xc: Galston
Klein
Ben-Ami

Any additional ideas for an agenda?

MEMORANDUM FOR CAROL RASCO

FROM: KATHI WAY

DATE: OCTOBER 21, 1994

SUBJECT: BRIEFING MEETING FOR FIRST LADY ON CHILDREN'S ISSUES

Following are some preliminary thoughts on a way to organize information for the initial briefing with Mrs. Clinton.

Reauthorizations for the upcoming year:

0 Child Care and Development Block Grant

0 Child Abuse Treatment and Prevention (CAPTA)

0 Abandoned Infants Assistance Act

0 Adoption Opportunities Program

0 Family Planning (Title X)

Administration Initiatives:

0 Immunizations

0 Crime Bill (Ounce of Prevention)

0 National Education Goals

0 Welfare Reform (Child Care for the Working Poor, teen pregnancy prevention).

0 Health Care Reform

Other initiatives:

0 NGA Chairman's Agenda

0 Oregon Project

0 Consolidated Services

0 EZ/EC

It would be helpful to get an idea of the breadth of the interest. While there has been much conversation about the problems with youth and not much conversation about young children beyond the Head Start work and Immunizations.

Carnegie Corporation of New York

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David A. Hamburg, M.D.
President

September 30, 1994

MEMORANDUM

TO: Melanne Verveer

FROM: David A. Hamburg DAH

Thank you very much for your call. I enjoyed our conversation as I always do. The notion of a meeting on child health in the United States is an attractive one. Perhaps we can recapture the spirit of our January 1993 discussion in Blair House. Since then, the First Lady and her colleagues have no doubt acquired much insight into child health through their prodigious efforts in behalf of health care reform.

The Carnegie approach during the past decade has taken a broad view of child health, putting it in the context of all factors that influence healthy development during childhood and adolescence. This inevitably relates health to education and to the social environment that powerfully shapes the long-term results of development. Within this framework, we have put our main emphasis on prevention of casualties and promotion of health because of the lifelong consequences that flow from experiences in the early years.

The United States government has very strong capabilities in this field, especially in the Department of Health and Human Services. Foundations can contribute through the scope and flexibility of their action. In the first instance, we do this by adding to dependable knowledge about the problem being addressed. In addition to stimulating and supporting new research, we try from time to time to pull together research from many different sources to make a coherent account--providing an intelligible, credible synthesis of major facets of healthy child development. We try very hard to connect this information with people who could make use of it for constructive social purposes. Although this often means the relevant professions, we deeply believe that it is crucial for the public at large to have

considerable understanding of ways in which healthy child development can be fostered. This is one of the important contributions the First Lady has already made; she could do even more in the next couple of years.

Foundations also tend to use existing and emerging knowledge for the creation of models or demonstrations that show how the knowledge could be used to solve a problem in the real world. In doing so, we build in feasible measures to evaluate the results, to sort out what is good for whom under what conditions. We try to spot interesting innovations across the country--of course there are a great many--and undertake careful assessment of the best practices available. All that gives foundations the sense of what is possible, the most important frontiers and ways in which we can achieve better results than we are now getting. Thus, foundations can have a stimulating effect upon the nation, but they are simply too small to bring about a truly national transformation of the sort that is needed in view of the serious problems and heavy casualties we are experiencing in childhood and adolescence today. This is where the First Lady's continuing commitment can make an immense contribution.

In light of these considerations, it makes sense to invite to the forthcoming meeting on child health some key people from the United States government and from foundations. I attach a list of reasonable people to invite from the foundation community. I would be glad to discuss these at your convenience. In constructing such a meeting, you will of course have to balance two competing considerations: inviting enough people to get around the contours of these complex problems, and yet not inviting so many that meaningful exchange is impaired.

Various approaches might well be useful over the next couple of years. I will not comment on a legislative strategy since we have no special competence in that field and it appears problematic at best under present circumstances. A strategy focusing on the Executive Branch would permit more options. In the spirit of reinventing government, better ways of using existing funds and human resources can be delineated. This effort is well under way, but it necessarily takes time and would surely benefit from a specific, well-informed focus on child and adolescent development.

Best of all from my perspective would be an educational strategy, using the bully pulpit function of high office. This approach is singularly important in child health because public understanding has a direct and strong bearing on the shaping of healthy lifestyles, as well as judicious use of the health care system and the fundamental uses of education for health.

Carnegie, like several other foundations, has been particularly interested in building a professional consensus on the base of the best available scientific work, linking independent experts with the policy community, and informing the public as widely as possible. From these efforts, we have sorted out key issues and constructive approaches. What follows is a substantive summary of the issues in child health that could profitably be addressed in the fall meeting and over the next couple of years.

Enclosures

SUGGESTED FOUNDATION INVITEES TO FALL MEETING
ON CHILD HEALTH

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TOWARD HEALTHY CHILD DEVELOPMENT

A WAY OF VIEWING HEALTHY CHILD DEVELOPMENT

The human child is an ancient creature, shaped by many millennia of biological evolution in ways that pose critical requirements for adequate development. These essential requirements simply have to be met if the child is to grow and develop, to thrive and learn and pursue a vigorous, constructive, adaptable life. These requirements have always been difficult to meet; but if met, they provide profound advantages to our species--ways of learning and adapting and creating that are unparalleled in the annals of life on earth.

During their years of growth and development, children need dependable attachments, protection, guidance, stimulation, nurturance, and ways of coping with adversity. Infants, in particular, need caregivers who can promote attachment and thereby form the fundamental basis for decent human relationships throughout the child's life. Similarly, early adolescents need to connect with people who can facilitate their momentous transition to adulthood with sensitivity and understanding. Usually, despite the radical transformations of recent times, such people are within the child's immediate family; if not, they exist to some extent in the extended family. But if these caregivers cannot provide the necessary conditions for healthy development, then others must make an explicit effort to connect children with persons outside the family who have the right attributes and also the durability to do so.

The role of the family as the fundamental unit responsible for the health, education, and general well-being of children is crucial. Whatever has happened to it, it is still the central organizing principle of society. Yet there have been dramatic changes in the structure and function of American families in just a few decades. Some of these changes

represent new opportunities and tangible benefits. Others represent serious jeopardy to the well-being of children--on a large enough scale to pose a major problem for the entire society.

So we must find different ways to meet the essential requirements for healthy child and adolescent development--not only through the family, but also through a set of pivotal institutions that have a strong bearing on the outcomes.

To meet the requirements for healthy child and adolescent development, intervention should start early with family-equivalent functions. The pivotal institutions are schools, churches, community organizations, child care agencies, and the health care system--all augmented by educational functions of the media. A developmental sequence of interventions starts with prenatal care and goes on to preventive pediatric care, parent education, social supports for young families, high-quality child care, and preschool education. The next step is upgrading of the elementary and middle grade school experience as these schools develop partnerships with strong sectors of American society.

PREVENTING THE CASUALTIES OF EARLY LIFE

Many indices show that the United States is suffering heavy casualties during the years of growth and development--in educational failure, poor health, and very high-risk behavior. Generally, these casualty rates are considerably higher than those of other technically advanced democracies.

Within the scientific and professional communities, a remarkable consensus is emerging on the conditions that influence child and adolescent development--and how parents and others can cope with the changes in a competent way. Much has become known about

ways to prevent the damage being done to children. It is crucial now to have well-informed, wide-ranging, multi-faceted public discussions so that constructive decisions can be made by individual families and by policymakers.

What are the essential requirements for healthy child development and the principal opportunities for meeting these requirements? Can we illuminate a developmental sequence of experiences fostering healthy child development and ways of accomplishing this sequence under contemporary American conditions? In what ways can families be strengthened (if necessary) to meet the developmental requirements? What extra-familial influences can strongly help to meet them? For fulfilling the requirements of healthy child development, what motivation, information, skills, and professional services are highly beneficial? For each phase of development, is there a strong scientific-professional consensus on these questions? These questions need to be addressed in informed public discussion guided by responsible leaders. They need to begin at the beginning: our youngest children.

What could be more important than a decent start in life? All the rest depends on this foundation. The first few years provide the opportunity for a decent start. Such a beginning greatly increases the odds of good health, lifelong learning, the acquisition of constructive skills, and the development of valued human attributes including prosocial behavior. In short, the time from conception through the third year has a great bearing on physical, cognitive, emotional, and social development--for better or worse.

If there is not a decent start, opportunities are diminished for constructive development throughout childhood and adolescence. Some of this is reversible later at high cost. Some is not reversible at any cost. If a poor start leaves an enduring legacy of

impairment, then high costs follow. They may show up in various systems: health, education, justice. We call them by many names: disease, disability, ignorance, incompetence, hatred, violence. By whatever name, these outcomes involve severe economic and social penalties for the entire society. So this is a high stakes game we are playing with our children and hence with the future of our nation.

Progress in child health during this century has been great, yet very uneven. Progress has come from improved social and economic conditions as well as great advances in biomedical science, public health, and pediatric practice.

Preventive Interventions in the First Few Years of Life

As a consequence of efforts to improve the health of children, programs have grown up in a categorical and fragmented manner which often fails to provide comprehensive and integrated services for children. During the past decade, we have mainly been treading water. We need now to formulate a vision of what it would take to fulfill the promise of present knowledge for the health of all our children. To do so, we need to build a consensus on crucial elements:

1) Preparation for parenthood through accurate, meaningful education for children and adolescents in schools, in families, and communities.

2) Availability of family planning services for all sexually active men and women, including adolescents; this means not only contraception but true planning of families based on knowledge and judgement.

3) Prenatal care during all pregnancies, beginning in the first trimester of pregnancy. This should include educational and social support components.

4) Obstetrical and prenatal care environments which enhance opportunities for early attachment between parents and infant.

5) Optimal nutrition during pregnancy and beyond.

6) A stimulating, growth-promoting, health-protective environment in the early years.

7) Arrangements for day care for children of working parents as needed--care of high quality to foster development, not custodial in nature.

8) Completion of immunizations against all of the preventable diseases for all children.

9) Conjunction of child health and social services to minimize the occurrence of disorders such as failure to thrive, developmental attrition, and child abuse.

10) Early detection of developmental disabilities and the provision of appropriate services to provide effective care.

11) School health services, including early detection and treatment of learning disorders.

12) Strengthening of research, not only on the disorders of childhood and adolescence but on developmental biology as well as the development of long-term healthy lifestyles.

Preventive services have been found to be effective and indeed cost-effective. One of the reasons the United States compares so unfavorably with the other established democracies

on measures of health status (infant mortality being a powerful example) is our failure to emphasize primary and preventive care. One of the main contributors to the cost escalation in the health care sector has been the nation's fascination with expensive tertiary care while neglecting investment in prevention. Yet, the knowledge base on preventive interventions has grown.

Many of the causes of damage to children are interrelated and potentially preventable at reasonable cost. One vivid example is prenatal care--now weak or absent for at least a quarter of pregnant women in the United States. Yet prenatal care has a powerful capacity to prevent lifelong damage and is highly cost effective. At its best, prenatal care is a two-generation intervention that helps both children and parents.

High-quality, early prenatal care for all pregnant women is the essential building block for children's healthy development. It should include vigorous outreach efforts to bring poor young women into prenatal care early.

The essential components of prenatal care are medical care, education, and social support services. Education begins with prenatal care because early, effective care protects the vulnerable brain of the growing fetus, thus allowing the child later to develop its full learning capacities; and it makes use of the distinctive motivation of the pregnant mother as well as the young father to strengthen their knowledge and skill in caring for themselves and their prospective baby. Moreover, the educational component of prenatal care can be expanded to include a constructive examination of options for the life course--links to job training, formal schooling, or other education likely to improve prospects for the future of

the young family. In poor communities, young parents need a dependable person who can provide social support for health and education through the months of pregnancy and beyond.

If the United States implements this enlarged vision of prenatal care, every year many thousands of babies could be saved. But save them for what? Further opportunities are needed to foster healthy child and adolescent development. Evidence is accumulating that interventions in the first few years and then in early adolescence can shape a person's lifelong course in healthy, learning, constructive ways:

- Well-baby care with emphasis on disease prevention and health promotion;
- Parent education to strengthen competence and build close parent-child relationships;
- Social support networks in which parents give mutual aid to foster health and education for their children and themselves;
- Child care of high quality outside the home, especially in day care centers;
- Preschool education in the Head Start mode; enhanced education in elementary and middle grade schools; and
- Constructive activities beyond school hours in community- based organizations.

Such interventions have strong potential to prevent damage as reflected in indices of health and education.

Well-baby care oriented to preventing lifelong damage is vital not only for child health but for building parental competence. This care gives well-informed guidance and emotional support to help families attain healthy lifestyles. It provides vital services--for

example, early treatment of ear infections and correction of vision deficits so that hearing and visual impairments do not interfere with education.

Five crucial aspects of high-quality child health care need to be considered. It should be comprehensive, continuous, coordinated, accessible, accountable. These desiderata for poor communities constitute something more than a hypothetical ideal. A concrete example has been of national importance over several decades: community health centers, originally known as neighborhood health centers. They still flourish in various parts of the country despite inadequate funding. They offer a range of medical and support services in the community and have proved their accessibility to low-income populations. Some of these centers have been carefully evaluated, and the evidence of their value is clear.

The most effective preventive medicine for infants is immunization against the common infections of childhood. Clearly the best course to pursue is comprehensive immunization at appropriate times in the earliest years. The administration's bold initiative in this field needs to be widely understood and pursued with long-term commitment.

A substantial amount of research in child development makes clear that intervention programs can help parents become teachers of their own children--at least to make clear to their children the strong value they put on intellectual achievement and constructive human relations. Research has shown that quality day care plus parent education can yield strong results in cognitive and social development during infancy and early childhood in high-risk urban poverty populations. Often the adolescent mothers involved in these intervention efforts benefit as manifested by their going on to higher levels of education; and there is some evidence of beneficial effects on younger siblings. Like prenatal care, this can be a

two-generation intervention--benefiting young parents and their children, even for the entire life span.

The lessons of Head Start have wide applicability. This kind of early stimulation, encouragement, instruction and health care--all with substantial parental involvement--can also be incorporated into a variety of child care settings, and thereby help to reduce casualties. The linkage of health and education is fundamental in these interventions. The basic concepts can be usefully adapted to earlier ages. But Head Start is not best seen as a one-time event--akin to immunization. Rather, it is a valuable part of a development-promotion sequence throughout childhood and adolescence.

Home visiting by human services professionals can be a relatively efficient and effective way of addressing the many needs of poor families with young children. Home visitors can engage family members in solving problems of housing, food, health, child rearing, child development, and family relationships.

Research evaluations of home visiting programs show that they can have beneficial effects on health and well-being, especially for poor adolescent mothers and their families. Families that have had the benefit of home visiting have lower rates of small-for-gestational-age and low-birthweight babies, the babies are healthier at birth, have fewer accidents in the first year of life, are immunized more often, experience less child abuse and neglect, and show improved cognitive performance. These benefits can be long lasting, as demonstrated by the best- studied early intervention programs aimed at preventing damage to disadvantaged children.

Barriers to Health Care for Young Children

Research has clarified five barriers that stand between children and preventive primary health care: 1) Absence of insurance or other source of financing. 2) Capacity problems in the health care system. 3) Services that are not "user friendly". 4) Lack of motivation to seek health care. 5) Serious social disorganization in the community.

Research and field experience suggest that the first barrier--having no source of payment for care--is the most potent one. When children and their families have insurance, they are able to increase their participation in preventive services and health care generally. However, access to health insurance does not level the playing field, particularly for high-risk and/or low-income children and pregnant women. Access to insurance is not equivalent to access to health care, and reducing the financial barrier does not necessarily eliminate the other four.

A wealth of experience gives clues about what to do to improve the health care system, in addition to providing all citizens with a financing source for health care.

Increasing service capacity. There are several clear remedies for increasing the service capacity of distressed communities. They include increasing grant-supported services such as community health centers; supporting the training and deployment of health professionals and mid-level professionals (nurse-midwives, physicians assistants) committed to working in medically underserved areas; and delivering care in unconventional ways and in unconventional settings (e.g. services provided via home visiting, through school-based clinics, or in conjunction with Head Start centers).

Making services more "user friendly". Achieving this goal through broad scale changes in national policy is not easy because the tone and details of services usually are set by leaders at the local rather than at the national level. But standards of performance, training funds, and incentives that emanate from central sources, such as the federal government, can signal attention to these intangibles, and highlight success stories.

Increasing motivation. Raising the level of motivation and information that individuals need to act in their own best interests requires education, social support, and outreach to those who, despite a functioning health care system, still fail to use its most basic offerings, such as immunizations.

Repairing social disintegration. The last barrier, the disintegration of our poorest communities is, of course, one of the most pressing national problems. It has little to do with health or preventive services, and much to do with poverty, discrimination, economic development, revitalization of schools, and the strengthening of families and communities.

EARLY ADOLESCENCE: A CRITICAL AND NEGLECTED OPPORTUNITY

Early adolescence (ages 10-15) is a crucially formative and badly neglected period. It is a time of biological upheaval and social transition. There is much exploratory behavior, including very risky behavior that has lifelong significance. Many dangerous patterns emerge during these years: becoming alienated from school and dropping out; starting to smoke cigarettes, drink alcohol, and use other drugs; starting to drive automobiles and motorcycles in high-risk ways; not eating an adequate diet or exercising enough; risking

early pregnancy and sexually transmitted diseases; and in some ways worst of all, undertaking the use of weapons, even highly destructive ones.

Initially, adolescents explore these new possibilities tentatively. Experimentation is typical of adolescence. Before damaging patterns are firmly established, there is a vital opportunity to prevent lifelong casualties. This opportunity is frequently missed in most communities now--all too often with tragic results.

Preventive Interventions for Early Adolescents

The public policy response to adolescence has been problem specific, often overlooking the underlying needs of adolescents under contemporary conditions. To meet the essential requirements for healthy adolescent development, we must help adolescents to acquire constructive knowledge and skills, inquiring habits of mind, dependable human relationships, a reliable basis for earning respect, a sense of belonging in a valued group, and a way of being useful to others. These basic needs can be met by a conjunction of pivotal institutions: family; school; churches; community-based organizations; the health-care system; and the media.

Interventions in early adolescence include:

1) Reforming middle grade schools to create small communities for learning, where stable, close relationships with adults and peers allow for intellectual and personal growth.

2) Creating school environments which promote healthy lifestyles, with particular emphasis on a life sciences curriculum.

3) Training in life skills including decisionmaking, conflict resolution, and resistence to peer pressure.

4) Strengthening social support mechanisms for adolescents by reengaging families with their children's schools, and, where necessary, providing mentors to supplement the family.

5) Creating safe havens in community-based organizations after school, when many adolescents are left alone, and where healthy lifestyles could be learned.

6) Providing a perception of opportunity and of value to the community for adolescents by engaging them in community service, and work-study programs.

7) Making health care services and counseling available in "adolescent friendly" and accessible locations, including school-based or school-linked.

As children experience puberty and emerge into an era in which they feel they should quickly become adults, they in effect ask, "How shall I use my body?" Any responsible education system must answer that basic question with a substantial life sciences curriculum that gives them accurate information about their bodies, including the effects of various high-risk behavior patterns. But information is not enough.

Life skills training can become a vital part of education in schools and community organizations, so that adolescents can learn how to make informed, deliberate and constructive decisions--rather than ignorant, impulsive, and destructive ones. Such training can also enhance their interpersonal skills, their ways of relating decently to others, learning from their experiences, even unpleasant ones, such as how conflicts can be resolved without

violence. Skills can be developed for establishing dependable friendships and participating in supportive problem-solving groups. But even this is not enough.

People need people, especially to weather the inevitable difficulties of growing up, the stresses of education, and the turbulent search for ways to protect our own health and the health of those we care about. To the extent that contemporary families are unable to meet these needs, specially designed social support interventions can be exceedingly helpful.

Thus, the life sciences curriculum linked with life skills training and social support interventions can provide the vital information, skills and motivation necessary to meet the requirements for healthy adolescent development. Moreover, this conjunction of information, skills and motivation for development, indeed for survival, can be provided through the foresight and cooperation of several pivotal institutions that powerfully shape the transition from childhood to adulthood: family, schools, health care system, media, and community organizations that reach out to youth.

But there is still a serious unmet need for accessible health care. It may be at or near the school. In any event, it must be arranged in such a way that adolescents can clearly recognize that the care is available, within reach, and adapted to their distinctive needs.

Education can contribute to the development of healthy lifestyles. Through education in various channels, motivation may be strengthened and sustained, accurate information assimilated, and relevant skills developed. Such education involves not only the schools and health professionals but also the media. Family, churches, and community organizations can contribute as well. In poor communities, a key element in motivation is the perception of opportunity. Without such perception and concomitant hope, there is little incentive to avoid

the immediate pleasures associated with psychoactive drugs and other health-damaging behavior.

Recent school-based and community-wide preventive interventions have been carried out in careful research designs. These focus on cigarette smoking but have made some extension to alcohol and other drugs as well--"gateway" substances. The results are clear: It is feasible to diminish substantially the use of gateway substances in early adolescence. Moreover, this can be done in a way that enhances personal and social competence pertinent to other aspects of adolescent development. In school and out, it is possible to build competence, to earn respect, to construct a friendship group capable of resisting pressure to use drugs, and to delineate a vision of an attractive future and prospects for a decent life. An important part of this in poorer communities has to do with making early opportunities visible to young people before the drug pathway becomes firmly established. Work-study activities are helpful in this regard, along with training in essential, generic employability skills and practical employment counseling.

Nearly one million adolescents between the ages of twelve and nineteen are victims of violent crimes each year, and this has been true at least since 1985. Over all the concerns about adolescent violence hangs the threat of firearms. Yet, there is overwhelming evidence that we can intervene effectively in the lives of young people to reduce or prevent their involvement in violence. For example, research indicates that conflict resolution and mediation programs show positive effects in reducing violence. Assertiveness, taught as a social skill, helps young help learn how to resist unwanted pressures and intimidation, resolve conflicts nonviolently, and make sound decisions about the use of weapons.

Programs which promote healthy and enduring relationships with adults as well as peers, such as mentoring and community-based youth activities, have the potential to provide constructive alternatives to joining violent groups.

Barriers to Health Care for Adolescents

Many adolescents are in need of preventive primary health care and treatment for health problems, yet they are likely to face barriers to these services. There is a growing consensus about these barriers: 1) Lack of health insurance and limitations in coverage. 2) Inadequate information about the availability of services. 3) Health services that may not be appropriate to the adolescent developmental and experiential levels. 4) Scarcity of experienced and well-trained health providers who treat the health problems of adolescents, especially when the adolescents are poor and uninsured. 5) Lack of independent legal access to services. 6) Concerns about parental consent and notification and fear that confidentiality will be breached. 7) Gaps among service systems for adolescents with multiple health problems.

There are numerous examples of promising adolescent health promotion, primary prevention, and treatment interventions, but they have been implemented only sporadically. These promising interventions can provide considerable guidance for program implementation and the continuing design of more effective approaches for adolescents.

OVERCOMING DISADVANTAGE

The problems of children in poverty intensify--indeed dramatically highlight--the problems of modern societies altogether. The poignant dilemma is that great technical advances are associated with massive dislocations--and children are often caught in the crunch, especially in the inner city. Degraded conditions became a breeding ground for disease and violence. So it is clearly in the self-interest of the entire nation to consider the well-being of all our children.

For the child growing up in an area of concentrated poverty, two crucial prerequisites to healthy, constructive development appear to be seriously lacking: secure attachments to dependable and successful adults, and the perception that opportunities exist in the mainstream economy. To the extent that families and communities are eroded, disintegrated, or otherwise weakened under circumstances of persistent poverty and social depreciation, it is necessary to focus on other social support networks--by strengthening the family or by providing substitute experiences that meet these essential needs.

With younger children, social supports have to become a deliberate feature of effective interventions throughout development: in prenatal care, child care, preschool education, after-school and Saturday experiences during elementary years, and in the reform of the middle grade schools. At every level, in some developmentally appropriate way, it is possible to construct parent groups, parent education, outreach to families through indigenous paraprofessionals, and links with professionals as needed for more serious problems. In short, social support networks that sustain effort and hope are crucial for health and education in poor communities.

opportunities, and by strengthening our scientific and professional commitment to tackle these problems over a wide spectrum of constructive approaches.

There is reason to believe that powerful sectors have begun to converge on the problems of children: business, government, clergy, media, science and several professionals including the military. If a broad public consensus emerges on the facts, multi-sectoral leadership continues to grow, and constructive policy options are fully considered, we could see a real transformation in the health and well-being of all our children. The First Lady could provide extraordinary leadership for this great effort. Some possibilities include highlighting promising approaches, mobilizing multiple sectors of society, and examining needed linkages between existing services. The First Lady could do a great deal to educate the public and policymakers. One option would be through a high-level mechanism such as a Council on Children and Families. No doubt she would utilize a variety of opportunities for this vital mission, always conveying to the American people an accurate and inspiring picture of what is needed and what is possible. In this way, she would make a contribution of enduring value.

David A. Hamburg, M.D.
President
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