old woman had sustained bloody skin tears that were not reported to her physician

also produced a \$3,000 class B fine for the facility.

Beverly Enterprises Vice President Jack MacDonald said the corporation's health care consultants are "reviewing the events surrounding the incidents that have been cited" and engaging in discussions with state officials about the alleged impending loss of a patient's eye. "It would be inappropriate to comment further on specific details of the allegations noted in the citations," MacDonald said. "We have undertaken a full review of the facility. We are very concerned and interested in seeing that the care and services in the facility are of the highest quality."

—Phyllis Capen

Capen is a free-lance writer living in Houston.

In California

## Beverly sues for nursing home licenses

Beverly Enterprises, the nation's largest nursing home chain, is suing the California Dept. of Health Services over the agency's unwillingness to license seven facilities the chain wants to operate in the state.

The health department is currently attempting to revoke the licenses of three nursing homes already being operated by Beverly in Northern California — Beverly Manor in Los Gatos, Julia Convalescent Hospital in Mountain View, and Beverly Manor in Santa Cruz, with total annual revenues of about \$9 million. In its lawsuit, filed in superior court in San Francisco, the corporation is seeking an injunction to prevent the health department from refusing to license its new facilities as long as revocation action is pending against existing ones. The corporation contends that the health department is attempting to coerce it into a settlement of the dispute over the existing facilities.

State regulators contend that the deaths of nine elderly patients in the three Beverly facilities were related to improper care, a charge that is flatly denied by Beverly's chairman, Robert Van Tuyle. Corporate officials contend the allegations cannot be proven in court.

The corporation, with annual revenues of more than \$1 billion and \$20 million invested in its new California facilities, filed its suit Aug. 19, after rejecting a state

offer to settle the revocation actions against the three existing facilities.

In August, the state offered to stay revocation actions against the three homes for three years if corporate officials agreed to forgo an administrative hearing protesting the revocation action, paid \$393,825 of \$459,350 in fines against Julia and Beverly Manor in Los Gatos, and accepted provisional licenses for all three facilities as well as its new state facilities. Moreover, state officials insisted that they would henceforth rate the performance of the Beverly chain against other nursing homes in the state. Beverly's failure to perform as well as other operators, the regulators said, would lead to the revocation of licenses for Julia, Beverly Manor in Los Gatos, and Beverly Manor in Santa Cruz; refusal to license any new Beverly facilities for 12 months, and expiration of provisional licenses.

In court papers, attorneys for Beverly complained that state officials were coercing the corporation to give up its constitutional right to a Nov. 3 hearing on the revocation actions, taking improper punitive actions against homes that had rectified patient care problems, and thwarting the chain's ability to do business in the state. A hearing on these issues is scheduled for Sept. 25.

At stake in the suit is the fate of the three existing homes as well as four

homes recently purchased by Beverly and two homes the chain recently built. Beverly recently bought Summerfield Convalescent Hospital in Santa Rosa, Healdsburg Convalescent Hospital in Healdsburg, Ukiah Convalescent Hospital in Ukiah, and Palm Terrace Health Care Center in Laguna Hills. The corporation recently built Rancho Mirage Health Care Center in Rancho Mirage and another, apparently unnamed, facility in Ridgecrest.

Beverly officials assert that state officials should explain what the company must do to obtain licenses for its new facilities. But Hank Schoenlein, a regional official for the California Dept. of Health Services, said the state has already addressed that issue. Regulators told the corporation it must comply with state health requirements if it expects to operate new enterprises.

"Everyone who applies to license a health facility in California is evaluated in terms of compliance with the laws and regulations of the state," Schoenlein said. "Issuing a license is not a routine matter. Considerable time and effort is being spent evaluating an application. Among other things, we look at the compliance record of applicants who have licenses at other facilities."

Beverly Corporate Vice President and General Counsel Bob Palmerville said

he was not certain "what the state was trying to do" in its recent actions involving his company. "We only know that they're not behaving in a proper manner when they try to force us into a settlement. We call this case our 'tying case,' because the state is attempting to tie issuance of license on activities unrelated to the nursing home. The state even denied our license for a home health agency."

As the dispute between the Beverly chain and the state continues, homes owned by the chain in California have received additional citations from the state health department.

In August, Beverly Manor of Santa Cruz was issued a \$30,000 citation for allegedly failing to consult a doctor when an elderly woman with a history of breathing problems exhibited lung problems for more than four hours; she was transferred to an acute care hospital only at the insistence of her daughter, said state health officials. Hospital personnel found the woman had fluid in her lungs.

Also in August, Beverly of Los Altos was given a \$30,000 citation involving the death of a 76-year-old heart patient who had lost 21.1 pounds in a 13-day stay at the home.

—Phyllis Gapen

*Gapen is a free-lance writer living in Houston.*

## Nursing home is fined \$5,000 over death

A San Jose, Calif., nursing home has become the fifth nursing home in the area to be fined by the state since July in incidents involving patient deaths.

Following an investigation by the state Dept. of Health Services, Bethany Convalescent Hospital was fined \$5,000 for an incident involving a 69-year-old woman patient who fell out of bed and died two days later, the *San Jose Mercury News* reported.

State investigators said that the patient was admitted July 11, and that the nurse's notes from the first night recommended restraints because the woman tried to get out of bed. On July 12, a physician's order for postural restraints was obtained, but that night the woman was found by a nurse on the floor by the foot of the bed.

She was promptly moved to a hospital, where she was diagnosed with a broken hip and arm, but she died before treatment could be begun. The coroner's office attributed the death to arteriosclerosis, aggravated by the fall.

The state investigator's report asserted that there was "no evidence that the physician's order to use [postural] supports was implemented on the night of July 12-13."

The same home also was fined \$10,000 recently as the result of a fall by another patient, a 72-year-old woman who broke her left hip. The woman told investigators that the nurse's aide who helped her up after she fell did not immediately report the fall and warned the woman not to tell anyone, lest the aide be fired.

PUBLIC OPINION MESSAGE

DEAR: SENATOR ABOOD

NAME: CAROLYN N. TURNER  
TITLE:  
ADDRESS: 120 KATLIAN ST.  
CITY: SITKA, AK  
PHONE: 747-6846

ZIP: 99835

BILL NO: SCR 47

SUBJECT: OPERATION OF PIONEERS' HOMES

MESSAGE: I'M OPPOSED TO THE PRIVATE SECTOR RUNNING THE PIONEERS HOME. I SUPPORT THE STATES CURRENT PROGRAM. PLEASE DO NOT CHANGE THE PRESENT SYSTEM.

POMID: 12143335  
DATE: 02/25/88  
TIME: 14:33:35  
LIONAME: SITKA LIO

COPIES: REPRESENTATIVE    SENATORS

GRUSSENDORF

ELIASON  
FANNING  
HENSLEY  
JOSEPHSON  
UEHLING  
FISCHER  
JONES  
KERTTULA  
BINKLEY  
DUNCAN  
HALFORD  
ZHAROFF  
FAIKS

RECEIVED  
FEB 29 1988

PUBLIC OPINION MESSAGE

DEAR: SENATOR ABOOD

NAME: EVERITT CALHOUN  
TITLE:  
ADDRESS: 120 KATLIAN ST.  
CITY: SITKA, AK  
PHONE: 747-6216

ZIP: 99835

BILL NO: SCR 47

SUBJECT: OPERATION OF PIONEERS' HOMES

MESSAGE: I FAVOR SENATOR KERTTULA'S RESOLUTION. THE GOVERNOR CAN FIND OTHER WAYS TO ECONOMIZE THAN THE WELFARE OF THE ELDERLY. THE CARE NOW GIVEN IS SECOND TO NONE. KEEP IT THAT WAY. PRIVATE MANAGEMENT WOULD HAVE TO CUT CORNERS TO MAKE A PROFIT, AND THAT WOULD JEOPARDIZE THE WELFARE OF THE RESIDENTS. EVERITT CALHOUN, RESIDENT, SITKA PIONEER HOME

POHID: 12122107  
DATE: 02/24/88  
TIME: 12:21:07  
LIONAME: SITKA LIO

COPIES: REPRESENTATIVE      SENATORS

GRUSSENDORF

ELIASON  
FANNING  
HENSLEY  
JOSEPHSON  
UEHLING  
FISCHER  
JONES  
KERTTULA  
BINKLEY  
DUNCAN  
HALFORD  
ZHAROFF  
FAIKS

RECEIVED  
FEB 25 1988

PUBLIC OPINION MESSAGE

DEAR: SENATOR ABOOD

NAME: ORVILLE R. WHEAT  
TITLE: SITKA PIONEERS HOME  
ADDRESS: 100 KATLAN  
CITY: SITKA  
PHONE: N/R-  
BILL NO: SCR 47  
SUBJECT: OPERATION OF PIONEERS' HOMES  
MESSAGE: I ASK YOU TO SUPPORT SCR 47. TO CONTRACT OUT PIONEERS HOMES TO THE PRIVATE SECTOR WOULD LOWER OUR STANDARD OF LIVING.

ZIP: 99835



POHID: 12151122  
DATE: 02/23/88  
TIME: 15:11:22  
LIONAME: SITKA LIO

COPIES: REPRESENTATIVE      SENATORS

GRUSSENDORF

ELIASON  
FANNING  
HENSLEY  
JOSEPHSON  
UEHLING

RECEIVED  
FEB 25 1988

Joan Pope

2/22/88

Sitka Pioneers' Home

120 Kathleen St.

Sitka, Alaska

99835

RECEIVED  
FEB 25 1988

Senator Abood

Senate State Affairs Committee

Pouch V.

Juneau, Alaska 99811

Dear Senator Abood,

~~Please support Senator Kirtulla's  
resolution SCR 47 relating to  
the Pioneers' Homes. I agree with  
this resolution as a resident of  
the Sitka Pioneers' Home. I am  
against the privatization of any  
Pioneers' Home.~~

Thank you.

Joan Pope

Sitka Alaska

Feb 22, 1988

RECEIVED

FEB 25 1988

Senator Mitch Abood,  
Juneau Alaska

Dear Chairman Abood,

I would like for you to use your  
Voting Power to ~~help pass the SCR 47~~  
~~that Senator Ketchala has recommended.~~

I am very much in favor of the way  
our administration is being carried on  
instead of Private Contract.

I urge you to try & help our ~~business~~  
I think they could be more happy  
with out the Private Contract  
to keep our jobs in Alaska  
Private Contractors usually come from  
out of states.

Yours Truly

Mrs. Ira Leon & Opal M Roberts

120 Kallain St  
2 Pioneer Home

Sitka Alaska

99835

2/21/88

RECEIVED  
FEB 24 1988

Senator Mitch Abood  
Chairman  
Senate Affairs Committee  
Pouch 6,  
Tuneau, Alaska 99811

Dear Senator Abood:

Please support ~~Senate~~  
~~Concurrent Resolution No 49~~  
~~relating to the operation of~~  
~~the Pioneer Homes.~~

Alaska has earned a  
fine reputation in its treatment  
of its Pioneer Homes that it would  
be most unfortunate to  
make a change in administration  
from the present status to the  
private sector. In other states  
where programs, similar to  
that of the Pioneer Homes,  
which have been established  
under the private sector

The results have been  
far from satisfactory.

I will be grateful for  
your support.

Sincerely yours,  
Helen Hartigan

RECEIVED

FEB 24 1988

ALBERT J. BROOKMAN, DR.  
200 EASTMAN ST.  
SITKA, AK 99836

I

Senator Mitch Abood Feb. 18, 1988  
Chairman Senate State Affairs Comm.  
Alaska State Senate, Juneau, Alaska  
Reference to Senate Comment Res. #SCR47.

Dear Senator Abood :-

There was a lot of concern and indignation when the Residents of Sitka Pioneer's Home found out that the ~~Legislature~~ proposes to let the management of Juneau Pioneer's Home out on contract instead of being operated by the Dept. of Administration as all Pioneer's Homes have been operated since the first one was built.

We will be grateful to you and all the other State Affairs committee members if you will recommend a "do pass" to ~~Sen. Keritula's Senate Bill S.C.R. #47.~~

Sincerely,

Al Brookman Sr.

2-22-88

Senator Nitch Abood Chairman  
State Affairs Committee  
P.O. Box 1

Juneau Alaska. 99811

RECEIVED

FEB 24 1988

Dear Senator Abood,

I personally am asking you to urge  
passage of SCR 47. I am also asking  
as President of the Residents Council at  
the Ketchikan Pioneer Home, on behalf  
of the residents.

We made a choice to come to live here at  
Pioneer's Home because we could afford to live here  
and the level of care was known to be good.  
We are, as a group, afraid the way change  
if the State loses complete control.  
Most of us in this home are over 70, a good  
many past 80 and we are not able to make  
a change at this time in our lives. We  
ask you to help prevent the administration of  
these homes going out of State control.

Respectfully

Jilora Nygard

President Ketchikan Pioneer Home  
Residents Council

SCR

50

SENATE COMMITTEE REPORT

FIRST COMMITTEE OF REFERRAL

Date of 3/2/88 5-DAY NOTICE  
IN ACCORDANCE WITH UNIFORM RULE 23

FURTHER:

\*\*FISCAL NOTE(S) ATTACHED  \*\*  
IN ACCORDANCE WITH AS 24.08.035  
(see below)

2/16/88 DATE TURNED INTO OFFICE 3/14/88

Mr. President:

State Affairs Committee considered SCR 50

Relating to senior citizen housing

and recommended:

replace with CS SCR 50  same title  
 attached amendment(s) and  new title

do pass

do not pass

no recommendation

individual recommendations

further referral to Finance

letter of intent adopted and attached

\*\* Committee  attached or  adopted fiscal note(s)  
 zero  fiscal impact

MEMBERS SIGNING DO PASS

OTHER RECOMMENDATIONS

[Signature]  
[Signature] (DO-PASS)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

[Signature]  
Chairman signature and recommendation

Committee Backup Attached



# Alaska State Legislature

SENATOR JIM DUNCAN

P. O. BOX V JUNEAU, ALASKA 99811

(907) 465-4766

COMMITTEES:  
FINANCE  
RESOURCES  
BUDGET AND AUDIT

February 24, 1988

## MEMORANDUM

TO: Senator Mitch Abood, Chair  
Senate State Affairs Committee

FROM: Senator Jim Duncan

SUBJECT: SCR 50, Relating to Senior Citizen Housing

SCR 50, Relating to Senior Citizen Housing would focus attention on what I think is an area of critical need in the housing continuum for senior citizens in Alaska. We already have an excellent Pioneer's Home System for our elders and some fine apartment facilities such as Mountain View available. The time has come to address the need for intermediate care facilities and more housing alternatives for seniors in this state.

Because our senior citizens are a valuable resource to this state and we all want them to live out their lives with dignity and independence, alternative housing situations should be developed which respond to their needs and desires. To accomplish this the resolution directs the Department of Administration to work with the Older Alaskan's Commission, Alaska State Building Authority and other appropriate state agencies to identify housing alternatives for the elderly. The Department would be required to provide an inventory of existing housing as well as a projection of future needs for senior housing in this State.

The resolution further directs the Department to report their findings to the Legislature and the Governor by January 15, 1989, with detailed, comprehensive recommendations for the legislative and executive actions required to provide housing arrangements which best meet the needs of all senior citizens in this state.

I urge you to schedule this resolution for a State Affairs Committee hearing as soon as possible.



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## Older Alaskans Commission

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Box C  
Juneau, Alaska 99811-0209  
907/465-3250

### POSITION PAPER

#### Senate Concurrent Resolution 50

##### "Relating to Senior Housing"

This Resolution asks the Governor to direct the Department of Administration, the Older Alaskans Commission, the State Building Authority, and other appropriate agencies to develop, by January, 1989, a set of recommendations for executive and legislative actions which may be needed to provide alternative housing arrangements to meet seniors' varying needs. Such alternative housing arrangements are meant to complement the present system of Pioneer Homes and other senior citizen facilities, such as senior apartments and private nursing homes. We understand that the sponsors intend the report to focus on the use of private dwellings or other residential settings where social and health services could be "brought in" to support and assist the senior's living situation, whether for a single senior or a congregate home shared by several seniors.

The Resolution also calls for an inventory of all existing senior housing in the state, and a needs assessment of the future needs of seniors around the state for various types of housing alternatives, including supportive services in the home.

Many legislators have expressed interest this year in the development of "supportive" or "assisted" living residential facilities for seniors--something with more staff support and congregate services than a senior apartment building, but less intensive than a nursing home. Many seniors and senior groups are asserting that there is a strong need for a variety of alternative housing situations in this category.

The Older Alaskans Commission and the Department are in support of the resolution, if adequate staff or contractual resources can be made available to perform meaningful work which will result in a practical, ready-to-implement package of recommendations.

A fiscal note is attached. The present staff resources will not be able to meet the intent of this Resolution, especially not in the first half of FY 89, as the staff resources and a

significant part of the OAC contractual and travel budgets will be needed to prepare a new three-year State Plan as required by our federal funding sources. The ongoing OAC work of monitoring the 50 grants programs and the 55 employers of 160 senior workers must also continue.

The housing plan would need a great deal of work, such as meetings with housing agencies, realtors, financial institutions, municipal agencies, and the drafting of proposed legislation and demonstration project budgets. No agency now keeps an inventory of senior housing, so a search must be done to update the inventory in the Commission's 1985 Report on Housing.

Projecting accurately the functional needs of seniors for what kinds of support services, to be provided in what settings, in different size communities, will require considerable research and sample interviewing. There is no public data base on functional abilities of impaired adults, and age alone is not a valid indicator of functional need.

The Older Alaskans Commission last did a Housing Report, including an inventory of senior housing, in 1985. Unfortunately, many of the recommendations made in that report, although still valid today, have not been implemented.

The Commission respectfully requests that if the Legislature wishes the Executive Branch to proceed with the task set out in SCR 50, that both the Legislature and the Governor now make a commitment that the State of Alaska will indeed move forward to take affirmative and active leadership to cause alternative senior housing to happen--before the rapid aging of our Alaskan population turns this "issue" into a "crisis."

APPROVED BY:

APPROVED BY:

*for* Connie Lipe, Ex. Dir.  
Dove Kull, Chair  
Legislative Committee  
Older Alaskans Commission

John M. Andrews  
John M. Andrews, Commissioner  
Department of Administration

DATE: March 10, 1988

DATE: 3/11/88

FISCAL NOTE

REQUEST:

Revision Date: \_\_\_\_\_  
Title: Relating to Senior Housing

Agency Affected: Administration  
BRU: Older Alaskans Commission

Sponsor: Duncan, Szymanski, Kertrula  
Requestor: \_\_\_\_\_

Components: \_\_\_\_\_

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
PERSONAL SERVICES		37.7				
TRAVEL		4.5				
CONTRACTUAL		5.3				
SUPPLIES		.3				
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	52.8	0	0	0	0

CAPITAL	0	0	0	0	0	0
---------	---	---	---	---	---	---

REVENUE	0	0	0	0	0	0
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FUNDING: (Thousands of Dollars)

GENERAL FUND		52.8				
FEDERAL FUNDS		0				
OTHER		0				
TOTAL	0	52.8	0	0	0	0

POSITIONS:

FULL-TIME		1.0				
PART-TIME						
TEMPORARY						

ANALYSIS : (Attach a separate page if necessary)

See Attached Page.

Prepared by: Connie J. Sipe, Executive Director *CJ Sipe* Phone: 465-3250  
Division: Older Alaskans Commission Date: 03/10/88

Approved by Commissioner: Joh M. Andrews *JMA* Date: 3/11/88  
Agency: Administration

Distribution (by preparer):

Legislative Finance  
Legislative Sponsor  
Requestor  
Office of Management and Budget  
Impacted Agency(ies)

# CONTINUATION of FISCAL NOTE ANALYSIS

For Bill/Resolution No. SCR 50

A project employee for at least 9 months will be needed (July through March). It is contemplated to hire a Project Coordinator at Range 18, Class Code 4677. The Commission will seek to hire from this class someone with expertise in either housing issues, or needs assessment and planning work. At this time, the only person on staff with real estate knowledge is the director, but the director does not have expertise in public housing development techniques.

A project employee is needed because the present staff resources will not be able to meet the intent of this Resolution, especially not in the first half of FY 89, as the staff resources and a significant part of the OAC contractual and travel budgets will be needed to prepare a new three-year State Plan as required by our federal funding sources. The ongoing OAC work of monitoring the 50 grants programs and the 55 employers of 160 senior workers must also continue.

A project position is needed because the Commission staff has been reduced from 21 to 13 full-time positions from FY 85 to FY 89, with no decrease in programs or responsibilities. A chart describing the staffing changes at the Commission is attached. The Commission's FY 89 budget includes a vacancy factor of over 10%, or two vacant positions. The present staff resources can not do justice to this task.

The project employee and, at times the executive director, will need to travel a fair amount in order to meet with key agencies and individuals in the housing market, and in order to hold town meetings and conduct sample needs assessments. A small professional services contract or RSA may be needed to analyze raw data available at the University in Anchorage, a study of Longevity Bonus recipients and their "self-declared" functional disabilities.

The project employee can use existing office equipment.

OLDER ALASKANS COMMISSION BUDGET HISTORY  
21-Oct-87

BUDGET	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88 *	Preliminary FY 89
ADMINISTRATION	\$1,250,500	\$1,144,800	\$1,117,100	\$892,500	\$763,300	\$714,600	\$793,500
GRANTS	\$6,572,400	\$7,621,800	\$8,811,300	\$8,954,600	\$8,757,000	\$8,588,600	\$8,611,700
TOTAL	\$7,822,900	\$8,766,600	\$9,928,400	\$9,847,100	\$9,520,300	\$9,303,200	\$9,405,200
FEDERAL	\$4,955,400	\$5,105,400	\$5,665,500	\$5,276,800	\$5,388,300	\$5,608,100	\$5,680,300
SGF	\$2,867,500	\$3,661,200	\$4,262,900	\$4,570,300	\$4,132,000	\$3,695,100	\$3,724,900
TOTAL RECEIPTS	\$7,822,900	\$8,766,600	\$9,928,400	\$9,847,100	\$9,520,300	\$9,303,200	\$9,405,200
FULL TIME	21.0	21.0	21.0	15.0	14.0	13.0	13.0
PART TIME	8.0	8.0	8.0	11.0	2.0	2.0	2.0
STAFF MONTHS			311.2	240.0	162.6	167.2	168.4

\* Does not include supplemental of \$68.4 for personal services and \$16.8 for health benefits.

Position Title		Project Coordinator		No. of Positions	one	Range/Step	18A	Org. Unit	General
Time Status	F	Staff Months	9.0	Location		Juneau			
				Election District					
				Justification This project employee is needed for nine (9) months to complete the report to the Legislature due January 15, and to be available to work with the Governor or Legislature on possible bill introductions up to the March 1989 personal bill filing date.					
				A Project Coordinator can provide the level of research planning, and writing abilities needed to complete this study. The Commission will seek to hire someone with expertise in either housing issues, or needs assessment and planning work.					
				The Project Coordinator will operate with a significant degree of independence, under supervision of the Executive Director. The Coordinator will meet with public agencies, financial institutions, and private housing industry representatives, to discuss possible housing options. The Coordinator will conduct research on the functional abilities and correlated housing and service needs of seniors, write the report, and write detailed legislative proposals and demonstration project budgets.					
Type of Expenditure		Amount							
1		2		3					
Salary		28.0							
Benefits		9.7							
Premium Pay									
Other									
Total Personal Services		37.7							
Travel		9.5							
Contractual		5.3							
Commodities		.3							
Equipment									
Other									
Total Cost		52.8							
Funding Source for Total Cost									
Federal Receipts		1002							
G. F. Match		1003							
General Fund		1004		52.8					
GF Program Receipts		1005							
Other									

Request For  
New Position

Agency Administration  
BRU Older Alaskans Commission  
Component \_\_\_\_\_

Page 1 of 1  
Revised Date \_\_\_\_\_

FY 89

5-1926B ✓  
Lauterbach  
3/10/88

Original sponsors: Duncan, Szymanski  
and Kerttula

1 IN THE SENATE

2 CS FOR SENATE CONCURRENT RESOLUTION NO. 50 ( )

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 FIFTEENTH LEGISLATURE - SECOND SESSION

5 Relating to senior citizen housing.

6 BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF ALASKA:

7 WHEREAS senior citizens in the state are a valuable resource of expe-  
8 rience and have contributed with their accomplishments to the development  
9 of the state; and

10 WHEREAS it is the desire of all residents of the state that our senior  
11 citizens live out their lives in a way that enhances their individual  
12 dignity and independence; and

13 WHEREAS there may be housing alternatives that complement ur system  
14 of Pioneers' Homes and other senior citizen facilities and these alterna-  
15 tives might be appropriate for many senior citizens, including residential  
16 assisted living facilities or other alternative housing arrangements;

17 BE IT RESOLVED that the Alaska State Legislature respectfully requests  
18 the Governor to direct the Department of Administration and the Department  
19 of Community and Regional Affairs to

20 (1) work with the Older Alaskans Commission, the Alaska State  
21 Building Authority, and other appropriate state agencies to develop housing  
22 alternatives for senior citizens;

23 (2) conduct an inventory of existing senior citizen housing in  
24 the state;

25 (3) assess the future needs for housing for senior citizens in  
26 the state with particular attention to the type or nature of the housing  
27 alternatives that could meet the needs of senior citizens, including ar-  
28 rangements by which they could live in private dwellings while receiving  
29 certain types of social services to ease their lives; and

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(4) report to the legislature and the Governor by January 15, 1989, with detailed comprehensive recommendations for legislative and executive actions that are necessary to provide housing arrangements that will best meet the needs of all senior citizens in the state.