
DR.
FOSTER

MEMORANDUM OF CALL

Previous editions usable

TO:

☐ YOU WERE CALLED BY— ☐ YOU WERE VISITED BY—

OF (Organization)

☐ PLEASE PHONE ▶ ☐ FTS ☐ AUTOVON

☐ WILL CALL AGAIN ☐ IS WAITING TO SEE YOU

☐ RETURNED YOUR CALL ☐ WISHES AN APPOINTMENT

MESSAGE

RECEIVED BY	DATE	TIME

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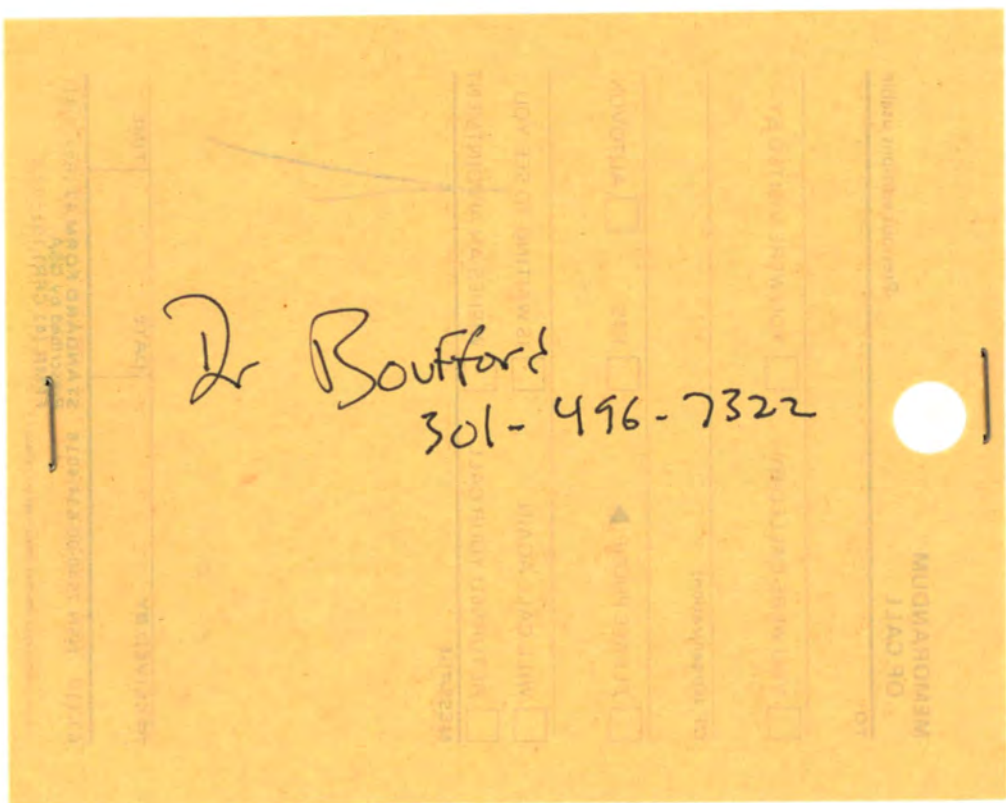

John:

Attached are 1) hard copy & disk "Hank" of precis

2) suggested possible "soft" rewrite of problematic response.

3) good person to help at HHS -
Dr. Felicia Stewart,
DAS Pub. Health
an Ob/Gyn
home - 202 342-2075
office through Phil Lee
690-7694

She comes highly recommended by my HHS contacts.

Mary

V+ Call if you need help.
301 588-7726

P.P.S. Joel's contact found O in Jenn. papers, but Joel wasn't sure how far back they looked
Eric Berman didn't call me back

Charge:

Dr. Foster has justified a hysterectomy on the basis that the woman had a "dismal social history," i.e., was unmarried, had four children, was unemployed, and received no welfare assistance (Meigs' Syndrome Complicated by Pregnancy, Journal of the National Medical Association, 1972).

Response 1:

- The procedure was medically necessary to remove a tumor with a high probability of malignancy. Dr. Foster noted in the article, however, that the woman's situation made the medically necessary removal of her reproductive organs "a bit less difficult." This comment reflected a value judgment Dr. Foster believes he should not have made then, and he would not make today.

Response 2:

- The procedure was medically necessary to remove a tumor with a high probability of malignancy. Dr. Foster noted in the article, however, that the woman's situation made the medically necessary removal of her reproductive organs "a bit less difficult." This comment reflected Dr. Foster's knowledge of the patient's social circumstances and her concerns for the future of her family. By this comment, Dr. Foster expressed his hope that there might be some beneficial consequence in spite of the patient having to undergo this major surgical procedure.

To the extent this comment sounds insensitive, Dr. Foster regrets ~~that~~ that implication. He intended to express

IMMEDIATE
OFFICE OF THE ASSISTANT SECRETARY
FOR HEALTH 95 FEB 10 P6:42

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FAX: (202) 690-6960
PHONE: (202) 690-7694

HEALTH "FAX"

TO:	FROM:
John Podesta	Harriet Rabb

FAX NUMBER: _____

MESSAGE:

Typed corrections to follow

PLEASE CALL: FTS _____ ASK FOR _____

IF ANY PROBLEMS WITH TRANSMISSION

NUMBER OF PAGES 3 (NOT COUNTING COVER PAGE)

A review of Dr. Henry Foster's written work reveals an accomplished clinician and researcher in the field of obstetrics and gynecology. He has written on a variety of topics, with a particular focus on the diagnosis and management of high risk pregnancies. He is not just a doctor and scientist, however; Dr. Foster is also the sponsor of a successful, community-based ~~anti-~~ teen pregnancy (prevention) program, and has written extensively about this program and about ~~the lack of~~ access to health care for the underserved.

Dr. Foster is the author of four textbook chapters relating to high-risk pregnancies, including two chapters on the particular issues surrounding sickle cell disease and pregnancy. He has published widely ~~on the management of~~ about ? pregnant (ies in) patients with sickle cell anemia, and has studied diagnostic tools for use in management of the disease. In his writings on sickle cell anemia, Dr. Foster demonstrates his awareness of the agonizing family planning decisions faced by sickle cell patients in light of the ~~grave~~ life-threatening risks of ~~having~~ child-bearing, and discusses the importance of high quality, non-directive counselling. One of the goals of his research is to maximize a patient's chances of bringing a pregnancy safely to term, if that is her desire.

to them of family planning

Dr. Foster has also written on the physiology and management of ~~pregnancy~~ complications of pregnancy, including toxemia (a non-specific syndrome which can result in convulsions, coma, or death), abdominal pregnancy, early cervical cancer, Meig's Syndrome (a rare type of ovarian tumor), thalassemia syndrome (a

genetic disorder affecting the rate of hemoglobin production) and endometrial stromal sarcoma (a cancer of the uterine lining). In particular, Dr. Foster has maintained a research focus on the amniotic fluid and how analyzing its characteristics can be useful in the diagnosis and management of high risk pregnancies.

In his community, Dr. Foster has devoted himself to helping those less fortunate and, in particular, to ~~fighting~~ preventing teen pregnancy. Dr. Foster has written a great deal based on his experience with the "I Have a Future Program" at Meharry Medical College, ~~the anti-~~ whose development he spearheaded. The program ~~operates in~~ public housing projects and ~~centers on~~ fosters the values of self-esteem, physical and mental well-being, completion of school, development of job skills, sexual responsibility, self control and ability to handle interpersonal conflict, the value of helping others, positive social values and family values. ~~with appropriate parenting~~. ~~The location of~~ locating the program within community sites allows for ~~close proximity to~~ interaction w/ the teens families and a better opportunity to involve parents and siblings, an important aspect of the program. ~~Dr. Foster's deep concern for the well being of the children of Tennessee, and the enthusiasm and creativity with which he seeks to help them, are evident in his writing about this novel program.~~

Dr. Foster has also written about the medical and social barriers to the health of urban infants, stressing the importance of quality pre-natal care. ~~He has noted that infant mortality is~~

His research has suggested ~~inversely associated with socioeconomic status, and has conducted research tending to show~~ that blacks and whites will give birth to equally healthy children where the socioeconomic status of the two groups is the same for a sustained period of time.

While acknowledging that this country has been a world leader in its concern for medical ethics, Dr. Foster remains vigilant in safeguarding the ethical conduct of research. He is committed to protecting the vulnerable from being used inappropriately as research subjects, and his writings reflect his strong beliefs ~~that anyone incapable of providing voluntary~~ regarding informed consent, ~~should not be allowed to serve as a research subject~~.

Privileged and ~~Confidential~~

HENRY W. FOSTER, JR., M.D.
Candidate for Surgeon General (PAS)
Health and Human Services

Dr. Foster has been a Senior Scholar-in-Residence at the Association of Academic Health Centers since 1994, a Professor at Meharry Medical College since 1973, and Clinical Professor at Vanderbilt University since 1975.[1]

Dr. Foster has written a number of journal articles, chapters in textbooks and speeches on topics in obstetrics and gynecology, medicine, family planning and minority medical schools.

Dr. Foster is currently working on a study of the gender shift in the physician work force and its implications for health care reform. The purpose of the study is "to determine from a national sampling what might be the differences in attitudes between genders and varying age groups towards health care reform. And if differences are found, what is likely to be the magnitude of their effect on health care reform."

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[1] Dr. Foster received a B.S. from Morehouse College in 1954, and an M.D. from the University of Arkansas in 1958. Dr. Foster served his internship with Wayne State University in Detroit Receiving Hospital from 1958 to 1959. He served his residency in General Surgery at Malden Hospital, from 1961 to 1962, and in Obstetrics and Gynecology at George W. Hubbard Hospital, from 1962 to 1965. Dr. Foster received an Honorary Doctor of Science degree from the University of Arkansas in 1993.

Between internship and residency, Dr. Foster served as a Medical Officer, with the rank of Captain, in the U.S. Air Force, from 1959 to 1961. At Tuskegee Institute, from 1965 to 1973, Dr. Foster was Chief of Obstetrics and Gynecology at John A. Andrew Memorial Hospital, and from 1970 to 1973, he was Director of the Maternity and Infant Care Project #556. From 1973 to 1990, Dr. Foster was Professor and Chairman of the Department of Obstetrics and Gynecology at Meharry College, where he went on to serve as Dean of the School of Medicine and Vice President for Health Services, from 1990 to 1993. Dr. Foster was Acting President of Meharry Medical College from 1993 to 1994. Dr. Foster is a member of a number of medical societies and professional organizations. His hospital appointments have included Larson Air Force Base, George W. Hubbard Hospital of Meharry Medical College, Vanderbilt University Hospital, Blanchfield Army Hospital, Metropolitan Nashville General Hospital, and Baptist Hospital.

Clinical Trials for Non-invasive Abortion Technique

The May 1985 issue of the AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS published the results of a clinical trial performed under the supervision of Dr. Foster at the Department of Obstetrics and Gynecology, Meharry Medical College, Nashville Tennessee. The study tested the use of naturally occurring hormones to induce abortion. The study was developed to evaluate the safety, efficacy, and patient acceptability of non-invasive abortion by inducing menstruation after conception by using vaginal suppositories in the early stages of pregnancy. Of the 60 subjects, fifty-eight of the patients were African-American and two patients were caucasian. All women were 49 days (seven weeks) pregnant with the exception of one woman who was actually 56 days (eight weeks) pregnant due to a miscalculation on her part. The report specifically noted that "because gestations were so early ... the passage of identifiable fetal tissue was not a usable endpoint." Accordingly, the study based therapeutic success of the drug on sustained menstruation and a decrease in a hormone found in pregnant females. The study resulted in 55 successes under the test criteria. Four persons required hospitalization and one patient withdrew and gave birth to a male infant. The study noted that simplicity of administration, avoidance of uterine instrumentation, and increased cost efficiency were potential advantages of the early abortion technique.

On Abortion

In "Clinical Management: Sickle Cell State and Pregnancy," published in the March 1977 URBAN HEALTH, Dr. Foster wrote about the procedures used in his unit at Hubbard Hospital of Meharry Medical College and revealed that the pregnant sickle cell patients were "advised of the availability of pregnancy termination," which his unit performed into the second trimester.

Dr. Foster co-wrote "Reproductive Performance in Women with Sex Chromosome Mosaicism," published in the May 1980 OBSTETRICS AND GYNECOLOGY. The article addressed naturally occurring, spontaneous abortions. However, the final sentence stated that subsequent pregnancies of couples with a history of such spontaneous abortions should "be monitored by amniocentesis in such case so that abortion can be available for genetically abnormal fetuses when found."

Similarly, in a chapter Dr. Foster co-authored in the book Hematologic Problems in Pregnancy, he advised that "the couple [who are potential carriers for the genetic disorder thalassemia] must be provided with genetic counseling and offered antenatal diagnosis, with the option of pregnancy termination." The article did point out that certain types of this disorder result in fetal death in utero.

Also, in "Sickle Cell Anemia Not a Risk for PTL," published in the Fall 1991 ASK THE PERINATOLOGIST NEWSLETTER, Dr. Foster wrote that the ability to ascertain fetal hemoglobin status allowed for genetic counseling and, thus, the option of termination.

In his article, "Contraceptives in Sickle Cell Disease," published in the May 1981 SOUTHERN MEDICAL JOURNAL, Dr. Foster characterized abortion as a "contraceptive measure." But, he did state, "The use of abortion solely as a form of contraception, though acceptable in some parts of Europe, has not become prevalent in the United States. Clearly this would not be ideal in sickle cell disease."

In "Managing Sickle Cell Anemia in Pregnant Patients," an article by Dr. Foster published in the December 1980 CONTEMPORARY OB/GYN, Dr. Foster argued that, although pregnancy poses a significant risk to the mother with sickle cell anemia, the decision to risk pregnancy is a viable option for those women. However, he continued by saying, "For patients who choose not to take this risk, the option of elective abortion must be available." Dr. Foster later explained that he prefers his patients use barrier contraceptives and have the option of "therapeutic abortion when contraception fails." Dr. Foster reasserted this idea in his article, "Contraceptives in Sickle Cell Disease," published in the May 1981 SOUTHERN MEDICAL JOURNAL.

In "Abdominal Pregnancy: Report of Twelve Cases," co-written by Dr. Foster and Dr. Donald T. Moore and published in August 1967 in OBSTETRICS AND GYNECOLOGY, the authors wrote that prompt termination of the pregnancy is the proper course of action in the case of abdominal pregnancy. However, they also recognized that in five of the twelve pregnancies observed, the baby was born, but died shortly after birth, and that another three of the twelve carried living fetuses to 39+ weeks, of those, two were completely normal and survived.

On Sterilization

Dr. Foster wrote "Removal of the Normal Uterus," published in the January 1976 SOUTHERN MEDICAL JOURNAL, in which he stated, "Recently, I have begun to use hysterectomy in patients with severe mental retardation. Hysterectomy can be done either for sterilization or to eliminate the menses, which is of significant hygienic benefit to these severly [sic] handicapped individuals."

"Meigs' Syndrome Complicated by Pregnancy," an article by Dr. Foster published in the September 1971 JOURNAL OF THE NATIONAL MEDICAL ASSOCIATION, reported a case involving a rare type of tumor on a pregnant patient's

ovary. In the article, Dr. Foster mentioned that the patient was a 35 year old unmarried black woman who was the head of a two-room, four child household, unemployed, and not on Welfare. Upon explaining that the patient's pelvic organs had to be totally removed, Dr. Foster added, "The dismal social history made this decision just a bit less difficult."

On Family Planning

In April 1972, Dr. Foster participated in an Emory University symposium, Family Planning In the South. Dr. Foster gave a presentation entitled "A Rural Hospital and Family Planning." In his presentation, Dr. Foster addressed problems of family planning in a rural setting and a black physician's views on family planning. In his speech, Dr. Foster stated that, "[i]n recent years, there has been an outcry by various groups that the intent of family planning is black genocide and that the ultimate effect will be black genocide." He agreed that, "these apprehensions are quite understandable and often not without foundation." In discussing this sentiment, Dr. Foster recounted a June 1970 meeting of the First National Congress on Optimal Population and Environment which invited participants including 45 blacks representing moderate black institutions. Dr. Foster noted that after the Congress convened the black participants formed a caucus which, "observed that the Congress had been derelict in obtaining significant black input to reflect black interest, and that the purpose of the conference was to use those delegates invited to legitimize a preconceived plan of vicious extermination." Dr. Foster believed that some might find the views irrational, as he recognized that, "the majority of this country's health providers have never even in the vaguest way planned a program of genocide for black people." He continued explaining that, "what has occurred, ... is that many well intentioned family planning programs have been set up for large segments of our black population without adequate consideration of many other factors." Dr. Foster concluded that "the end results of far-reaching family planning programs can have very disastrous consequences for black people. Nonetheless, I support family planning but this support is of necessity, conditional."

In addressing the conditions he would place on family planning, Dr. Foster emphasized that programs should be voluntary and that coercive family planning programs should not become national or local legislative policy. Dr. Foster felt that family planning should be voluntary and that coercive sterilization laws, if enacted, would amount to social welfare legislation which would remove the right of women on welfare to have children.

In his speech, Dr. Foster also pointed out that family planning programs are

based on the erroneous assumption that there is a common national life style and, accordingly, blacks should be included at meaningful policy making and administrative levels when providing family planning services for black people. He stated that "to those that are deprived socially and economically the procreative processes often become the only fulfilling life experience available. To curtail or remove this avenue of expression is often tantamount to taking away the only need for existence....Every human being has the need to feel creative."

In discussing family planning in rural areas, Dr. Foster stated that "rurality is characterized by a relatively unsophisticated folk culture and at times is actually primitive." Dr. Foster recognized that the social organization of family, religion, government, and education reflect the deprivation caused by cultural, geographic, and economic isolation. He blames the isolation and resulting unsophistication as the reason the "rural psychology is strongly oriented to fatalism which...explains their strong resistance to any alteration in reproduction and reproductive process." Dr. Foster found a common genesis between delivery of family planning services to minorities and rural areas and noted the value of family planning but stressed the need to know the difference between family planning and population control.

On Affirmative Action

In a speech entitled, "Reaching Parity for Minority Medical Students: A Possibility or a Pipe Dream?" presented by Dr. Foster to the 105th Meeting of the Association of American Medical Colleges on November 1, 1994, he addressed the problem of lack of parity for underrepresented minorities in medical school, why the problem exists and how to change it. Dr. Foster stated, "This nation has a moral obligation to effect equal access to educational opportunities for all of its citizens." Dr. Foster acknowledged that there had been improvements in the numbers of underrepresented minorities in medical school, but argued that the improvement was not enough and was moving too slow. He also argued that part of the problem was not just the number of minorities starting medical school, it was also the attrition of minorities in medical school. One of the problems Dr. Foster identified as causing the attrition was dismissal for inadequate academic performance. Dr. Foster blamed this on the inadequate preparation for the rigor of premedical curriculum that began in kindergarten and progressed through college.

As far as solutions, Dr. Foster stated, "What is needed will not likely occur and that is a domestic 'Marshall Plan.' The best teacher-pupil ratios should exist in the inner city rather than the reverse. The welfare system which now exists should be scuttled forthwith." Dr. Foster went on to advocate more modest efforts that were

already in the works, including increasing the numbers of minority first-year medical students to 3000 by the year 2000, recruitment efforts involving cooperation between medical schools and undergraduate colleges, identification and recruitment of qualified college students who opt not to go to medical school, creating health sciences magnet schools in high schools with a high minority enrollment, and development of health sciences programs in existing high schools.

On Labor Law and Pregnant Women

In his Presidential Address to the Association of Professor of Gynecology and Obstetrics, March 4, 1994, Dr. Foster generally defended the importance of OB/GYN clerkships against attacks by some people who were advocating taking it out of the required clerkships. In the speech, Dr. Foster said, "Obstetrics has, in my view, always been undervalued in our country. Look at the labor laws and practices--they single out and often punish expectant mothers. I have read that, during World War II in Great Britain, pregnant women received double food rations--I wonder if this logical and humane thought ever occurred to policy makers in this country." This seemed to be a digression, and he did not explain what the specific problems were.

On Health Care and Health Care Reform

In "How Can We Provide Good Health Care for Everyone?" a speech presented to the Lonnie S. Burnett Vanderbilt OB/GYN Society, on June 18, 1994, Dr. Foster generally hit on points relating to improving health care and access to health care. In the speech, Dr. Foster stated, "I cannot see how universal coverage can be successful without having employer-mandate as a component." He seemed to support a British-type healthcare reform in which adequate health care would be available to all, but the wealthier people could opt for additional coverage from a private-fee-for-service sector. He said, "I believe that adequate housing should be available to everyone in this country, but to have a Beverly Hills type home can only accrue through maximizing the free enterprise system."

In an article entitled "A Black Health Crisis," the July 13, 1987 NEWSDAY quoted Dr. Foster as saying, "Until we make a national commitment, there won't be a sizable improvement in the health gap [between whites and African-Americans]."

Dr. Foster wrote a chapter, "Ambulatory Gynecologic Surgery," printed in Ambulatory Obstetrics and Gynecology in 1980. In the chapter, Dr. Foster argued that selective out-patient surgery was a means of lowering national health care costs and accused insurance companies, hospitals and physicians of opposing such a move

because of financial incentives to utilize in-patient procedures and fill hospital beds.

On Human Research Subjects and Biomedical Research

In an editorial, "Biomedical Research Subjects: Who Should Be Exempt?" published in the November 1975 JOURNAL OF MEDICAL EDUCATION, Dr. Foster advocated the exemption of certain categories of people from serving as research subjects. He explained that he would exempt captive individuals such as the fetus, the child, the military/prisoner, and the poor. He would further exempt those non-captive people where there appears to be "a deficiency or absence of those biosocial defense mechanisms essential for coping with a very complex society." In this category, he included "the functionally illiterate, the senile, those who do not command the language, and the mentally incompetent."

Dr. Foster also wrote "Children and the Institutionalized Mentally Infirm," published in RESEARCH INVOLVING CHILDREN in 1976. Using a hypothetical research project, this article criticized the methods of obtaining informed consent from children and institutionalized mentally ill. While advocating the exemption discussed above, Dr. Foster stated that he would permit biomedical research on children with the informed consent of their parents. However, in determining who should be classified as a child he stated that "because of the differences in life styles between blacks and whites, quite possibly adulthood as a practical matter begins earlier for the former group and accordingly, a more workable definition of childhood may be appropriate."

In that article, Dr. Foster also suggested that the relationship between biomedical research and the financing of medical education should be examined because there can be pressure to lure the research dollar to fund education and that pressure may be detrimental to the rights of biomedical research subjects.

Finally, Dr. Foster pointed out some problem areas using the hypothetical case. In talking about the use of a placebo for a portion of those patients in a study, he asked, "Even when patients receive prior advice [that a placebo may be administered], is it just or fair to knowingly deny a potentially beneficial agent to one group and provide it for another - even if on a chance basis?"

On Sex Education

The Summer 1990 issue of the JOURNAL OF HEALTH CARE FOR THE POOR AND UNDERSERVED published a presentation by Dr. Foster entitled "A Model for Increasing Access: Teenage Pregnancy Prevention." The presentation recognized the

gaps and disadvantages of school-based programs to provide pregnancy services and proposed a community-based intervention program. The I Have A Future (IHAF) Program at Meharry Medical College, discussed in the presentation, was anchored, not in schools, but in a residential setting: the public housing projects. The program was open to all adolescents, including students who had dropped out or been expelled from school, claimed to more adequately address idle time, and also was in closer proximity to families providing a better opportunity to involve parents and siblings. The presentation noted that "[i]nappropriate teen pregnancy has become a major social issue in this country."

The presentation continued, stating that "[Adolescent pregnancy] is a problem that affects all ethnic, social, and economic classes," and that "discounting the non-white contribution to our nation's teenage pregnancy and birth rate does not change our statistical ranking relative to other western nations." The article also stated that "abortion rates in the United States are substantially higher than those for other western countries."

In discussing the rationale for the program design, the presentation stated that "[d]espite the agreement that American youth need knowledge about human reproduction in order to act responsibly in matters of sexuality, there are nonetheless, continuing barriers to the availability of this education, and indeed conflicting studies as to its value." The article stated that "the literature does show that sex education programs are most likely to be effective when actively coupled with direct access to contraceptives." The highlighted program consisted of activities which included exercises to teach an edited version of Nguzo Saba, Seven Principles of Blackness-Pro-Social Attitudes drawn from Swahili.

On August 5, 1986, the UNITED PRESS INTERNATIONAL reported that a Governor's Task Force on Healthy Children, of which Dr. Foster was Chairman, concluded that teaching sex education in public schools was one way to reduce the rising death rate among babies born to high-risk women, such as African-American teenagers and African-American women of all ages who have previously given birth to low-birthweight babies or who have medical conditions particularly associated with reproductive problems.

Not Chosen as President of Meharry Medical College

According to the November 9, 1993 NASHVILLE BUSINESS JOURNAL, Dr. Foster, who was the Acting President of Meharry Medical College, was a candidate to replace the previous President. However, later articles disclosed that a different

candidate was chosen. No article explained the reason Dr. Foster was not selected.

Aside from the above, a limited review of the available public record revealed no information that might bear negatively on Dr. Foster's candidacy, generate controversy, or disqualify him from serving as Surgeon General.

January 30, 1995

Dr. Foster -- General Charge and Response

Charge:

Dr. Foster is morally unfit to be the Surgeon General of the United States. He is an abortionist who has performed dozens of abortions himself, advocated abortion as a method of contraception, promoted the use of abortion-inducing drugs, and recommended abortion as a means of preventing the births of sick or retarded babies. He has advocated the sterilization of retarded women, performed hysterectomies for that purpose, and even justified sterilization on the basis of a woman's "dismal social history." Finally, he has publicly lied about his record, claiming he had performed "less than a dozen" abortions, until the real facts were forced out. He would set the worst kind of example -- especially to our young people -- as our nation's leading physician.

Response:

- Dr. Foster is the victim of a right-wing smear campaign intended to paint him as something he is not and to stand his record of achievement and dedication on its head. Let's be clear -- Dr. Foster is a physician of singular commitment and distinction who has dedicated his life to maternal and infant care. In a 38-year career, he has devoted himself to delivering thousands of babies, improving the health of mothers and babies alike, and reducing teenage pregnancy through his nationally acclaimed "I Have A Future" program, which was cited by President Bush as a "Point of Light."

- Dr. Foster is no "abortionist". He believes abortions should be safe, legal and rare. And he has always recognized and fulfilled his own responsibility as a doctor to inform and counsel his patients about all their options. But he does not advocate and has never advocated the use of abortion as a method of birth control. And he has consistently advocated only voluntary, informed family planning.

- Dr. Foster answered an initial question about the number of abortions he had performed without reviewing the whole record and this was certainly a mistake. But to suggest that he has deliberately lied about that record is outrageous and unfair. His record is one that any doctor would be proud of. He has no apologies to make.

- Dr. Foster's life of professional and academic achievement, leadership in his community, caring for others and service to society stand as a moral example for us all.

Dr. Foster has never performed an illegal abortion. He has given an accounting from available records which, as he has pointed out, cover his practice from 1973 to the present. As Dr. Hill noted to the AP, Dr. Foster was not an abortionist. In Alabama, Dr. Foster, as any obstetrician/gynecologist, did have to deal with emergencies resulting from botched illegal abortions performed by others.

STERILIZATION

Charge:

Dr. Foster advocates hysterectomies as a means of sterilization. He has performed hysterectomies to sterilize severely retarded individuals.

> "Recently, I have begun to use hysterectomy in patients with severe mental retardation. Hysterectomy can be done either for sterilization or to eliminate the menses, which is of significant hygienic benefit to those severely handicapped individuals." (Removal of the Normal Uterus, Southern Medical Journal, 1976).

Response:

- Dr. Foster stressed in this article that "obstetricians and gynecologists must guard vigilantly against the injudicious and indiscriminate removal of the normal uterus."

- Nonetheless, he recognized that hysterectomy might be appropriate for some severely retarded women in rare circumstances. Medical theory and practice have changed in the intervening decades, and Dr. Foster, along with the mainstream of the American medical community, no longer accepts the sterilization of a mentally retarded woman by hysterectomy as appropriate, although other medical reasons might justify such a procedure.

- Dr. Foster has always insisted on informed consent by the woman or her legal guardian prior to performing any such procedures.

Charge:

Dr. Foster has routinely encouraged sterilization of patients with sickle cell disease after they have been able to deliver a child. (Clinical Management: Sickle Cell State and Pregnancy, Urban Health, 1977).

Response:

- Dr. Foster actively opposed routine sterilization of sickle-cell-disease patients. He has encouraged counseling, screening, and patient management to enable women with sickle cell disease to have healthy children. Since the beginning of his professional career, Dr. Foster has conducted pathbreaking scientific research on the diagnosis and treatment of sickle cell disease and has improved maternal and child survival rates.

Charge:

Dr. Foster's work and writings show a cavalier attitude toward sterilization. For example, he stated in 1972 that the number of tubal sterilizations -- 193 -- performed in one calendar year in a rural county with a small population was "low and in need of improving." (A Rural Hospital and Family Planning, 1972).

Response:

- Dr. Foster is not at all cavalier about sterilization. In a textbook on Ambulatory Gynecologic Surgery, he wrote: "As with abortion, the psychosocial dynamics associated with sterilization are profound and require special counseling. Sterilization should be offered only to mature women with no further desire of pregnancy."

- In the 1972 article, Dr. Foster was describing the need to provide family planning to those people in the region already seeking such services after informed consent. His statement simply reflects a physician's appreciation of patient concerns and needs.

- Dr. Foster has consistently advocated only voluntary, informed family planning. Moreover, he recognizes family planning as only part of an overall strategy to improve health care, including reduction in infant mortality. He has stressed his opposition to "coercive sterilization," (same 1972 source) both in his statements and writings.

- Dr. Foster has eloquently stated on numerous occasions that he, the father of two children, he knows that the creation of a human being is one of the greatest joys anybody can have.

ABORTION FOR CONTRACEPTIVE PURPOSES

Charge:

Dr. Foster advocates the use of abortion as a means of contraception. He has specifically referred to abortion as "a contraceptive measure." (Contraceptives in Sickle Cell Disease, Southern Medical Journal, 1981)

Response:

- Dr. Foster does not equate abortion and contraception. In his writings and speeches, Dr. Foster has used the words abortion and contraception to denote two very different concepts. Dr. Foster has never advocated that abortion be used in place of contraceptives.

- Although Dr. Foster acknowledged in his 1981 article that abortion is viewed as a type of contraceptive in some parts of Europe, he did not advocate the use of abortion as a contraceptive measure in the United States.

- Dr. Foster has not promoted the use of abortion for contraceptive purposes. In discussing its use as a contraceptive measure for women with sickle cell anemia, he stated that "clearly this would not be ideal."

- Instead, Dr. Foster has stated his preference that, even when the health of the woman is at issue, abortion is used only when other methods of contraception fail.

- Dr. Foster has not advocated the use of abortion. His ultimate recommendation in the article was that barrier methods of contraception combined with timing should be used by women with sickle cell disease because abortion, a surgical procedure, carries greater risks to the patient.

Charge:

Dr. Foster is cavalier and indifferent to the use of abortion.

Response:

- Dr. Foster has dedicated his 38 years of medical practice to improving the maternal and child health care of his patients. He has delivered thousands of babies and instructed hundreds of young physicians.

- Dr. Foster has focused much of his energy on promoting family planning in order to prevent unwanted pregnancies and abortions.

- Dr. Foster has expressed his concern about reliance on abortions rather than on birth control measures. (Family Planning and the Black Community, 1975).

• Dr. Foster believes that, particularly for adolescents, abstinence is the best way to prevent unwanted pregnancy. For those who do not abstain from sexual activity, Dr. Foster believes that safe and reliable contraception is the next best available alternative. If these measures fail, Dr. Foster believes that, it is the responsibility of a good physician and staff are obligated to provide counseling on pregnancy options, including both adoption and pregnancy termination.

• If a pregnancy termination is selected by the patient, it should be done as early as possible in the pregnancy. He believes that abortion should be safe, legal, and rare.

Charge:

Dr. Foster has promoted in-home abortions to make them more available as contraceptives. (Articles characterizing Upjohn Study).

Response:

• Dr. Foster has never promoted the use of in-home abortions.

• Dr. Foster believes abortions should be performed only as a last resort, but he also believes that when they are done they should be done in the safest manner possible. Therefore, he supports research into safer methods.

• As Chairman of the Department of Obstetrics and Gynecology at Meharry Medical College, Dr. Foster was the principal investigator for an FDA-approved multi-center clinical trial to test the efficacy and safety of an abortifacient suppository administered during early pregnancy. The trial was a research project conducted in an academic health science center and was approved by the internal human investigations review board. All medical procedures were conducted in the hospital. All patients were volunteers who were legally approved for pregnancy termination in the state of Tennessee.

Charge:

Dr. Foster's treatment of abortion as a contraceptive measure is evidence of the liberal mind set that promotes sexual promiscuity among young people and does not require them to take responsibility for their actions.

Response:

• Dr. Foster has devoted a significant portion of his professional life and career to battling sexual promiscuity among young persons. He has established such programs as "I Have A Future," which provides positive alternatives to teenage

pregnancy. Through "I Have A Future," Dr. Foster and his team have helped build the self-esteem of high-risk young men and women by providing education and job opportunities.

• Dr. Foster anchored the "I Have a Future" program directly in the neighborhoods where the young participants live. By doing so, in addition to ensuring better access to social and medical support services, parents also can be more involved with their children's choices.

Charge:

Dr. Foster has justified a hysterectomy on the basis that the woman had a "dismal social history," i.e., was unmarried, had four children, was unemployed, and received no welfare assistance (Meigs' Syndrome Complicated by Pregnancy, Journal of the National Medical Association, 1972).

Response 1:

- The procedure was medically necessary to remove a tumor with a high probability of malignancy. Dr. Foster noted in the article, however, that the woman's situation made the medically necessary removal of her reproductive organs "a bit less difficult." This comment reflected a value judgment Dr. Foster believes he should not have made then, and he would not make today.

Response 2:

- The procedure was medically necessary to remove a tumor with a high probability of malignancy. Dr. Foster noted in the article, however, that the woman's situation made the medically necessary removal of her reproductive organs "a bit less difficult." This comment reflected Dr. Foster's knowledge of the patient's social circumstances and her concerns for the future of her family. By this comment, Dr. Foster expressed his hope that there might be some beneficial consequence in spite of the patient having to undergo this major surgical procedure.

February 10, 1995

Memorandum to Evelyn Lieberman
FROM: The Office Of Media Affairs
RE: Editorials on Foster Nomination

St. Louis Post-Dispatch- February 9, 1995
Negative

The editorial criticizes the White House for the Foster appointment and takes on the pro-choice stance of the White House.

The Washington Post- February 9, 1995- Editorial
Neutral

The editorial criticizes the White House for putting a tangible number on the abortions performed by Foster, but it points out that he is a capable nominee.

The Washington Times- February 7, 1995- Editorial-
Negative

Analyzes the ever-changing number of abortions Dr. Foster is supposed to have done. The piece blames the White House for not getting the correct number out and says the nomination should not go forward.

The Washington Times- February 6, 1995- Editorial-
Negative

The piece criticizes Dr. Foster's views on various issues (teen pregnancy, abortion). The piece goes on to remind readers of the repeated botched nominations of the Clinton Administration.

The Los Angeles Times- February 7, 1995- Metro-
Positive

The piece praises Dr. Foster for his work with teen pregnancy and urges the Clinton Administration to stick by him.

The Chicago Tribune- February 9, 1995- Editorial
Neutral

The piece harshly criticizes the Administration's handling of the nomination, but points out that Dr. Foster should be given a chance to be heard.

The Chicago Tribune- February 7, 1995- Editorial
Positive

The piece effectively points out that Dr. Foster should be judged on his entire career and that he should be able to defend himself in confirmation hearings.

St.Petersburg Times- February 7, 1995- Editorial
Positive

The piece praises Dr. Foster and his distinguished career. The editorial reminds pro-life advocates that abortion is a legal procedure. The piece stresses the need for confirmation hearings to take place.

The Atlanta Journal and Constitution- February 4, 1995-
Editorial- Positive

This piece was written before the abortion controversy so it does not address the issue. The piece praises Foster and the Clinton Administration for their choice.

The Atlanta Journal and Constitution- February 7, 1995-
Editorial- Neutral

The piece criticizes the Clinton Administration for "fumbling yet another high profile appointment." However, the editorial goes on to say that Foster should be judged on his entire career and that confirmation hearings should take place. The piece urges the White House to strongly support Foster.

Star Tribune- February 7, 1995- News
Positive

The piece points out Dr.Foster's qualifications and mentions his many supporters. The piece is very positive overall.

The San Francisco Chronicle- February 8, 1995- Editorial-
Positive

The piece points out Dr. Foster's many qualifications and

accomplishments. The piece states that the outcry from pro-lifers is unfounded because abortion is legal. The piece lightly criticizes the Administration's handling of the nomination, but points out that the nomination should not be in jeopardy for that reason alone.

The Houston Chronicle- February 8, 1995- Editorial- Positive

The piece criticizes "the narrow-minded fixation" of the senators who know little about Foster's qualifications. The editorial urges senators to look at Foster's full record instead of just judging him on the abortion issue. The piece lightly criticizes the Administration for its handling of the nomination.

The Miami Herald- February 7, 1995- Editorial- Positive

The piece stresses the fact that Dr. Foster should be judged by his entire career and not just a few abortions.

Memphis Commercial Appeal- February 9, 1995- Viewpoint Negative

The piece essentially criticizes the President for his efforts in the baseball talks and briefly criticizes the handling of the Foster nomination.

The New York Times- February 10, 1995- Editorial- Negative

The editorial harshly criticizes the Clinton Administration for its "bungling" of yet another nomination. The editorial calls for the nomination to be withdrawn.

IMMEDIATE
OFFICE OF THE ASSISTANT SECRETARY
FOR HEALTH

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HEALTH "FAX"

95 FEB 10 PM 5:58

TO: John Podesta
Marvin Krislov

FROM: Harriet Babb

FAX NUMBER: 456 2215, 1647

MESSAGE: [redacted]

PLEASE CALL: FTS _____ ASK FOR _____

IF ANY PROBLEMS WITH TRANSMISSION

NUMBER OF PAGES 3 (NOT COUNTING COVER PAGE)

A review of Dr. Henry Foster's written work reveals an accomplished clinician and researcher in the field of obstetrics and gynecology. He has written on a variety of topics, with a particular focus upon the diagnosis and management of high risk pregnancies. He is not just a doctor and scientist, however; Dr. Foster is also the sponsor of a successful, community-based teen pregnancy prevention program, and has written extensively about this program and about access to health care for the under-served.

Dr. Foster is the author of four textbook chapters relating to high risk pregnancies, including two chapters on the particular issues surrounding sickle cell disease and pregnancy. He has published widely about pregnancies in patients with sickle cell anemia, and has studied diagnostic tools for use in management of the disease. In his writings on sickle cell anemia, Dr. Foster demonstrates his awareness of the agonizing family planning decisions faced by sickle cell patients in light of the life-threatening risks to them of childbirth, and discusses the importance of high quality, non-directive family planning counselling. One of the goals of his research is to maximize a patient's chances of bringing a pregnancy safely to term, if that is her desire.

Dr. Foster has also written on the physiology and management of complications of pregnancy, including toxemia (a non-specific syndrome which can result in convulsions, coma, or death),

abdominal pregnancy, early cervical cancer, Meig's Syndrome (a rare type of ovarian tumor), thalassemia syndrome (a genetic disorder affecting the rate of hemoglobin production) and endometrial stromal sarcoma (a cancer of the uterine lining). In particular, Dr. Foster has maintained a research focus upon the amniotic fluid and how analyzing its characteristics can be useful in the diagnosis and management of high risk pregnancies.

In his community, Dr. Foster has devoted himself to helping those less fortunate and, in particular, to preventing teen pregnancy. Dr. Foster has written a great deal based upon his experience with Meharry Medical College's "I Have a Future Program," whose development he spearheaded. The program fosters the values of self-esteem, physical and mental well-being, completion of school, development of job skills, sexual responsibility, self control and ability to handle interpersonal conflict, the value of helping others, positive social values, and family values. Locating the program in community sites allows for interaction with the teens' families and a better opportunity to involve parents and siblings, an important aspect of the program.

Dr. Foster has also written about the medical and social barriers to the health of urban infants, stressing the importance of quality pre-natal care. His research has suggested that blacks and whites will give birth to equally healthy children where the socioeconomic status of the two groups is the same for a sustained period of time.

While acknowledging that this country has been a world leader in its concern for medical ethics, Dr. Foster remains vigilant in safeguarding the ethical conduct of research. He is committed to protecting the vulnerable from being used inappropriately as research subjects, and his writings reflect his strong beliefs regarding informed consent.

DRAFT

Dr. Foster At-A-Glance: Henry W. Foster M.D., 61, is an eminent scholar and academic administrator, a practicing physician, and a community leader. In 1972, he was one of the youngest members ever inducted into the Institute of Medicine of the National Academy of Science. In 1991, the "I Have A Future" program he developed was named a "Point of Light" by President Bush for its pioneering work in preventing teen pregnancy and building self esteem among at-risk youth.

EDITORIAL SUPPORT FOR HENRY W. FOSTER, JR., M.D.

"Instead of fixating on the number of abortions performed by Foster, how about answering the most pertinent question: Is he qualified to be the nation's public health spokesman? Yes, if you judge Foster on his medical credentials and community service.

"A dean and acting president of Meharry Medical College, Foster has been endorsed by the American Medical Association and ACOG. He's won national recognition and awards for his campaign to reduce infant mortality and to curb teen pregnancy and drug abuse. His *I Have a Future* program encourages young people to delay sexual activity, develop job skills and improve self-esteem. As Surgeon General, Foster says he will continue working to reduce out-of-wedlock pregnancy."

-- **USA Today, Feb. 7**

"Dr. Henry Foster has an excellent background to be the next surgeon general. ... Foster's commitment to reducing teen-age pregnancy and its rippling effects on children is longstanding and deeply felt. ... While practicing in Massachusetts and Alabama as well as Tennessee, Foster was committed to reducing teen-age pregnancy, drug abuse and smoking. His work has generated support from many directions; the Bush Administration referred to him as one of its "thousand points of light."

-- **Los Angeles Times, Feb. 7**

"Foster appears to be the right person to speak to the nation about public health. He has been nationally recognized for his *I Have a Future* campaign to persuade teen-agers to forgo teen sex ... and develop job skills."

-- **Philadelphia Daily News, Feb. 8**

"Ultimately, what matters most is the totality of Foster's medical practice and his service to his community. From all accounts, he has been a conscientious physician, a respected educator and the originator of an admired program to reduce teen pregnancies in Nashville. ... A medical professional with Foster's credentials deserves a fair confirmation hearing, not a witch hunt arranged by abortion foes."

-- **Atlanta Journal-Constitution, Feb. 8**

"[T]he Tennessee obstetrician-gynecologist, whom President Clinton picked last week to replace Dr. Joycelyn Elders, made a name for himself by delivering babies -- thousands and thousands of them -- and by preaching abstinence to teenagers in two Nashville housing projects.

"Members of the Senate, where the Foster nomination will survive or die, ought to withhold judgment until after hearings. They should weigh the doctor's total record, too, including the I Have a Future program he started in Nashville to urge teenagers to delay sexual relations and childbearing."

-- **Chicago Tribune, Feb. 7**

"[President Clinton] should stand behind what seems like a well-qualified candidate. Foster is no apologist for teen-age sex, as his predecessor, Dr. Joycelyn Elders, was sometimes accused of being. Indeed, he has effectively preached sexual abstinence as by far the wisest and safest choice for teenagers. ... Foster's work to curb teenage pregnancies caused him to be honored as a "Point of Light" by former President George Bush."

-- **Denver Post, Feb. 9**

"Instead of narrowly focusing on a single issue, Foster's detractors ought to consider his many qualifications. Foster is widely known for his *I Have a Future* program to reduce pregnancy among teens in public housing in Nashville. Preventing teen pregnancy, research shows, is critical to help reduce associated problems, including welfare dependency, child abuse and neglect.

"We urge President Clinton to hang tough on Foster's nomination. Whatever one may think about abortion, fact is it's legal. A qualified professional ought not be rejected for public service simply because he provided a legal medical procedure."

-- **Chicago Sun-Times, Feb. 7**

DRAFT

Dr. Foster At-A-Glance: Henry W. Foster M.D., 61, is an eminent scholar and academic administrator, a practicing physician, and a community leader. In 1972, he was one of the youngest members ever inducted into the Institute of Medicine of the National Academy of Science. In 1991, the "I Have A Future" program he developed was named a "Point of Light" by President Bush for its pioneering work in preventing teen pregnancy and building self-esteem among at-risk youth.

PROFESSIONAL PEER SUPPORT FOR HENRY W. FOSTER, JR., M.D.

"The American Medical Association enthusiastically supports the nomination of Henry W. Foster, MD for the position of Surgeon General of the U.S. Public Health Service. Dr. Foster is a leading expert in the field of reproductive health,....a dedicated teacher, a dependable leader, and a concerned advocate for improving access to quality health care for women and underserved populations....He brings the requisite experience, knowledge, and commitment to provide effective leadership as the Surgeon General. We firmly believe that Dr. Foster will serve in the position of Surgeon General with distinction and make many positive contributions to the nation's health."

James S. Todd, MD
Executive Vice President
American Medical Association

"Dr. Foster is a highly qualified physician and administrator who would be an outstanding Surgeon General. He has had a distinguished academic career and has directed numerous successful community outreach ventures, including Meharry's teen initiative, the "I Have a Future Program," focusing on sexual responsibility, self-esteem and job skills. Dr. Foster is a nationally known, well-respected physician and a great human being who brings a broad perspective and experience to a variety of health and social issues -- knowledge, skill and experience that are essential for America's Surgeon General. I am absolutely confident that he would serve with distinction."

Louis W. Sullivan, MD
President, Morehouse School of Medicine
Former U.S. Secretary of Health and Human Services.

"I have known Dr. Foster for many years. He is a very intelligent, conscientious, and able physician. His calm, well-balanced approach to problem solving will serve him and the people of the United States well in carrying out the duties of the office of Surgeon General. He is highly qualified, and an excellent choice for the position."

William C. Andrews M.D.
President
American College of Obstetricians and Gynecologists

"The National Medical Association strongly supports the nomination of Henry Foster MD as United States Surgeon General....The NMA believes that Dr. Foster's presence of U.S. Surgeon General will greatly enhance the Administration's ability and capacity to protect the health and welfare of our nation and applauds [President Clinton's] excellent selection."

Tracy M. Walton Jr., MD
President
National Medical Association

"On behalf of the deans of the 27 graduate schools of public health in the nation, I wish to go on record in support of Dr. Henry Foster as U.S. Surgeon General. Dr. Foster is well known and respected by the academic public health community for his work with the underserved and for his keen understanding of the role prevention plays in reducing morbidity and delaying mortality. He is a recognized leader in the health professions education field and will, no doubt, contribute greatly to fulfilling the administration's primary care and public health workforce goals."

Harvey V. Fineberg, MD, PHD
President
Association of Schools of Public Health

"The American College of Preventive Medicine is pleased to support the nomination of Henry Foster, MD, for the position of Surgeon General of the United States. Dr. Foster will bring to the position a record of leadership and an understanding of the medical training and health care delivery needs of this nation. The American College of Preventive Medicine, the national professional society for physicians committed to disease prevention and health promotion, looks forward to working with Dr. Foster on common goals to improve the health of the public."

Roy L. DeHart MD
President
American College of Preventive Medicine

"Dr. Foster's life experience in both urban and rural settings equip him well to understand the diversity of our nation. Moreover, his clinical, academic and administrative responsibilities have prepared him well to ensure that our nation's response to the issues, particularly, of teen pregnancy and primary care, are appropriate, workable and effective."

Christopher G. Atchison, Director
Iowa Department of Public Health
President,
Association of State and Territorial Health Officials

"I have known and worked with Dr. Henry (Hank) Foster for many years. He is a highly qualified and experienced clinician, clinical scientist, educator, medical administrator, a practitioner of problem-solving efforts. He is a good friend of good work. He is goal oriented, and his goal is a better, healthier life for all Americans. He is a fine choice for Surgeon General."

John E. Chapman, MD
Dean of Medicine
Vanderbilt University

DRAFT

Dr. Foster At-A-Glance: Henry W. Foster M.D., 61, is an eminent scholar and academic administrator, a practicing physician, and a community leader. In 1972, he was one of the youngest members ever inducted into the Institute of Medicine of the National Academy of Science. In 1991, the "I Have A Future" program he developed was named a "Point of Light" by President Bush for its pioneering work in preventing teen pregnancy and building self-esteem among at-risk youth.

DR. HENRY W. FOSTER, JR. IN HIS OWN WORDS

"In many ways, health care in America is a paradox. We hold some of the world's greatest expertise in health and health interventions; people come from around the globe to be the beneficiaries of this care. Yet in terms of health-care outcomes, we don't do nearly as well as we should as a nation."

February 2, 1995
The White House

"There is nothing more stifling than a compromised beginning. We must assure healthier starts for our children. Another of my special concerns is the epidemic of teen pregnancies. We have the highest teen pregnancy rate in the Western world....I will also put tremendous emphasis on other pressing health issues for which prevention can be very effective -- such issues as AIDS and tobacco consumption, especially by our children."

February 2, 1995
The White House

"We spend over 11 percent of our gross national product on health, and while we clearly do care about our children, we must increase this concern and become more efficient and resourceful in our problem-solving. In the past we have been reactive. We must become more proactive. We must define and develop comprehensive approaches that aid young children and their families during the early years of family formation. The emphasis must highlight prevention, access to quality services and time and appropriate utilization, and a continuity of health care that contributes to family stability and better outcomes for children's lives."

January 1991
Foreword to <u>Alive and Well</u>

"Today, the medical education system must respond to the nation's need for more minority and generalist physicians, more primary care and health services research, and increase access to primary care, particularly in underserved rural and inner city communities."

September 30, 1993
Presented to Governor's Medicaid Taskforce, Nashville Tennessee

"Rural health is a serious problem in dire need of a solution. Quality of life and health status are interdependent. To help set the stage, let me begin with a question. "What everyday item typically eludes rural children?" [The answer is] clean water....The U.S. ranks 19th worldwide in infant mortality. An African American born in the U.S. is less likely to survive its first year of life than a baby born in Cuba, Jamaica, Trinidad or Tobago. For the wealthiest nation in the history of humankind, these kinds of outcomes are unconscionable."

February 24, 1994
Kellogg Conference, Tuskegee University

"When you have had the good fortune to participate in the miracle of birth as many time as I have, it is difficult to stand on the sidelines and watch so many people wasting the precious gift of life. It is difficult to look around America today and see so much needless suffering because of a lack of knowledge about prevention, or a lack of access to quality health care, or the lack of a moral center that leaves no room for violence or abuse of any kind. But all is not lost. America is moving forward to confront our health care crisis and the crisis of values that has led to too much irresponsible behavior."

February 10, 1995
Speech at George Washington University

DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

95 FEB 7 A11 : 26

FACSIMILE

DATE FEB 8 1995

TO: (NAME, ORCANIZATION, CITY/STATE AND PHONE NUMBER):

John Podesta
Assistant to the President
and Staff Secretary
The White House

PHONE: 456-2702

FROM: (NAME, ORCANIZATION, CITY/STATE AND PHONE NUMBER):

Kevin Thurm
Chief of Staff
DHHS

PHONE: 690-6133

RECIPIENT'S FAX NUMBER: ( ) 456-2215

NUMBER OF PAGES TO SEND (INCLUDING COVER SHEET): 5

COMMENTS:

THE TENNESSEAN — Tuesday, February 7, 1995
A GANNETT NEWSPAPER

Foster shares goals of many of his critics

MEMBERS of Congress who might be reluctant about Dr. Henry Foster's nomination as surgeon general should recognize that their goals and his are the same.

Foster was an inspired choice of President Clinton to replace the controversial Joycelyn Elders as the nation's most visible health advocate. Foster's record of service strikes at the very heart of what many members of the new Congress, including conservative Republicans, have been advocating.

His "I Have a Future" program, aimed at curbing teen pregnancy, has targeted at-risk young people, instilling in them a sense of responsibility. The program was hailed by the Bush administration as one of its 1,000 Points of Light.

Meanwhile, Foster established a highly respected reputation as an administrator, serving at one time as acting president of Meharry Medical College.

As a obstetrician/gynecologist, Foster's profession is helping to give life. He estimates he has delivered about 10,000 babies.

Soon after he was nominated by Mr. Clinton, however, some critics focused on the fact that Foster has performed a dozen or so abortions in his career. According to the White House, the pregnancies in most of those cases had been caused by rape or incest, or has threatened the life of the woman.

Some strong anti-abortion activists seem to want to use those dozen abortions to portray Foster as an abortionist. He is not.

His anti-pregnancy program for teens teaches self-esteem. It also happens to offer contraceptives to young people who are determined to be sexually active. But to hear his detractors, one would think the program is nothing but a condom-distribution agency. It isn't.

Foster has a longstanding association with the Planned Parenthood program, serving as a board member. But to hear his opponents, one would think Planned Parenthood is nothing but an abortion factory. It isn't. It is a health service agency.

Doctor's efforts fight teen pregnancy, welfare

Abortion opponents are expected to lobby Congress about Foster's nomination, which is certainly their right. But before lawmakers make up their minds about Foster, they need to examine all of the doctor's lengthy resume — in context — not just the footnotes.

After they do, they will find that this nation has few physicians who have waged the kind of successful war against teen pregnancy that Foster has waged.

Lawmakers, no doubt, will be bombarded with information from Foster's supporters as well as his critics. But if they want to learn about Foster's impact, they should simply ask the kids who have benefited from Foster's program.

Plenty of those young people can be found here in Nashville.

A great deal of the conservative pitch in the past several months has been to get families off public assistance. Here's a man who has been active in trying to realize that very goal. One of the surest, shortest roads to welfare dependency today is through a teen pregnancy.

Prevent the pregnancy — and at the same time, underscore the need for responsible choices — and welfare can be avoided.

The White House could have given its nominee more backing by being more precise with the information about the abortions that Foster had performed. Surely White House officials realized that by nominating an ob/gyn, the issue of abortion would arise. No one should hide from the facts.

But to oppose Foster without taking a close look at what he has done, and what he stands for, would be a disservice. If he is rejected, it would not only be a loss for Foster and the White House. It would be a loss for a nation that could use the talent, energy and the personal skills of such a devoted man.

Teens say Foster's vision brightens future

By TAMMIE SMITH
Staff Writer

"I Have A Future," the Meharry Medical College teenage pregnancy prevention program, is generating national attention — and controversy — because it was founded by U.S. surgeon general nominee Dr. Henry Foster.

Yes, the program counsels teens about birth control. Yes, it does give contraceptives to teens.

But that's only part of the picture.

Snapshots of the young people whose lives are changed by the program help fill out the frame.

They are of teens like Tonika East, 17, and Jason Gordon, 18. They live in public housing, a challenging place to grow up. But these young people — outgoing and articulate with goals — give a lot of the credit to "I Have A Future" for improving their chances of success.

"A bonus of the program has been the neighborhood effects."
DR. LORRAINE WILLIAMS GREENE
Director, I Have a Future

"I [joined] because everyone else was doing it," Tonika, a high school senior, said smiling, recalling her motives for becoming a "Future" kid in the sixth grade.

These days, others want to be like her. Through the program, she's become well-traveled, with trips to Atlanta, Washington, Gatlinburg, Cincinnati, New Orleans and Florida. Some were rewards; others were to visit colleges she may choose to attend.

Tonika is the leader now, student body president at Pearl Cohn High School and top dog in IHAF's entrepreneurship program that teaches business ownership.

Jason's motive for getting involved in IHAF six years ago was strictly financial. He wanted the $10 "reward" for filling out the survey to get into the program. That $10 was a lot of candy for a 12-year-old.

The $10 reward is no longer offered, but some program activities have a waiting list of people who want to get involved. Maybe it's because other youngsters see where Jason is headed. He entered Fisk University as a freshman last fall and has gone from being a "Future" kid to an employee, working 10 hours a week as a peer counselor. His goal is to one day own his own business.

"This program gives a lot of people a chance," he said. "Some of us would have made it to college anyway. This program helped ensure that."

In the spotlight

Thursday, President Clinton nominated Foster, former acting president of Meharry, to be surgeon general and offered some marching orders.

"I want Dr. Foster, to use what he's learned to help America attack the epidem-

Turn to PAGE 2A, Column 1

Teen-age Pregnancy

Tonika East, 17, now Pearl Cohn Comprehensive High School's student body president and head of its I Have a Future's entrepreneurship program: *"I [joined] because everyone else was doing it."*

Jason Gordon, 18, a freshman at Fisk University and peer counselor, got involved in I Have a Future six years ago. *"This program gives a lot of people a chance. Some of us would have made it to college anyway. This program helped assure that."*

Dr. Lorraine Williams Greene, I Have a Future director and a clinical psychologist: *"We deal with issues such as how to be in relationships, how to be intimate with someone and not necessarily have sexual intercourse."*

Chammaine Harris, 18, a participant in I Have a Future: *"Let's say you are on a date, dancing, and things start getting hot. Are you going to be passive, or stand up for what you believe?"*

Calvin Peters oversees one of I Have a Future's entrepreneurship programs: *"We have some kids who have never been out of Nashville. Their eyes light up when they see that bus," that comes to take them to IHAF meetings.*

Teens thank Foster for brighter future

FROM PAGE 1A

ic of teen pregnancies."

With specialties that Foster's "I Have A Future" program will be a model for a national teen pregnancy prevention initiative, it is being scrutinized from all angles, especially by Clintons conservative critics, who claim it is simply a program to dispense contraceptives.

The attention has put Dr. Lorraine Williams Greene, director of the program, and participants such as Tonika and Jason in the media spotlight.

Greene, a clinical psychologist, said the program's agenda does include talk about birth control. And contraceptives are given out.

"If a young person requests it, we give it to them. We talk about responsible sexuality. It is available."

But people who would reduce "I Have A Future" to a program that simply hands out condoms completely miss the mark, she says.

The discussion about birth control is part of a 15-week family life education process that focuses primarily on family dynamics and relationships.

"We deal with issues such as how to be in relationships, how to be intimate with someone and not necessarily have sexual intercourse," Greene explained.

"How do you deal with social situations where you find yourself needing to refuse things?"

Or as Chammaine Harris, 18, said: "Let's say you are on a date, dancing, and things start getting hot. Are you going to be passive, or stand up for what you believe?"

Greene said their message to the young people is simple: Sex just doesn't fit into their lives right now.

But it's not just talk, Greene added. Counselors give teens reasons to want to delay sex and parenthood. Youths are kept busy with field trips, after-school activities such as dance and karate classes, support groups, tutoring sessions and jobs.

But there are critics. The Family Institute, a Nashville conservative research group focusing on family issues, said "I Have A Future" comes up short.

The Institute, a yearold project of Mark Tidf and Jeff Whitesides, was created, Tidf said, to strengthen families. They have reviewed a fact sheet about the Meharry program.

"While the IHAF program seeks to delay the outcomes of 'early pregnancy and childbearing [among others]' there is no mention in the entire document of abstinence or delaying sexual activity," they said in a press release.

Nationally, antiabortion groups and conservatives have attacked Foster's nomination. The 61-yearold medical educator has long ties to the Planned Parenthood Federation of America. He also has acknowledged he performed a limited number of abortions in his long medical career.

His "I Have a Future" program stresses abstinence. It does not perform abortions.

Touching communities

At John Henry Hale public housing, where some "Future" gatherings are held, you walk down streets where all the houses look alike — brick buildings with house numbers stenciled on doors and small yards that are more dirt than grass.

When a school bus stops at a corner, among the students who tromp off is a young girl holding a baby in one arm, books in the other. Another girl gets off the bus holding a teddy bear and school books.

Despite all the rap songs romancing about the hood, the future physical environment is nothing to sing about.

It is in this setting that Meharry social workers and psychologists dispense options.

With the field trips, the money-making endeavors, the program exposes kids to life beyond their neighborhoods.

"We have some kids who have never been out of Nashville," Calvin Peters, who oversees the entrepreneurship program, explained. "Their eyes light up when they see that bus."

The program's impact extends beyond the children enrolled, Greene said, pointing to the difference in community attitudes in John Henry Hale and Preston Taylor homes compared to other housing projects that don't have IHAF.

At John Henry Hale and Preston Taylor, you hear more talk about higher education, even among students not in IHAF, she said.

"In one measure, students at the intervention sites scored higher on self-esteem. The program emphasizes the seven principles of Kwanzaa, an African-American cultural holiday celebrated right after Christmas. The principles include self-determination unity, collective work and responsibility, cooperative economics, purpose, creativity and faith.

"A bonus of the program has been the neighborhood effects," Greene said. "The kids at the intervention site just have a stronger sense of community, sense of responsibility for self and family."

Are there fewer pregnancies?

Greene said the best way to measure their success is to do long-range tracking of participants. That takes money they don't have. To run the program takes about $400,000 annually. Each site has a director and four case managers.

The most extensive evaluation effort so far of the 6-yearold program was funded by a grant and lasted 33 months. In it, data was gathered from young people in two public housing projects without the program, comparing it with data from young people at John Henry Hale and Preston Taylor — some in IHAF, some not.

Information was compiled on 198 kids, Greene said.

"We do know there was one known pregnancy among those in the intervention group during this 33 months, and 89 known pregnancies among those in the comparison sites."

Still, she cautions against generalizing the data because there was about a year's age difference in the groups compared.

But, if you let the youngsters tell it, there is less sexual activity among those in the program.

Part of it is knowing they are not the only one deciding on abstinence. Part of it is having adults they can talk to openly. Part of it is realizing the possible repercussions of early sexual activity.

"When I first came to Nashville, I used to follow the crowd," said Amelia Turner, 18, a Hume-Fogg honor student who does not live in public housing but has made it a point to be involved in IHAF for five years.

"It got to the point where I would see how people were living. There has to be a better way."

Turner has applied to five colleges, but favors Howard University. She said she wants a dual degree in medicine and biomedical engineering.

"This would be a nice program to have in other cities. In the little town I come from, there is nothing to do, so you may go over to your boyfriend's house. This takes you away from that. You don't have time to do crazy things."

Clinton needs to stand by his man

"*Go With Hank.*"

No, it's not a campaign slogan but it could be.

"*Go With Hank*" is my suggestion to the Senate Labor and Human Resources Committee, where President Clinton's nominee for surgeon general, Dr. Henry W. (Hank) Foster, will soon appear.

I'll also borrow a line from country music singer Tammy Wynette and urge Clinton to "*Stand By Your Man*" despite the cries from many conservatives who are already criticizing Foster's nomination.

The Washington Times, a conservative newspaper, made that point in its Friday edition, saying, "President Clinton yesterday chose medical educator Henry W. Foster Jr. to be surgeon general, a nomination that sparked controversy when the White House confirmed that his medical practice included performing abortions."

The newspaper report added: "His practice included a whole range of reproductive activities, including abortion, a senior administration official said last night."

That came after Gary Bauer, president of Family Research Council, a conservative think tank, said his agency is going to ask the Senate to exercise due diligence and remember the last

Dwight Lewis

election.

"Dr. Foster appears to be Elderslite," Bauer said, referring to the last surgeon general, Dr. Joycelyn Elders.

Elders served as surgeon general from mid-1993 until December 1994 when she was forced to resign by Clinton for the way she answered a question about masturbation.

Elders' firing also came because many saw her as a political liability for Clinton, who is likely to seek reelection in 1996.

So, the question now is this: Will Clinton back away from Foster before his confirmation hearings the way the President did with Lani Guinier.

Remember her? In 1993 the President picked Guinier to head the civil rights division of the Justice Department, but withdrew her name after she was labeled a "quota queen" in the media and support among Senate Democrats began to erode.

I hope that this time Clinton has enough guts to go with his pick, but I'm not 100% sure he will.

On Friday, White House press secretary Mike McCurry said officials who conducted background interviews of Foster were aware he had performed a limited number of abortions. But McCurry was unsure if Clinton knew it.

The surgeon general, as Clinton said when nominating Foster on Thursday, is "the public face of our public health service."

I don't know of a better public face to have now as the nation's surgeon general than Hank Foster.

And, yes, this comes despite the fact that Foster has revealed that he supports abortion rights and the distribution of condoms to youths.

When Elders was about to face her confirmation hearings, Foster — who attended medical school in Arkansas with Elders for two years — said she would have strong opposition because she favors education over ignorance.

Foster also favors education over ignorance. And, even if you don't know him, you could tell it by listening to him at the White House on Thursday as he talked about the need for America to do something about the monumental problem of teen-agers having babies out of wedlock.

If confirmed, Foster will work hard to see that teen-age pregnancy is reduced in our nation. I'm sure he will be just as concerned about other health problems facing this country, such as cancer and AIDS, and will urge Americans — both young and old — to do the right things to help prevent disease.

Foster said of Elders, prior to her confirmation hearings, "As surgeon general, Dr. Elders will deliver her message persuasively. She will maximize this healthcare bully pulpit which the position of Surgeon General affords. I sorely hope the American populace will be the beneficiaries of her strength, intellegence and commitment to superlative health care outcome for all citizens."

Foster didn't know it at the time, but he could have been writing his own speech for a confirmation hearing before the senate's Labor and Human Resources Committee.

If given the opportunity, he will do a great job. That's why it's important for the committee's members to "*Go With Hank*" — and for President Clinton to "*Stand By Your Man.*" ■

(Lewis is a columnist, regional editor, and editorial board member of *The Tennessean.*)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

95 FEB 9 P3:00

FACSIMILE

DATE_____

TO: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

John Podesta
Assistant to the President and
Staff Secretary
The White House

PHONE: 456-2702

FROM: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

Kevin Thurm
Chief of Staff
DHHS

PHONE: 690-6133

RECIPIENT'S FAX NUMBER: ( ) 456-2215

NUMBER OF PAGES TO SEND (INCLUDING COVER SHEET): 4

COMMENTS:

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"Doctors of Foster's generation are old enough to remember when women died from illegal abortions. They are old enough to have seen the need for this choice and old enough to have seen the sorrow facing such a choice. It's not a cliche, but a lifetime of experience, that prompts such a man to say of abortion: 'My wish is that it be safe, legal and rare.'"

-- Ellen Goodman, Boston Globe, Feb. 9

DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

95 FEB 10 P12 : 39

FACSIMILE

FEB 10 1995

DATE

TO: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

John Podesta
Assistant to the President and
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The White House

PHONE: 456-2702

FROM: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

Kevin Thurm
Chief of Staff
DHHS

PHONE: 690-6133

RECIPIENT'S FAX NUMBER: ( ) 456-2215

NUMBER OF PAGES TO SEND (INCLUDING COVER SHEET): 2

COMMENTS:

Foster-Alabama,0433
Foster Was Lone Obstetrician for East Alabama's Black Women
With PM-Surgeon General, Bjt
By JAY REEVES

BIRMINGHAM, Ala. (AP) - As the lone obstetrician at a black hospital during the days of racial segregation, Dr. Henry Foster was the only source of health care for thousands of poor, pregnant women in rural east Alabama.

Foster delivered hundreds of babies at John A. Andrew Hospital in Tuskegee from 1965 to 1973. When complications left him no other choice, he sometimes did abortions, a colleague and a relative say.

''Back then the medical treatment for Negroes was just deplorable,'' Dr. Calvin Dowe, a former colleague of Foster, recalled Thursday. ''Hospitals in the surrounding areas didn't even consider them people,''

While medical services were not segregated by law, Foster cared for almost every pregnant black woman in at least five counties.

Dowe, a general practitioner who is black, said he never referred women to Foster for abortions and did not know anyone who did. Women simply went to him because there was nowhere else to turn.

''Realistically, I don't see how any obstetrician can say he never has done an abortion. It's the nature of the business,'' Dowe said.

Abortions performed by Foster over his 38-year medical career have become a source of controversy since President Clinton nominated him to replace fired Surgeon General Joycelyn Elders. Foster, 61, initially acknowledged fewer than a dozen of the procedures but now says he did 39.

Dowe and William Hill, Foster's uncle, said they do not know how many abortions he performed at Andrew Hospital, which closed in 1987. But both said Foster did only what was medically necessary.

''He had to perform some for medical emergencies. He wasn't an abortion doctor,'' said Hill, 90, who still lives in Tuskegee.

Foster moved to Tuskegee in 1965 after completing his residency at Meharry Medical College in Nashville, Tenn. Dowe said the head of obstetrics at Andrew died about the same time, and Foster agreed to take over.

''With the training he had, he could have gone a lot of places. It was a form of mission work,'' Dowe said.

Foster was a member of a Baptist church in Tuskegee, and he took flying lessons under Charles A. Anderson, leader of the famed Tuskegee Airmen, an all-black squadron during World War II.

Foster also developed what became a national model for regional perinatal health systems. The White House was drawn to Foster by programs he started later in Nashville combatting teen-age pregnancy.

AP-WX-02-10-95 0857EST<

DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C 20201

95 FEB 9 P6:43

FACSIMILE

DATE FEB 9 1995

TO: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

John Podesta
Assistant to the President and
Staff Secretary
The White House

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FROM: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

Kevin Thurm
Chief of Staff
DHHS

PHONE: 690-6133

RECIPIENT'S FAX NUMBER: ( ) 456-2215

NUMBER OF PAGES TO SEND (INCLUDING COVER SHEET): 9

COMMENTS:

DRAFT

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PROFESSIONAL PEER SUPPORT FOR HENRY W. FOSTER, JR., M.D.

"The American Medical Association enthusiastically supports the nomination of Henry W. Foster, MD for the position of Surgeon General of the U.S. Public Health Service. Dr. Foster is a leading expert in the field of reproductive health,....a dedicated teacher, a dependable leader, and a concerned advocate for improving access to quality health care for women and underserved populations....He brings the requisite experience, knowledge, and commitment to provide effective leadership as the Surgeon General. We firmly believe that Dr. Foster will serve in the position of Surgeon General with distinction and make many positive contributions to the nation's health."

James S. Todd, MD
Executive Vice President
American Medical Association

"Dr. Foster is a highly qualified physician and administrator who would be an outstanding Surgeon General. He has had a distinguished academic career and has directed numerous successful community outreach ventures, including Meharry's teen initiative, the "I Have a Future Program," focusing on sexual responsibility, self-esteem and job skills. Dr. Foster is a nationally known, well-respected physician and a great human being who brings a broad perspective and experience to a variety of health and social issues -- knowledge, skill and experience that are essential for America's Surgeon General. I am absolutely confident that he would serve with distinction."

Louis W. Sullivan, MD
President, Morehouse School of Medicine
Former U.S. Secretary of Health and Human Services.

"I have known Dr. Foster for many years. He is a very intelligent, conscientious, and able physician. His calm, well-balanced approach to problem solving will serve him and the people of the United States well in carrying out the duties of the office of Surgeon General. He is highly qualified, and an excellent choice for the position."

William C. Andrews M.D.
President
American College of Obstetricians and Gynecologists

"The National Medical Association strongly supports the nomination of Henry Foster MD as United States Surgeon General....The NMA believes that Dr. Foster's presence of U.S. Surgeon General will greatly enhance the Administration's ability and capacity to protect the health and welfare of our nation and applauds [President Clinton's] excellent selection."

Tracy M. Walton Jr., MD
President
National Medical Association

"On behalf of the deans of the 27 graduate schools of public health in the nation, I wish to go on record in support of Dr. Henry Foster as U.S. Surgeon General. Dr. Foster is well known and respected by the academic public health community for his work with the underserved and for his keen understanding of the role prevention plays in reducing morbidity and delaying mortality. He is a recognized leader in the health professions education field and will, no doubt, contribute greatly to fulfilling the administration's primary care and public health workforce goals."

Harvey V. Fineberg, MD, PHD
President
Association of Schools of Public Health

"The American College of Preventive Medicine is pleased to support the nomination of Henry Foster, MD, for the position of Surgeon General of the United States. Dr. Foster will bring to the position a record of leadership and an understanding of the medical training and health care delivery needs of this nation. The American College of Preventive Medicine, the national professional society for physicians committed to disease prevention and health promotion, looks forward to working with Dr. Foster on common goals to improve the health of the public."

Roy L. DeHart MD
President
American College of Preventive Medicine

"Dr. Foster's life experience in both urban and rural settings equip him well to understand the diversity of our nation. Moreover, his clinical, academic and administrative responsibilities have prepared him well to ensure that our nation's response to the issues, particularly, of teen pregnancy and primary care, are appropriate, workable and effective."

Christopher G. Atchison, Director
Iowa Department of Public Health
President,
Association of State and Territorial Health Officials

"I have known and worked with Dr. Henry (Hank) Foster for many years. He is a highly qualified and experienced clinician, clinical scientist, educator, medical administrator, a practitioner of problem-solving efforts. He is a good friend of good work. He is goal oriented, and his goal is a better, healthier life for all Americans. He is a fine choice for Surgeon General."

John E. Chapman, MD
Dean of Medicine
Vanderbilt University

DRAFT

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DR. HENRY W. FOSTER, JR. IN HIS OWN WORDS

"In many ways, health care in America is a paradox. We hold some of the world's greatest expertise in health and health interventions; people come from around the globe to be the beneficiaries of this care. Yet in terms of health-care outcomes, we don't do nearly as well as we should as a nation."

February 2, 1995
The White House

"There is nothing more stifling than a compromised beginning. We must assure healthier starts for our children. Another of my special concerns is the epidemic of teen pregnancies. We have the highest teen pregnancy rate in the Western world....I will also put tremendous emphasis on other pressing health issues for which prevention can be very effective -- such issues as AIDS and tobacco consumption, especially by our children."

February 2, 1995
The White House

"We spend over 11 percent of our gross national product on health, and while we clearly do care about our children, we must increase this concern and become more efficient and resourceful in our problem-solving. In the past we have been reactive. We must become more proactive. We must define and develop comprehensive approaches that aid young children and their families during the early years of family formation. The emphasis must highlight prevention, access to quality services and time and appropriate utilization, and a continuity of health care that contributes to family stability and better outcomes for children's lives."

January 1991
Foreword to <u>Alive and Well</u>

"Today, the medical education system must respond to the nation's need for more minority and generalist physicians, more primary care and health services research, and increase access to primary care, particularly in underserved rural and inner city communities."

September 30, 1993
Presented to Governor's Medicaid Taskforce, Nashville Tennessee

"Rural health is a serious problem in dire need of a solution. Quality of life and health status are interdependent. To help set the stage, let me begin with a question. "What everyday item typically eludes rural children?" [The answer is] clean water....The U.S. ranks 19th worldwide in infant mortality. An African American born in the U.S. is less likely to survive its first year of life than a baby born in Cuba, Jamaica, Trinidad or Tobago. For the wealthiest nation in the history of humankind, these kinds of outcomes are unconscionable."

February 24, 1994
Kellogg Conference, Tuskegee University

"When you have had the good fortune to participate in the miracle of birth as many time as I have, it is difficult to stand on the sidelines and watch so many people wasting the precious gift of life. It is difficult to look around America today and see so much needless suffering because of a lack of knowledge about prevention, or a lack of access to quality health care, or the lack of a moral center that leaves no room for violence or abuse of any kind. But all is not lost. America is moving forward to confront our health care crisis and the crisis of values that has led to too much irresponsible behavior."

February 10, 1995
Speech at George Washington University

The American College of Obstetricians and Gynecologists

ISSUES IN WOMEN'S HEALTH

ACOG NEWS RELEASE

For Release: *Contact:*

MEDIA ADVISORY

EVENT: **MEDICAL GROUPS SPEAK OUT TO SUPPORT HENRY W. FOSTER, M.D. FOR SURGEON GENERAL**

WHO: **The American College of Obstetricians and Gynecologists**
The American College of Physicians
The American Medical Women's Association
The National Medical Association
The American Psychiatric Association
The American Academy of Pediatrics
Association of American Medical Colleges
American College of Emergency Physicians
American Society for Reproductive Medicine
Association of Minority Health Professions Schools
Association for Academic Health Centers

DATE: **Friday, February 10, 1995**

TIME: **9:00 a.m.**

WHERE: **National Press Club, Main Lounge**
14th and F Streets, NW
Washington, DC 20045

CONTACT: **Greg Phillips, Public Information Specialist**
The American College of Obstetricians and Gynecologists
(202) 484-3322

# # #

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FAX TRANSMISSION

U.S. Department of Health and Human Services
Office of the Secretary

DATE: _____

TO: AVIS Laurel Oe

_____

FAX: 456-2215 **PHONE:** _____

FROM: **Victor Zonana**
Deputy Assistant Secretary for Public Affairs/Media
Phone: (202) 690-6343
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TOTAL NUMBER OF PAGES TRANSMITTED: _____

COMMENTS:

13TH STORY of Level 1 printed in FULL format.

August 18, 1992

SECTION: NATIONAL NEWS; Section A; Page 3

LENGTH: 535 words

HEADLINE: Hospital merger hot topic in Nashville

BYLINE: By Darryl Fears STAFF WRITER

BODY:

Nashville, Tenn. - In spite of several raucous public hearings on the most important hospital merger in Nashville's history, the 40-member metropolitan council today is expected to approve a plan to have a mostly black-run hospital take over a mostly white one.

Three years after it was first proposed, the plan would take effect to let Meharry-Hubbard Hospital staff Nashville Metropolitan General Hospital for a year. If the Metro Board of Hospitals approved of Meharry- Hubbard's work during the year, Meharry-Hubbard would enter an agreement to staff the General Hospital for 30 years. The move, some say, would save Nashville $ 50 million.

"I expect a lively meeting," said Dr. David Satcher, Meharry Medical College president, who initiated the most recent merger proposal in 1988. "There will be a lot of politics, a lot of filibustering, and then they will vote."

A recent poll of council members indicated that the merger will pass easily.

The idea of merging mostly white Metropolitan General with historically black Meharry-Hubbard, run by one of the most respected black medical colleges in America, has stirred an ugly feud.

The mostly black supporters of the merger, chanting during council meetings on the issue, have claimed that black doctors will save the city $ 50 million. Merger opponents have said a struggling Meharry simply can't get the job done.

"The opposition is trying to stir up a lot of hysteria," said Michael Grant, president of the local chapter of the National Association for the Advancement of Colored People. He supports the merger, as do other powerful local political figures, including Mayor Phil Bredesen.

7TH STORY of Level 1 printed in FULL format.

The Ethnic NewsWatch
Emerge

January 31, 1994

SECTION: Vol. V; No. IV; Pg. 38

LENGTH: 1718 words

HEADLINE: The Stakes are High for Black Doctors and Hospitals

BODY:

The Stakes are High for Black Doctors and Hospitals.

PRESIDENT CLINTON'S health plan depends upon swelling the ranks of primary-care providers who will give low-cost quality care to the nation. However, only one-third of U.S. doctors are in primary care specialties -- general internal medicine, pediatrics and family practice -- and their numbers are steadily decreasing. The Association of American Medical Colleges (AAMC) found in a 1992 survey of graduating U.S. medical students, that the percentage of doctors with primary-care specialties fell from 36 percent in 1982 to 14.6 percent in 1992.

African-American doctors who pursue primary care are essential to the health reform, said Kenneth B. Chance, former director of health policy at the Joint Center for Political and Economic Studies. In an article in the center's Focus magazine, he observed: "If the ranks of minority health professionals are not increased, the efforts of President Clinton to address the health-care needs of the poor and underserved Americans will only achieve limited success."

Dr. Herbert Nickens, vice president for minority health, education and prevention at AAMC is impressed with several aspects of the Clinton health plan. There are incentives to attract physicians into primary-care practice in underserved rural and urban areas. They include tax incentives, increased reimbursements, retraining of specialists as primary-care providers, scholarships and a loan forgiveness program.

But Nickens is concerned about the role of African-American physicians. "One of the problems with health care reform is that, as we start to organize delivery systems, wherein doctors are employees, or contractors to multiple systems, there is certainly a danger of minority doctors being excluded, whether via the old boys' network or via plain old racial discrimination."

As every television network in the nation flooded its lights on the Sept. 22 unveiling of Clinton's plan, America's elite medical leadership shared the spotlight. Chief among these were newly-appointed Surgeon General Joycelyn Elders, new Centers For Disease Control Director Dr. David Satcher and former Health and Human Services Secretary Louis Sullivan. In addition, officers of the National Medical Association, the nation's largest black physician's group, were in attendance.

It is startling to realize how many of our nation's medical elite are African-Americans. On another level, it seems ironic that, while the top health leadership is African-American, many of today's African-American doctors feel

they are fighting for their professional lives.

For many Americans, the word "physician" summons the image of the wealthy specialist whose group membership allows him to devote Wednesdays to a round of golf at an exclusive club. In contrast, African-American doctors tend to pursue private primary practices among the urban poor for relatively meager reimbursements from Medicaid. Their huge practices, born of both community needs and lower fees, mean leisure time is scarce. But this practice pattern is adopted by choice in fulfillment of a long tradition of service.

The Clinton health reform plan will support their mission because the plan emphasizes preventive care and uses primary care providers as a means of providing health care for the medically underserved, echoing the traditional avenues of the practices of African-American doctors. But other aspects of the Clinton model -- notably the adoption of group practice as the norm, and the crackdown on widely-publicized fraud in government health programs -- do not auger well for African-American doctors.

Black physicians in the United States are not a homogenous group; they engage in every specialty and contribute to all aspects of medicine. Some are astronauts, neurosurgeons, health policy analysts and medical journalists. Other characteristics:

- Though 12 percent of the U.S. population is African-American, the 20,874 black physicians and 5,000 African-American dentists in the nation constitute only 3 percent of the the country's doctors.

- African-American doctors tend to settle into private practice.

- Earnings are much lower on average compared to white doctors.

- African-American physicians accrue much larger medical school debts and are likely to treat the poor, meaning they have large caseloads and insufficient support staffs.

As aforementioned, the emphasis on primary care should help increase the numbers, visibility and power of black physicians because more of them will go into primary care. But this will happen only if their expertise is tapped for structuring and accrediting the health networks that will provide care and the government boards that will rate and accredit networks.

Still, the emphasis on primary care is a two-edged sword, points out Dr. Anita Jackson, a surgeon and alumna of the Harvard School of Public Health.

"African-American doctors are already overrepresented in primary care and underrepresented in specialties. The Clinton plan's focus on primary care will serve to further shrink the number of African-American specialists," she said.

Many doctors and community health centers share this concern. "It's difficult to find specialists to whom we can refer our patients and who will care for them well," said Meseret Bezuneh, vice president for operational support at Anthony Jordan Health Center in Rochester, N.Y.

"Traditionally, post-professional training has always been an old boys' network," said Anita Jackson, who is in an ear, nose and throat surgery residency in Memphis, Tenn. "It's hard for minorities and women to break in.

Now the government is saying We don't need all these specialists.' Well, there are an estimated 300 otolaryngologists trained in the country a year, and only three are black. Now, will we be facing a scenario where only one is black? But most of their patients will be black because we are at higher risk for the sort of cancers and disorders that ENT surgeons treat."

Nickens fears that two tiers of physician status could evolve from the Clinton plan, with minorities at the bottom. "Specialties are still seen as more desirable. As you reduce the number of specialists, and increase generalists for the 50-50 split the administration wants, you could have exclusion of minorities from specialties at even higher rates than we see today."

While the majority of African-American doctors go into primary care, those with a lot of school debt may stay in school longer to specialize, make more money and pay off their loans. Though the Clinton plan pushes for primary care physicians, it recognizes the financial pressures that help push doctors into specialty practice. This is especially germane to African-American doctors who have fewer financial resources and more debt burden when they leave medical school, according to the Joint Center for Political and Economic Studies. A debt of $90,000 to $100,000 is not unusual, which makes it harder for them to choose primary care, especially in poorer neighborhoods, since specialists make much more money. The plan's recognition of medical school debt as an important factor in the shunning of private practice should benefit African-American physicians by easing the debt burden, either through loan forgiveness or financial incentives to practice in underserved areas.

Besides the external barriers to success in the Clinton model, there will also be internal challenges for African-American physicians. Chief among these will be the paradigm shift to group practice.

Most, although certainly not all, African-American doctors practice alone. They have not been part of the trend toward group practice, but this will have to change under the new system.

Dr. Lawrence Sanders, associate director for community health at the DeKalb County Board of Health, foresees another change. "The role of the community health center will have to be redefined. It will play a big role in urban and rural areas in concert with public health agencies in a partnership that utilizes a team approach with nurses and other clinicians. Health educators and community leaders will also work with physicians."

Clinton's health plan makes it clear that eliminating fraud in Medicaid and future government health programs is a priority, and that the administration

anticipates this will result in substantial savings.

But the tough talk about fraud is upsetting, too, because black doctors are fined, prosecuted, stripped of their licenses and jailed disproportionately for minor infractions of the federal statutes governing Medicaid fraud.

In order to keep African-American doctors from being singled out for fraud and being adversely affected by the new health plan, most experts agree that they must be represented on federal and state fraud-control operations.

Black hospitals are "especially vulnerable" to any sweeping health reform changes, observed Nickens. "There were 200 black hospitals opened by the turn

of the century. Eight are left today." The eight are Meharry/Hubbard in Nashville; Howard University in Washington, D.C.; Southeast Specialty Hospital in Greensboro, N.C.; Riverside General in Houston; Norfolk Community, Richmond Community and Newport News General hospitals, all in Virginia, and Charles Drew in Los Angeles.

All but two of the existing black hospitals at the turn of the century closed after the earlier revolution in health care: the 1910 Flexner report, a landmark study which sought to evaluate and reorganize American medical education. It damned black doctors and black hospitals as substandard and incompetent, delivering death blows to all but Howard and Meharry, the two that Abraham Flexner deemed worth saving.

"There is no question that the reform plan could endanger black hospitals again to the degree that market competition is introduced," observed Nickens, "and as hospitals find themselves bidding for contracts and business, they are certainly in great danger."

And that danger is not limited to the hospitals. The medical schools associated with Howard, Meharry and Drew train a disproportionate number of black physicians with the expectations that most will go on to serve the poor in primary care settings -- care that will directly benefit most African-Americans.

ETHNIC-GROUP: African-American

LANGUAGE: English

LOAD-DATE-MDC: February 22, 1994

The American College of Obstetricians and Gynecologists

9 FEB 95 P6:43

DEPARTMENT OF GOVERNMENT RELATIONS

DEPARTMENT FAX NUMBER: (202) 488-3985

DATE: February 9, 1995

TO: John D. Podesta

FROM: Kathy Bryant

RE: Dr. Foster

NUMBER OF PAGES (including this page): 4

RECIPIENT'S FAX NUMBER: 456-2215

COMMENTS:

IF THERE IS A TRANSMISSION PROBLEM, OR IF YOU WOULD LIKE TO SPEAK WITH SOMEONE AT ACOG, PLEASE CALL (202) 863-2509.

409 12th Street, SW Washington, DC 20024-2188 (202)638-5577

John,

Thank you for taking time to meet with me this morning. The meeting was very helpful to me. We are eager to do all we can to assist Dr. Foster.

I remain concerned about the explanation of the 1978 transcript going to the Hill. I have attached a copy of the version that I was given from HHS. My suggestion would be to modify it to read as follows:

> Please note that this 1978 transcript was never checked for accuracy or clarity prior to its publication. Dr. Foster has not performed 700 abortions. Dr. Foster does not recall making this statement or any statement similar to it so we cannot clarify what was intended.

I left the first sentence as is, but wonder how much it helps. Below are the questions that I would need to know answers to in order to decide what if anything should be said. How do we know this is true? Is the normal practice for it to be checked? Who normally checks for accuracy?

I'm happy to discuss this if you think it matters.

Thanks again.

Kathy

26TH STORY of Level 1 printed in FULL format.

The Washington Post

April 3, 1991, Wednesday, Final Edition

SECTION: FIRST SECTION; PAGE A1

LENGTH: 1522 words

HEADLINE: Prescription Written in Black and White; Race Clouds Debate Over Nashville's Meharry Teaching Hospital

SERIES: Occasional

BYLINE: David Maraniss, Washington Post Staff Writer

DATELINE: NASHVILLE

BODY:

When he was 2 years old, David Satcher was saved by a black doctor from Anniston, Ala., who visited the Satcher farmhouse and treated him for what the family thought was a fatal case of whooping cough. From that episode, a legend was born. Satcher became known as the little boy who refused to die, and people said his mission in life was ordained: He would grow up to be a great doctor.

Now, at age 50, after mastering his profession and healing the sick in Cleveland, Los Angeles and Atlanta, Satcher finds himself struggling here with the most important medical case of his career. His patient is the school where he is president, Meharry Medical College, a historically black school that, for 115 years, has trained more black doctors than any institution in the nation. One of them was the Dr. Jackson of Anniston who saved Satcher's life in 1943.

The crisis at Meharry centers on its training hospital, Meharry Hubbard, a bright-white tower that was constructed 15 years ago and features modern facilities but too many empty beds. With a capacity of 250, Meharry Hubbard rarely has more than 100 patients. The numbers have been so low that the school lost or is about to lose accreditation for its residency programs in surgery, pediatrics and obstetrics-gynecology. Meharry's financial sheets are falling in the red about $ 5 million each year. All of this is making it increasingly difficult to lure new doctors and professors.

To save the hospital and perhaps the school, Satcher offered what in theory seemed a simple prescription. The city, he said, should close its aging and

equally overbedded inner-city hospital, Nashville General, where 60 percent of patients are white, and move its operations to Meharry Hubbard, where 80 percent of patients are black. Meharry essentially would give the facility to Nashville on condition that the merged hospital would serve as the school's teaching center, allowing the city to cut operating expenses and Meharry to regain sound health.

But things rarely are that simple in relationships between black and white institutions. Satcher's proposal was not conceived as a racial issue, yet, he said, it has brought to a rare public forum many complex and troubling questions that fester in American race relations.

The Washington Post, April 3, 1991

Will white patients go to a black-run hospital? Do Americans believe in integration only when blacks integrate white institutions? Can whites challenge the capability of a black institution without being inherently racist? Is there still a need for predominantly black schools? Can blacks have equal opportunity if denied economic resources to achieve equality? Those are among the underlying issues as the merger proposal, recently rejected by a metro hospital panel, heads toward a showdown vote this year in the Nashville Metro Council.Defining Integration in '90s

"Race is not the only issue involved here, but it is the central issue," Satcher said in a recent interview. "The merger strikes at the heart of what integration means in the 1990s, an issue that America is still having so much trouble with. Integration is not just blacks going to white institutions. It means a distribution of resources."

Those who oppose the merger contend that race has no place in the debate. "This is a business issue and a health-care issue," said William Ralph, a Nashville allergist and member of the board of hospitals that recently voted against the Satcher proposal. "It is not a racial issue and not a moral issue."

Others believe that race is a factor but find it difficult to measure. "There is a general perception that whites don't want to go to the black part of town for service," said Mansfield Douglas, a black member of the Metro Council. "It's a very difficult, imprecise notion, but it's there."

Eugene Fowinkle, vice chancellor of health affairs at Vanderbilt University, said it was hard to make clean distinctions between concerns about quality and race. "Some cried race, and there may have been some racial considerations," he said. "But most of the concerns I heard had to do with quality, not race. I think if we could overcome the quality concerns, we could get this merger accomplished."

Metropolitan Nashville provides a rich context for the debate from all perspectives. The capital of Tennessee, with 510,700 residents, has one of the nation's highest ratios of hospital beds per person. The city's 17 hospitals have 6,000 beds, about 2,000 of which are chronically unfilled. HCA, the massive private health-care firm, is located here, as is Vanderbilt University Medical Center, Nashville's largest private employer with 10,000 employees.

For generations, Meharry was shut out of the Nashville medical establishment. Only six years ago were its doctors granted access to practice at Nashville General. Through the years of Jim Crow segregation in the South, its distinguished doctors were banned from the Nashville Academy of Medicine. Yet

white doctors from Vanderbilt and other nearby hospitals were welcomed to teach and practice at Meharry and traditionally constituted about 40 percent of the faculty, making it the city's most integrated institution.

Within the city, Meharry's primary role has been to provide health care to the black and poor. Axel Hansen, 72, professor emeritus of ophthalmology, remembers that patients in the 1940s and 1950s were so poor that they could not afford to take taxis to the hospital. Undertakers, he said, provided the shuttle service for free or a nominal charge in hopes of getting burial work if someone died.

The Washington Post, April 3, 1991

On a larger scale, Meharry's mission has been more profound. Before the nation's major medical schools were integrated, Meharry and Howard Medical School in Washington trained virtually all of the nation's black doctors. They still produce 25 percent of black doctors. Their graduates are five times more likely than those from other schools to practice in underserved rural and inner-city areas. The predominantly black school also offers places in its first-year classes to minority students whose test scores would keep them out of other schools.

Meharry's Special Mission

"Some people raise the question: Do we need a Meharry when black students can go to a Vanderbilt?" Satcher said, gazing from his fifth-floor office across the Nashville skyline to the massive Vanderbilt complex in the distance. "They completely miss the fact that there are 126 medical schools in this country, and yet Meharry's mission stands out. With black life expectancy declining and less than 7 percent of the nation's doctors being black, this is possibly the most needed institution in the nation today."

Since Satcher presented the merger proposal two years ago, he has gained widespread support. Vanderbilt, which plays the lead medical role at Nashville General and gradually would relinquish that to Meharry under the plan, has endorsed the proposal as an institution, although many members of its faculty are against it. "We have made a conscious and serious decision that a strong Meharry is better than a weak Meharry for the country and this community," Fowinkle said.

The Chamber of Commerce, Nashville religious leaders and federal officials including Health and Human Services Secretary Louis W. Sullivan, Satcher's former boss and mentor at Morehouse College in Atlanta, also have expressed support. "The merger," Sullivan said during a recent visit to Nashville, "deserves every effort to help it succeed."

Board Rejects Proposal

But after two years of study, the seven-member metro hospital board, voted against the proposal earlier this year, despite a task-force report recommending it and an accounting study indicating that it would save money for the city. Board member Ralph and attorney William Willis, the board's chairman, led the opposition, charging that the early reports were based on false or misleading assumptions.

Ralph said that the hospital board had no moral obligation to Meharry and

that he looked at the issue "purely from an investment point of view . . . where do you put your money?" He cited indications that white patients would not follow the move to Meharry, located in predominantly black north Nashville. He also noted a hospital survey indicating that 85 percent of Nashville General's staff would quit rather than move.

Satcher and other black doctors are familiar with the nuances of race in medicine. Satcher's first patient during his residency at Case Western Reserve in Cleveland was a white man who left when he discovered that his doctor would be black, and such racial fear and ignorance persists, he said. Ralph countered that it is not racist to note that Meharry has lost accreditation in several important fields and had difficulty recruiting staff.

The Washington Post, April 3, 1991

"Race and medicine is a topic that most people would prefer not to dwell on," Satcher said. "When you raise the issue they clam up. But this debate has brought Nashville to the brink of truly dealing with race relations. Whatever happens to this proposal, something is happening to Nashville. It is dealing with an issue that very few cities have confronted."

GRAPHIC: PHOTO, DAVID SATCHER

LANGUAGE: ENGLISH

Dr. Alan Rosenfeld

7:30

good consent

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UP
PLEASE
EDIT

Dr. Henry Foster
Nominee for U.S. Surgeon General
February 10, 1995

A few weeks ago, hardly anyone outside Nashville, Tennessee knew anything about a man named Dr. Henry Foster. But after President Clinton announced his intention to nominate me for Surgeon General on February 2, it seems like everybody thinks they know everything about me.

It has been a turbulent two weeks, but my experience as a doctor has prepared me for this. For the past 38 years as a doctor, a teacher and a crusader against teen pregnancy, I have come face to face with real life and death challenges. When you see low-weight babies born to mothers barely old enough to drive a car, you have an appreciation of what trauma is all about. When you visit the homes of families living in grinding poverty and feel the palpable sense of hopelessness in their lives, you begin to know what being up against the odds really means.

Compared to that, shouted questions from swarming reporters and overwrought language from my opponents has not been all that hard to handle. But at the same time, it has been difficult and more than a little uncivil. It's certainly not we treat newcomers in Nashville.

Two weeks ago, no one, not even my wife St. Clair, my daughter Myrna and my son Wendell -- as devoted as they are -- followed my every move and my every word with rapt attention. Now, when I wake up in the morning and look out my window, the press is out there waiting and watching. When I go to my office, they follow me right into the elevator. And walking down the street, I have been punched in the face, inadvertently I think, with one of those huge microphones you see on t.v. I have never seen anything like it.

I have even picked up a new lexicon. The words that matter in Washington are not even in dictionaries in the rest of the country. Sound bites. Boom mikes. Stake outs. B-roll. Live shots. Talking heads. On-air analysis. Op-eds. They certainly never taught me those words in medical school or the hospital. It's bewildering to see yourself dissected over and over again.

People who have never met me analyze my character and my life's work. They attack me personally before they ever give me a chance to introduce myself or tell my story. But those attacks do not define me. I know who I am and what I stand for. I also know that I am a symbol in a larger debate that has polarized this country for many years. But the attacks do hurt.

So, you may be asking yourself, "Why do I want to be Surgeon General?" Let me tell you.

When you've had the good fortune to participate in the miracle of birth as many times as I have, it is difficult to stand on the sidelines and watch so many people wasting the precious gift of life.

It is difficult to look around America today and see so much needless suffering. Too many children suffer, because their parents have not been taught the value of prevention. Too many people don't have access to quality health care. And too many of us have turned away from those basic American values that can prevent violence or abuse of any kind from taking root.

But all is not lost. America is moving forward to confront both our health care crisis and the crisis of values that has led to far too much irresponsible behavior. As your Surgeon General, I believe I can turn the small ripples of success that we have produced into great waves of progress. I believe that I can draw attention and help develop lasting solutions to the tragic public health problems confronting us -- from the epidemic of violence to the spread of AIDS to the terrible problem of substance abuse. But I will be giving my greatest attention to what the President has called "our most serious social problem," the epidemic of teen pregnancy in this country.

I have some ideas about how to solve this problem. We are reducing teen pregnancy in the Nashville housing projects through "I Have a Future" -- a program we started at Meharry Medical College back in 1987. Our approach is to expand adolescent health care programs beyond the schools, and bring them to the community, where they can become a part of the fabric of everyday life. With an emphasis on abstinence and the involvement of the entire community, we have begun to replace a culture of hopelessness with one that gives young people clear pathways to healthy futures.

Since the President asked me to take on the job of Surgeon General, I have been in the fight of my life. But my fight is no tougher than the one I'm asking all Americans to join. That's the fight to improve the health of all citizens and to prevent teen pregnancy.

In my work with young people in Nashville, there is one lesson I stress above all others. To break the cycle of despair, you must learn that there is a reward for sacrifice. And earning that reward has a fringe benefit. It allows you to give something back. That is a hard lesson to learn, but it is one that has kept me going through these difficult weeks. Having President Clinton place his faith in me is something I could never have imagined as a young boy growing up in Pine Bluff, Arkansas. Now, I want to give something back to a country that has rewarded my work and sacrifice, and God willing, I'll have that opportunity.

fax to 456-1647

DRAFT

CALL OGC/HSR 690-7741

Question: Did Dr. Foster participate in a Prostaglandin study reported in May 1985 in Obstetrics & Gynecology?

Answer: Yes. Doctor Foster was the principle investigator in that study. It was a research project carried out in an academic setting at Dr. Foster's hospital which is a teaching hospital. Research is routinely done at that hospital.

Question: Describe the study.

Answer: The federal government [FDA] approved this stage three level of testing a prostaglandin drug for use as an alternative to surgical abortion. The research was designed to test the safety, efficacy and patient acceptability of the pharmceutical product.

Question: Who were the patients in the study?

Answer: They were sixty pregnant women who were in the early stages of pregnancy. All but one of the women were 49 day (seven weeks) or less pregnant; one patient, who had miscalculated her menses, was 56 days pregnant.

Question: Were there any deaths or serious side effects of the study?

Answer: No. Moreover, only four of the woman required an invasive procedure follow-on to the administration of the prostaglandin. All of them experienced the expected outcome. One patient chose to carry her pregnancy forward and thereafter delivered a normal child.

Question: What was Dr. Foster's role in this study?

Answer: This was a research project, and Dr. Foster was the principle investigator.

Question: Did Dr. Foster personally administer the prostaglandin to the women?

Answer: He is unable to recall whether he personally administered suppositories to the women, though he believes he may have done some. The remainder were probably administered by residents on his obstetrical and gynecological service at the teaching hospital.

GEORGETOWN UNIVERSITY

Joseph & Rose Kennedy Institute of Ethics
National Reference Center for Bioethics Literature

FAX 202-687-4148

FAX COVER PAGE

DATE: 6 Feb 1995

TO: Harriet Rabb -
per request of Richard Riseberg

FROM: ANITA NOLEN

FOR ASSISTANCE CALL 202-687-4150 or 202-687-6392

NUMBER OF PAGES TO FOLLOW: 19 pages
(may come in more than 1 transmission).

parents? In other words, you know, both parents may be carriers, but only one may show the polymorphism and the other may not. Is it a requirement for both parents? Do you recall?

MS. MISHKIN: My understanding is that it is not going to be a reliable test through anniocentesis unless both parents show the polymorphism.

DR. FOSTER: Now, the next question I have -- and then I will make my comments -- now, I read the research proposal, and I missed this delay. That bothers me a little bit, first. I have got to really clear that in my mind.

I have done a lot of anniocentesis and therapeutic abortions, probably near 700. As I read the protocol, the patient would be brought in the hospital, and that would be a 24 hour delay, which was not inordinate, based on the information that we have. It is very reasonable. But the clinical part, a catheter is introduced into the amniotic cavity, and that is the time when the fetus is studied, the blood vessels, and the sample is taken. Then the fetoscope is withdrawn, but the catheter is left in place, which is quite acceptable. In fact, this is one of the techniques we use for continuous prostaglandin infusion.

But there gets to be a real question with regard to infection after a 24 hour period with an indwelling

connection to the outside. I missed the entire reviewer's section about some extension beyond 24 hours, and if there is an extension of observation beyond 24 hours, does it involve the catheter being in place? This would be critical in my mind.

DR. MCCARTHY: Yes, it certainly does.

DR. FOSTER: I think that is something that really needs to be addressed in terms of the details of the research.

MS. MISHKIN: I am frankly bothered by anything coming as far as to the Ethics Advisory Board through all those reviews without this being quite clear. It was in the site visit review, and it was because of the ambiguity that I called the principal investigator.

Now, Dwayne Alexander was working on the application in front of him, and so he really addressed only the 24 hour delay. But because of the ambiguities I did call, and the investigators do intend to go to two weeks. I think it might not be inappropriate for the Board to make some strong statement about wanting to be clear on what the procedures proposed are here.

MR. LAZARUS: I wasn't clear either on the consent procedures.

DR. FOSTER: That doesn't come through. But the one thing I do want to say, and then I will get to the other

points I want to make about what all of the implications of fetoscopy are as I see it. I do think a longer observational period is an acceptable research modality provided safeguards are there. We have already talked about extending beyond the 20 weeks. That can be controlled for fairly well with ultrasonography for establishing fetal age, and a few other things. But I think you might want to consider the observation period without the catheter in place, because repeated amniocentesis has proven to be relatively safe in terms -- the danger is in leaving a conduit for bacterial migration.

So what I am really saying is I can see the investigators making a justification for an observation period of longer than 24 hours, but I find it a little difficult at this point to see that justification with an indwelling catheter in beyond this point.

And now I think the things we need to be concerned about irrespective of what we ultimately recommend in terms of going back or whatever. There was very, very strong community support for this proposal. Anyone who read the type of support, and the rather incisive and critical questions, I thought, that the community asked in regard to many of the social and medical implications. I think it is keen that we remember that there have been so many charges of disregard for ethic

makeups of our research, genocide and all the issues, if this is an indigenous decision by a community, I think we need to give that great respect, because it is a justification for us to say this is a decision that you made. If we say to the community no, we shouldn't do this, the community in a sense has a right to say you are willing to impose certain things on us externally that we feel are an abridgment, but here when we see something clearly directing us, you deny it. So that is something that has to be considered strongly in terms of sociology.

I think another thing that is very important from what I know about this -- Drew has been one of the few centers that had federal support prior to the moratorium in 1973, I believe, involving aborted fetal subjects on the research, has gone through the steps of animal experiments. They have used the ovine model very well with sheep and I think we certainly have to give that some accord. They have gone through all the steps prior to using humans.

Now, the implications of Kan's work I don't need to go over. You have made that very clear. So I will move on to my fourth point.

Mitch Spellman makes this point a lot, and it is a good point. There is a basis for basic research with regard to doing fetoscopy, irrespective of Kan's work.

There is a basic need. Now, I am going to go slowly and really try to make this point.

Kan's approach right now is the acceptable one. It is a reaction. It is an after-the-fact approach. It gives us an option simply to abort a defective pregnancy. Basic research will afford us a much broader and brighter horizon, might I add. And that is the possibility of diagnosing the defective fetus and then preventing the development of sickle cell disease in that fetus.

Now, I will try and paint a picture. In utero, for all of us normally, there is a different set of protein in two of the chains of our hemoglobin in early fetal life. The normal hemoglobin molecule has four chains, two upper alpha chains, which are proteins in a set sequence, and two lower, somewhat larger, beta chains in a set sequence.

The only difference between one who has sickle cell hemoglobin and a normal person is out of 184 amino acids in one of those chains, and that is in set sequence, there is an exchange of valine for glutanic acid, in the sixth position from the end. One of 184 chains. That is the only difference. But because of this change in the chain, certain physical and chemical defects, as you may call them, are imparted into the hemoglobin. It makes it less stable. Its ability to hold and release oxygen is affected. The stability of the red cell membrane is affected.

It changes its pattern of migration in an electrical field. This is how we do our hemoglobin electrophoresis.

Back to in utero, none of us has these beta chains when we are developing. We have another chain called a gamma chain, and that gamma chain is provided for through a mechanism which we yet do not fully understand, and this is where our basic research should continue. There are repressor genes and activator genes. Rarely, through chance, some people who were destined to have sickle cell disease never develop it. But they continue to make the gamma chains which make fetal hemoglobin throughout life, even in the postnatal period. And these people have absolutely no trouble. That is the ideal situation for the sickle cell person, is to be able to find that mechanism that will prevent the turning on of the activator genes from going from gamma chains to defective beta chains. So there is a clear need for this kind of research in spite of the work by Kahn and his group.

It is at this basic step where not only will we be able to diagnose the child destined to have sickle cell disease, but indeed, to prevent it. So I think that alone justifies continuation of this basic research approach.

Lastly -- well, that includes -- I wanted to say something about the basic science of the molecule. So there

is a real horizon out there that has to be untapped, and that is the ability to diagnose the abnormal hemoglobin, but not by default to get rid of the fetus. That is the thinking that if you want to prevent forest fires, cut down all the trees. I want to take a different approach. I want to see can we afford this fetus that was destined to be one thing, that our basic research will continue to allow us to do something about it.

So I just wanted these thoughts to be in the back of our minds, particularly in light of Kan's recent work as to the obsoleteness of this continued basic research approach.

MS. MISHKIN: Is the research to develop that therapy now ready for pursuing through fetoscopy now, or does one have to wait for more development in animals and other methods before you actually go to fetuses in utero?

DR. FOSTER: I think I understand your question, Barbara. Are you saying is our technique to such a point that we can go ahead with just the technique of amnioscopy?

MS. MISHKIN: No, I am asking whether one would endorse the Drew application today on the basis of the need to develop the prenatal therapy, or are we not yet there with respect to the therapy, with the animal work and so forth?

DR. FOSTER: I think the animal work has been done

I think that has been satisfied.

MS. MISHKIN: There is one other thing I forgot to mention on the risk benefit analysis, and that is the concern about using fetuses to be aborted. There is not much direction in the HEW regulations on this matter, but the Commission came down to a guideline that may or may not be useful for you, but I think it has some merit. That is, they felt that it was ethically acceptable to perform procedures on a fetus to be aborted if one would feel ready to perform those procedures on a fetus intended to go to term.

In other words, if one had done all of the animal work, including primate work, which they have done in this case, and if they were unable to do it on fetuses to be aborted to further assess the risk, if they would be willing then to go forward therapeutically with it on fetuses going to term. That condition has been met in this case, because there are apparently several groups who are performing amniocentesis on fetuses intended to go to term.

FATHER MCCORMICK: Fetoscopy, you mean?

MS. MISHKIN: In fetoscopy, yes.

MR. GAITHER: In somebody's judgment.

MS. MISHKIN: I mean the condition of its being performed on fetuses going to term has been met, and the

question is whether or not that meets your feeling of acceptability for performing the procedure on fetuses to be aborted. But this procedure is being performed on fetuses going to term.

MR. GAITHER: Can I just ask for some clarification, first? One, what are the purposes of this particular protocol? Is it particularly experience and safety, or does it get into the basic research questions that Dr. Foster was mentioning?

MS. MISHKIN: My understanding of the protocol is that it is to assess the risks of infection, of bleeding, of premature abortion, and so forth, that are attendant with fetoscopy. Now, Dr. Alexander also sees an additional benefit, which is developing the competence of the investigators to perform the procedure prior to trying to do it on fetuses going to term. That also is included. That is not the primary purpose of the application as written. The application is to determine with somewhat better certainty the risks involved to mother and fetus.

DR. FOSTER: And a part of that is improving the technique. It is not basically designed to go into a specific basic research question. As I understand it, it is what Barbara says, to assess the safety and to improve the technique. That is going to evolve from that. And that is one of the reasons I feel they are asking for a

somewhat longer observation period, because if you do the procedure and then proceed directly to the termination, you would deny some of the longer term effects, delayed bleeding and the like.

MR. GAITHER: Two further points of clarification, and then I will open the discussion. The work that is presently going on at Yale and the University of California, has that been subjected to these regulations and approved, the distinction being that it was therapeutic, that is, regarded to be of benefit to a possible child, and that is why it is different, or not? Do you know what the status is?

MS. MISHKIN: I am not entirely clear. My understanding is probably not with respect to the Yale group, because I do not think that is funded by HEW. I believe that is the information we got from Jerry Mahoney just recently. But as you know, the regulations are somewhat ambiguous with respect to whether or not research conducted at an institution but not funded by HEW must be reviewed by the IRB, and also subject to the same review standards. So it is a somewhat unclear point with respect to the Yale group.

DR. MCCARTHY: It is perfectly clear that the Yale group felt obliged under Section 474(b) of the Public Health Service Act to have Dr. Mahoney's research involving

fetoscopy reviewed by the IRB. They also made the interpretation, which I think is a reasonable one, although not the only possible one -- they made the interpretation that they need not review according to HEW standards. And in fact, there is some question in my mind as to whether Dr. Mahoney's work would have been acceptable under HEW standards, because I think they regard this as more than minimal risk -- not a great deal more, but somewhat more than minimal risk. Therefore, if they had followed our standards, his work would have had to come to the Board. Because it is not funded by HEW, they decided they could make that decision and they have made it and are carrying out that work.

MR. GAITHER: There would not have been a distinction based on their work being therapeutic and this work not, because of the abortion?

DR. MCCARTHY: No. As I understand it, initially they -- and I am not quite sure at what phase they are in. They have planned a series of steps, the later stages of which they intend to be therapeutic. As I understand it, they are still in the diagnostic phase of those steps, but I believe their approval goes all the way to -- assuming all the other stages are carried out with no untoward events -- they intend to go all the way to applying fetoscopy to therapeutic interventions to try

to assist fetuses that are in one way or another abnormal.

MR. GAITHER: Mr. Lazarus?

MR. LAZARUS: I think one of the key issues in this request is the problem of risk and how it is presented to the patient. Barbara says in her note that the risk presented by research cannot be characterized as minimal. Rather, it should be considered undetermined. And yet, the patient consent states that "I have been advised that these risks are minimal to me and to my fetus."

I think that one of the items that must be clarified is the whole consent procedure, and the nature of the risk must be spelled out a lot more consistently than they are spelled out under the present consent procedure that has been presented by Drew.

MS. MISHKIN: I think one of the problems is that minimal risk, as I pointed out, is not defined in the HEW regulations, and in the Commission's report and its deliberations, that was a problem in two areas. At one point they indicate -- and they indicate more strongly in subsequent reports -- that risk which has not yet been determined should not be classified as minimal, but should remain under the categorization of undetermined.

On the other hand, there were some Commissioners, although not all of them -- there was a difference of opinion on this point, as to whether when you are talking about a

fetus to be aborted, one can consider risk of abortion as a minimal risk to that fetus, whereas one would not consider risk of abortion a minimal risk to a fetus intended to go to term. This was one of the very difficult points where there was a lack of consensus among the Commission members.

So I think that when the IRB and the various people who reviewed the Drew application determined that it was minimal risk, that was not a clearly unacceptable determination. It was simply their interpretation, given very little guidance from the Department as to how to assess and categorize that risk.

MR. LAZARUS: It would seem to me, though, that a patient's consent is very important with the nature of the risk, which is undetermined. It should be very carefully spelled out.

MR. GAITHER: Particularly when one is conducting the research for the purpose of finding out how risky the procedure is.

MR. LAZARUS: Right.

MR. HALPERN: Underlining the illogic of the word "minimal" where you are saying we don't know what it means, well, the problem is it is in our HEW regulations, and if in fact the risk is minimal as the patient is told, it wouldn't be here.

MS. MISHKIN: That is right. It would not be before this Board if the risk were minimal. Then the IRB could have approved the project by themselves, although there is another provision that would need a waiver, so it probably would come here anyway. That is, the regulations currently provide that there be no change in timing or procedure of an abortion for research purposes that would add any additional risk, and that provision does not say "that would add more than minimal risk," but that "would add any additional risk." So it might have had to come here even so.

DR. MCCARTHY: But the determination , the very point that Mr. Lazarus made, was picked up in the Office for Protection from Research Risks, which refused to -- even though it had been reviewed by all of the subsidiary bodies -- refused to go ahead and fund until and unless it had been approved by this Board.

So it is that very point: If you are doing research to assess risk, it does not seem possible then to prejudge the outcome by calling it minimal. It may turn out to be minimal, but there is no justification for the research if you already know it is minimal.

MR. LAZARUS: And you are getting your consents under a false clause.

DR. MCCARTHY Yes, and I think the Office for

Protection from Research Risks was correct in making the judgment that it should come before this Board to comply with HEW regs.

MR. GAITHER: Yes, Dr. Henderson?

DR. HENDERSON: Let me just carry that a little further. One of the important criteria here is that the research is important and justified. I think this is what is indicated. Clearly we have got investigators who are very competent people and they have obviously proceeded step by step in reaching the point they have.

I guess there are a couple of thing in my own mind that are rather unclear. There are two centers where the work is being done now, Toronto and New Haven, where the risks now appear to be rather small. I think this is perhaps where the statement is that it is probably a minimal risk, that experienced people following along with two other centers, and doing what I interpret or what I understand is the same procedure that they are doing in New Haven and Toronto.

The question I guess I have, then is is it necessary to fund yet a third center? Should HEW fund a third center to be doing this? What are the advantages?

The initial point here, as they say, initially it is limited to an assessment of the safety. I find that fully justified to go -- initially one is doing a study to

assess the safety. But then I ask what is the ultimate objective, because we want research which is important and justified. What is it that it is leading to? Obviously there is an objective here.

I believe, as I interpret it, that they would hope to be defining sickle cell disease. Now, I think in talking with you earlier, the question is can you identify either the sickle cell trait or sickle cell disease before 30 weeks? Can you define it at this period in time?

Perhaps we are talking about, as you mentioned earlier, longer term basic research, which requires this technique to be used. Is it enough to say that it is important that we do longer term basic research employing this technique without defining what is that basic long term research, and are we at the point now to approve of this sort of application which is based on safety, for some sort of ill-defined subsequent future, when in fact we are supposed to be judging this that the research is important and justified.

Now, it is obvious that there are a lot of very good people who have looked at this, and I am asking the questions, I would say, out of ignorance, because I found some contradictions here which I am having trouble with.

FATHER MCCARTHY: Do you want to respond to

that, because I have got a different point I want to raise.

DR. FOSTER: Well, yes. I tried to make some of them and I will try again. I think there are quite a number of justifications, Don, for continuing. One of the biggest reasons -- I think the assumption is not completely correct that this work is being done at the other centers. I don't think there is anywhere the proportionate interest in sickle cell disease at either other center, nor is there the particular population base in either other center to be able to address this effectively.

Even if Kan's work proves to be what it is purported to be, based on what Ms. Mishkin has said, we are still left with 15 percent of a large population that is at great need, as you are probably aware. About eight percent of the blacks in this country harbor the sickle cell trait, and that is 2.5 million people, and 15 percent of that is a large part of the population.

So I think there is still in our current state of the art to continue to try and be able to diagnose sickle hemoglobinopathies prior to the 30th week. I think there may be ways that we can do it. As yet we can't do it very reliably.

So I think the justification for continuing this work is clearly there. The justification may not be

as strong as it was, but I certainly think it is within the realm of acceptability. This is what I personally feel.

Let me say one other question while I have the microphone. Let me address one other question regarding therapy versus research. I have not seen the research proposals that John Hobbins had at Yale, or what Kan has done at USC. But I do know that a lot of their fetoscopy work was therapeutic. The work on thalassemia was clearly therapeutic. It was done for the same reasons that we do amniocentesis, to decide whether or not the pregnancy should continue, and to provide a therapeutic abortion. In fact, I know much of that.

Hobbins' most recent article, which I believe was December of last year where he had, as I recall, about six or seven patients with sickle cell disease which he was working with. These were all therapeutic. He had tried to make a determination as to what type of hemoglobinopathy, whether it would be homozygous or heterozygous around the 22nd week, and the results were just inconclusive. His conclusion at the end of the article was that at this point we still can't do it. But that was clearly done to be therapeutic. Had he felt that he could have made the determination, he would have offered therapeutic

abortion. So I do know that some of the work has been therapeutic.

DR. MCCARTHY: That is correct. I should amend what I said. I think what Mahoney is doing is now tending to move into the preventive therapy and not -- so I would like to amend what I said before about therapy, because it was clearly for the purpose of giving parents the option of a therapeutic abortion. But now they hope to move into preventive therapy, which is the sense in which I was using "therapeutic."

MR. GAITHER: Is there an answer to Dr. Henderson's question, though? Do we know whether this technique will enable the researcher to determine the presence of the sickle cell disease?

DR. FOSTER: We never know that until we do the research. I mean, no, I don't think we know it beforehand.

MR. GAITHER: I think that is kind of a fundamental point here, because implicit in all of these papers, it seems to me, is precisely that, that this technique will enable the discovery of whether or not the disease is present. The question is whether it can be safely done. Now, if that is wrong, my whole reading of all of these papers is very much mistaken. I think it is a very fundamental point.

January 31, 1995

MEMORANDUM FOR BETH NOLAN
ASSOCIATE COUNSEL TO THE PRESIDENT

MARVIN KRISLOV
ASSOCIATE COUNSEL TO THE PRESIDENT

FROM: Stacy Reynolds SR
Office of Counsel to the President

SUBJECT: Results of Follow-up Interview with Dr. Henry W. Foster, Candidate for Surgeon General

I conducted my initial interview with Dr. Foster on January 26, 1995. On January 31, 1995, I conducted a follow-up interview to ask Dr. Foster to respond to certain aspects of the articles and speeches by him as well as items revealed in the public record research. This memorandum contains a synopsis of the issues and Dr. Foster's responses to those issues. To conserve time, I have inserted Dr. Frost's responses after the relevant portion of the public record vet.

Clinical Trials for Non-invasive Abortion Technique

PUBLIC RECORD VET:

The May 1985 issue of the AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS published the results of a clinical trial performed under the supervision of Dr. Foster at the Department of Obstetrics and Gynecology, Meharry Medical College, Nashville Tennessee. The study tested the use of naturally occurring hormones to induce abortion. The study was developed to evaluate the safety, efficacy, and patient acceptability of non-invasive abortion by inducing menstruation after conception by using vaginal suppositories in the early stages of pregnancy. Of the 60 subjects, fifty-eight of the patients were African-American and two patients were caucasian. All women were 49 days (seven weeks) pregnant with the exception of one woman who was actually 56 days (eight weeks) pregnant due to a miscalculation on her part. The report specifically noted that "because gestations were so early ... the passage of identifiable fetal tissue was not a usable endpoint." Accordingly, the study based therapeutic success of the drug on sustained menstruation and a decrease in a hormone found in pregnant females. The study resulted in 55 successes under the test criteria. Four persons required hospitalization and one patient withdrew and gave birth to a male infant. The study noted that simplicity of administration, avoidance of uterine instrumentation, and increased cost efficiency were potential advantages of the early abortion technique.

RESPONSE:

Dr. Foster stated that he had three responses to this: (1) The abortion procedure was a therapeutic measure; (2) He was in charge of a medical school with a residency program so he had an obligation to provide opportunities to teach the residents; (3) The study was an FDA approved trial.

On Abortion

PUBLIC RECORD VET:

In "Clinical Management: Sickle Cell State and Pregnancy," published in the March 1977 URBAN HEALTH, Dr. Foster wrote about the procedures used in his unit at Hubbard Hospital of Meharry Medical College and revealed that the pregnant sickle cell patients were "advised of the availability of pregnancy termination," which his unit performed into the second trimester.

Dr. Foster co-wrote "Reproductive Performance in Women with Sex Chromosome Mosaicism," published in the May 1980 OBSTETRICS AND GYNECOLOGY. The article addressed naturally occurring, spontaneous abortions. However, the final sentence stated that subsequent pregnancies of couples with a history of such spontaneous abortions should "be monitored by amniocentesis in such case so that abortion can be available for genetically abnormal fetuses when found."

Similarly, in a chapter Dr. Foster co-authored in the book Hematologic Problems in Pregnancy, he advised that "the couple [who are potential carriers for the genetic disorder thalassemia] must be provided with genetic counseling and offered antenatal diagnosis, with the option of pregnancy termination." The article did point out that certain types of this disorder result in fetal death in utero.

Also, in "Sickle Cell Anemia Not a Risk for PTL," published in the Fall 1991 ASK THE PERINATOLOGIST NEWSLETTER, Dr. Foster wrote that the ability to ascertain fetal hemoglobin status allowed for genetic counseling and, thus, the option of termination.

In his article, "Contraceptives in Sickle Cell Disease," published in the May 1981 SOUTHERN MEDICAL JOURNAL, Dr. Foster characterized abortion as a "contraceptive measure." But, he did state, "The use of abortion solely as a form of contraception, though acceptable in some parts of Europe, has not become prevalent in the United States. Clearly this would not be ideal in sickle cell disease."

In "Managing Sickle Cell Anemia in Pregnant Patients," an article by Dr. Foster published in the December 1980 CONTEMPORARY OB/GYN, Dr. Foster argued that, although pregnancy poses a significant risk to the mother with sickle cell anemia, the

decision to risk pregnancy is a viable option for those women. However, he continued by saying, "For patients who choose not to take this risk, the option of elective abortion must be available." Dr. Foster later explained that he prefers his patients use barrier contraceptives and have the option of "therapeutic abortion when contraception fails." Dr. Foster reasserted this idea in his article, "Contraceptives in Sickle Cell Disease," published in the May 1981 SOUTHERN MEDICAL JOURNAL.

In "Abdominal Pregnancy: Report of Twelve Cases," co-written by Dr. Foster and Dr. Donald T. Moore and published in August 1967 in OBSTETRICS AND GYNECOLOGY, the authors wrote that prompt termination of the pregnancy is the proper course of action in the case of abdominal pregnancy. However, they also recognized that in five of the twelve pregnancies observed, the baby was born, but died shortly after birth, and that another three of the twelve carried living fetuses to 39+ weeks, of those, two were completely normal and survived.

RESPONSE:

Considering the number of articles, I asked Dr. Foster to respond to more general questions about abortion, performing abortions, abortion as a contraceptive, and abortion after genetic testing. Dr. Foster stated that he definitely supports abortion in the case of rape, incest and threat to the health of the woman. He emphasized that abortion is legal. Dr. Foster stated that he has performed therapeutic abortions. He did not recall performing any purely elective abortions. He denied saying that abortion was a contraceptive measure but admitted that he could be taken out of context to that effect. He stated that abortion has been used in Europe (particularly in Germany) as a contraceptive method but that such use has never been accepted in the U.S. and he would not advocate it. Finally, as to genetic testing and abortion, Dr. Foster stated that Meharry has the capacity to perform antenatal diagnosis earlier than amniocentesis. He said it is up to the patient to decide if she wants to carry a child tested to possess a genetic disease to term or to terminate the pregnancy. According to Dr. Foster, most patients choose to have the baby. However, Meharry will perform the abortion if the patient chooses that route. Dr. Foster stated that he has never performed an abortion on a woman who chose to abort based on the genetic testing, but that he would have an obligation to do so if one of his patients so chose.

On Sterilization

PUBLIC RECORD VET:

Dr. Foster wrote "Removal of the Normal Uterus," published in the January 1976 SOUTHERN MEDICAL JOURNAL, in which he stated, "Recently, I have begun to use hysterectomy in patients with severe mental retardation. Hysterectomy can be done either for sterilization or to eliminate the menses, which is of significant hygienic benefit to these

severly [sic] handicapped individuals."

RESPONSE:

Dr. Foster stated that this quote was referring to one patient he had who was severely retarded and had cerebral palsy. He said she was a ward of her mother and the mother consented to the operation which he said was medically necessary. Dr. Foster explained that the woman broke out due to menstruation and suffered from bed sores and ulceration as a result. He stated that he would only perform such a procedure if it was therapeutic. He would never agree to sterilize a woman, even with the consent of her guardian, if there was no other reason than because she was handicapped. He did not see this as any different from a normal woman who asked for a hysterectomy or from a person who is mentally retarded who receives life saving surgery with the consent of his or her guardian.

PUBLIC RECORD VET:

"Meigs' Syndrome Complicated by Pregnancy," an article by Dr. Foster published in the September 1971 JOURNAL OF THE NATIONAL MEDICAL ASSOCIATION, reported a case involving a rare type of tumor on a pregnant patient's ovary. In the article, Dr. Foster mentioned that the patient was a 35 year old unmarried black woman who was the head of a two-room, four child household, unemployed, and not on Welfare. Upon explaining that the patient's pelvic organs had to be totally removed, Dr. Foster added, "The dismal social history made this decision just a bit less difficult."

RESPONSE:

Dr. Foster stated that he believed that the woman would be put in a better condition to better care for the children she did have and that this was something the woman wanted but could not afford otherwise. It was a side benefit to her. Dr. Foster assured me that he would not do this without a medical reason.

On Family Planning

PUBLIC RECORD VET:

In April 1972, Dr. Foster participated in an Emory University symposium, Family Planning In the South. Dr. Foster gave a presentation entitled "A Rural Hospital and Family Planning." In his presentation, Dr. Foster addressed problems of family planning in a rural setting and a black physician's views on family planning. In his speech, Dr. Foster stated that, "[i]n recent years, there has been an outcry by various groups that the intent of family planning is black genocide and that the ultimate effect will be black genocide." He agreed that, "these apprehensions are quite understandable and often not

without foundation." In discussing this sentiment, Dr. Foster recounted a June 1970 meeting of the First National Congress on Optimal Population and Environment which invited participants including 45 blacks representing moderate black institutions. Dr. Foster noted that after the Congress convened the black participants formed a caucus which, "observed that the Congress had been derelict in obtaining significant black input to reflect black interest, and that the purpose of the conference was to use those delegates invited to legitimize a preconceived plan of vicious extermination." Dr. Foster believed that some might find the views irrational, as he recognized that, "the majority of this country's health providers have never even in the vaguest way planned a program of genocide for black people." He continued explaining that, "what has occurred, ... is that many well intentioned family planning programs have been set up for large segments of our black population without adequate consideration of many other factors." Dr. Foster concluded that "the end results of far-reaching family planning programs can have very disastrous consequences for black people. Nonetheless, I support family planning but this support is of necessity, conditional."

In addressing the conditions he would place on family planning, Dr. Foster emphasized that programs should be voluntary and that coercive family planning programs should not become national or local legislative policy. Dr. Foster felt that family planning should be voluntary and that coercive sterilization laws, if enacted, would amount to social welfare legislation which would remove the right of women on welfare to have children.

RESPONSE:

Dr. Foster explained that this speech was given at about the same time that people learned about the Relf sisters in Alabama and other women in South Carolina who were sent to be sterilized on the threat of losing their welfare benefits. He said that there was no structured, definitive plan to commit genocide but that many efforts to control fertility result in a sort of genocide by not taking into account the concomitant need to provide support (i.e. vaccines) for the existing children. He said that a high birth rate is often associated with a high infant mortality and that both problems need to be addressed, not just the birth rate. Dr. Foster said that he believes in educational programs, not coercion, in reducing the birth rate.

PUBLIC RECORD VET:

In his speech, Dr. Foster also pointed out that family planning programs are based on the erroneous assumption that there is a common national life style and, accordingly, blacks should be included at meaningful policy making and administrative levels when providing family planning services for black people. He stated that "to those that are deprived socially and economically the procreative processes often become the only fulfilling life experience available. To curtail or remove this avenue of expression is often tantamount to taking away the only need for existence....Every human being has the need

to feel creative."

RESPONSE:

As to the common national lifestyle, Dr. Foster stated that there is no common national lifestyle because we live in a heterogeneous society. As to the rest, Dr. Foster stated that everyone wants a sense of importance and of being needed. He said that, where there are no other options, teens will have children to achieve this. His emphasis is on providing teens with other options in order to delay this. He mentioned the efforts of his I Have a Future program, discussed later. Dr. Foster stated, "Procreation is a very creative thing." He believes that procreation is a method of expression of creativity and wants to show people that there are other methods of expression, such as education.

PUBLIC RECORD VET:

In discussing family planning in rural areas, Dr. Foster stated that "rurality is characterized by a relatively unsophisticated folk culture and at times is actually primitive." Dr. Foster recognized that the social organization of family, religion, government, and education reflect the deprivation caused by cultural, geographic, and economic isolation. He blames the isolation and resulting unsophistication as the reason the "rural psychology is strongly oriented to fatalism which...explains their strong resistance to any alteration in reproduction and reproductive process." Dr. Foster found a common genesis between delivery of family planning services to minorities and rural areas and noted the value of family planning but stressed the need to know the difference between family planning and population control.

RESPONSE:

Dr. Foster stated that this is true. He has been there. When he talks about "rurality," he is talking in the aggregate and he definitely realizes that individuals may not necessarily fit the mold. He kept referring to the fatalism of rural people.

On Affirmative Action

PUBLIC RECORD VET:

In a speech entitled, "Reaching Parity for Minority Medical Students: A Possibility or a Pipe Dream?" presented by Dr. Foster to the 105th Meeting of the Association of American Medical Colleges on November 1, 1994, he addressed the problem of lack of parity for underrepresented minorities in medical school, why the problem exists and how to change it. Dr. Foster stated, "This nation has a moral obligation to effect equal access to educational opportunities for all of its citizens." Dr. Foster acknowledged that there had been improvements in the numbers of underrepresented minorities in medical school,

but argued that the improvement was not enough and was moving too slow. He also argued that part of the problem was not just the number of minorities starting medical school, it was also the attrition of minorities in medical school. One of the problems Dr. Foster identified as causing the attrition was dismissal for inadequate academic performance. Dr. Foster blamed this on the inadequate preparation for the rigor of premedical curriculum that began in kindergarten and progressed through college.

As far as solutions, Dr. Foster stated, "What is needed will not likely occur and that is a domestic 'Marshall Plan.' The best teacher-pupil ratios should exist in the inner city rather than the reverse. The welfare system which now exists should be scuttled forthwith." Dr. Foster went on to advocate more modest efforts that were already in the works, including increasing the numbers of minority first-year medical students to 3000 by the year 2000, recruitment efforts involving cooperation between medical schools and undergraduate colleges, identification and recruitment of qualified college students who opt not to go to medical school, creating health sciences magnet schools in high schools with a high minority enrollment, and development of health sciences programs in existing high schools.

RESPONSE:

As to the moral obligation to allow equal access to educational opportunities, Dr. Foster stated that "opportunity" is the key word. He said there was no obligation to pay for education but that everyone must be provided the opportunity to get an education. He said this is true because it is the right thing to do. Dr. Foster did explain that public education at lower levels must be provided and that it strengthens the nation. In order for a nation to remain strong, it must maximize the educational potentials of its citizens. Thus, he argues that there is a need to "strengthen the pipeline." This will help reduce the attrition of minority students at medical schools. Another thing Dr. Foster spoke about in helping minority students is to teach them "operative English." He explained that his program approaches it by telling the students that they should become bilingual, speaking "Ghetto-English" and operative English. This approach avoids the negative judgement of telling people that they (and by inference, their family and friends) do not speak properly.

As to solutions, he reiterated that he is for a "domestic 'Marshall Plan'" but that no fiscal plan would permit it. He said that inner city schools are behind and that better teacher-pupil ratios are needed to catch up. Once they catch up, he would be happy to return to the current levels.

On Labor Law and Pregnant Women

PUBLIC RECORD VET:

In his Presidential Address to the Association of Professor of Gynecology and

Obstetrics, March 4, 1994, Dr. Foster generally defended the importance of OB/GYN clerkships against attacks by some people who were advocating taking it out of the required clerkships. In the speech, Dr. Foster said, "Obstetrics has, in my view, always been undervalued in our country. Look at the labor laws and practices--they single out and often punish expectant mothers. I have read that, during World War II in Great Britain, pregnant women received double food rations--I wonder if this logical and humane thought ever occurred to policy makers in this country." This seemed to be a digression, and he did not explain what the specific problems were.

RESPONSE:

Dr. Foster stated that he was talking about the need for employers to be more supportive of pregnant women. He said that he had a practice of writing to the supervisors of his patients to tell them that their employee was pregnant and to ask that they provide facilities for the woman to lie down during breaks. He always got consent from the patient and usually had them take the letters to their employers. Dr. Foster explained that he was concerned because employers were often unwilling to help pregnant women out of fear that something would happen and they would be liable.

On Health Care and Health Care Reform

PUBLIC RECORD VET:

In "How Can We Provide Good Health Care for Everyone?" a speech presented to the Lonnie S. Burnett Vanderbilt OB/GYN Society, on June 18, 1994, Dr. Foster generally hit on points relating to improving health care and access to health care. In the speech, Dr. Foster stated, "I cannot see how universal coverage can be successful without having employer-mandate as a component." He seemed to support a British-type healthcare reform in which adequate health care would be available to all, but the wealthier people could opt for additional coverage from a private-fee-for-service sector. He said, "I believe that adequate housing should be available to everyone in this country, but to have a Beverly Hills type home can only accrue through maximizing the free enterprise system."

RESPONSE:

Dr. Foster stated that he just felt that universal coverage would not be successful without employer mandate. He said he still believes that it would be more likely to be successful with employer mandates and that employer mandates would enhance it. As to the British-type health care, Dr. Foster said that it was going to happen and that it is already occurring with Medicare and Medi-Gap insurance. He also reiterated that he does believe that we must provide adequate health care to all. Dr. Foster went on to say that he believes that people have a right to adequate housing and that people should not be on the street. He said he agrees with his wife who suggests that we do like they did after WWII

and build barracks for the homeless to provide them with spartan but humane living conditions.

PUBLIC RECORD VET:

In an article entitled "A Black Health Crisis," the July 13, 1987 NEWSDAY quoted Dr. Foster as saying, "Until we make a national commitment, there won't be a sizable improvement in the health gap [between whites and African-Americans]."

RESPONSE:

Dr. Foster stated that this was correct and that this is what health care reform is about. He said this reform is how you get inclusion. Dr. Foster told me that he met with the President the other day to advocate focussing on getting universal coverage for mothers and babies since true universal coverage did not get passed.

PUBLIC RECORD VET:

Dr. Foster wrote a chapter, "Ambulatory Gynecologic Surgery," printed in Ambulatory Obstetrics and Gynecology in 1980. In the chapter, Dr. Foster argued that selective out-patient surgery was a means of lowering national health care costs and accused insurance companies, hospitals and physicians of opposing such a move because of financial incentives to utilize in-patient procedures and fill hospital beds.

RESPONSE:

Dr. Foster stated that this was true when he wrote it but that things have changed now. In his words, today we follow "ancient China" in paying for health services. He explained that people only paid doctors when they were well in ancient China.

On Human Research Subjects and Biomedical Research

PUBLIC RECORD VET:

In an editorial, "Biomedical Research Subjects: Who Should Be Exempt?" published in the November 1975 JOURNAL OF MEDICAL EDUCATION, Dr. Foster advocated the exemption of certain categories of people from serving as research subjects. He explained that he would exempt captive individuals such as the fetus, the child, the military/prisoner, and the poor. He would further exempt those non-captive people where there appears to be "a deficiency or absence of those biosocial defense mechanisms essential for coping with a very complex society." In this category, he included "the functionally illiterate, the senile, those who do not command the language, and the mentally incompetent."

RESPONSE:

Dr. Foster explained that he was on an Ethics Panel formed by then-Secretary Califano to look at the problems of researching on certain vulnerable populations. He advocated the total exclusion of these people from biomedical research because they cannot volunteer. He did say that an interpreter would probably be enough to allow research on a person who did not otherwise command the language, but that it would depend on the nature of the research. Dr. Foster that researchers have, more or less, adhered to this exclusion and that research must now be cleared by an Internal Review Board that would not allow research that was to be conducted on these groups.

PUBLIC RECORD VET:

Dr. Foster also wrote "Children and the Institutionalized Mentally Infirm," published in RESEARCH INVOLVING CHILDREN in 1976. Using a hypothetical research project, this article criticized the methods of obtaining informed consent from children and institutionalized mentally ill. While advocating the exemption discussed above, Dr. Foster stated that he would permit biomedical research on children with the informed consent of their parents. However, in determining who should be classified as a child he stated that "because of the differences in life styles between blacks and whites, quite possibly adulthood as a practical matter begins earlier for the former group and accordingly, a more workable definition of childhood may be appropriate."

In that article, Dr. Foster also suggested that the relationship between biomedical research and the financing of medical education should be examined because there can be pressure to lure the research dollar to fund education and that pressure may be detrimental to the rights of biomedical research subjects.

RESPONSE:

As to the latter point about research funding and financing of medical education, Dr. Foster stated that the Internal Review Board took care of that concern. As to the use of children as research subjects, Dr. Foster stated that he would permit them to be used as subjects only if the research cannot be done on other subjects. If the condition being studied was one which could only be studied in children, i.e. childhood leukemia, then he would allow children to serve as research subjects with the consent of their parent or guardian. As to defining "child" differently for whites and blacks, Dr. Foster stated that race is often used as a proxy for poverty and that what he really meant was that socio-economic differences may cause differences in how a person is defined. His example was two 17 year-old girls. One was the child of a two-parent family who is still emotionally and financially dependent on her parents. The other is the head of her own household and a mother herself. Dr. Foster argues that defining "child" by a strict chronological limit, such as younger than 18 years-old, would not take into account these other facts.

PUBLIC RECORD VET:

Finally, Dr. Foster pointed out some problem areas using the hypothetical case. In talking about the use of a placebo for a portion of those patients in a study, he asked, "Even when patients receive prior advice [that a placebo may be administered], is it just or fair to knowingly deny a potentially beneficial agent to one group and provide it for another - even if on a chance basis?"

RESPONSE:

Dr. Foster stated that he merely posed this question, he does not know if he has the answer. He explained that the question arose from a real situation in which he and other doctors wanted to set up a national program to study the use of Prophylactic Partial Exchange Transfusions (PPET) in sickle cell patients but that they could not structure a research protocol because they felt that they could not deny people the benefits of PPET. Dr. Foster explained that preliminary results showed that PPET was very beneficial and really made patients feel better. Dr. Foster did state that placebos were not a problem, and were even necessary, in initial studies to determine if there are benefits of a given procedure or drug. However, where a procedure has been proven to be beneficial, as with PPET, denying it might not be ethical.

On Sex Education

PUBLIC RECORD VET:

The Summer 1990 issue of the JOURNAL OF HEALTH CARE FOR THE POOR AND UNDERSERVED published a presentation by Dr. Foster entitled "A Model for Increasing Access: Teenage Pregnancy Prevention." The presentation recognized the gaps and disadvantages of school-based programs to provide pregnancy services and proposed a community-based intervention program. The I Have A Future (IHAF) Program at Meharry Medical College, discussed in the presentation, was anchored, not in schools, but in a residential setting: the public housing projects. The program was open to all adolescents, including students who had dropped out or been expelled from school, claimed to more adequately address idle time, and also was in closer proximity to families providing a better opportunity to involve parents and siblings. The presentation noted that "[i]nappropriate teen pregnancy has become a major social issue in this country."

The presentation continued, stating that "[Adolescent pregnancy] is a problem that affects all ethnic, social, and economic classes," and that "discounting the non-white contribution to our nation's teenage pregnancy and birth rate does not change our statistical ranking relative to other western nations." The article also stated that "abortion rates in the United States are substantially higher than those for other western countries."

In discussing the rationale for the program design, the presentation stated that "[d]espite the agreement that American youth need knowledge about human reproduction in order to act responsibly in matters of sexuality, there are nonetheless, continuing barriers to the availability of this education, and indeed conflicting studies as to its value." The article stated that "the literature does show that sex education programs are most likely to be effective when actively coupled with direct access to contraceptives." The highlighted program consisted of activities which included exercises to teach an edited version of Nguzo Saba, Seven Principles of Blackness-Pro-Social Attitudes drawn from Swahili.

RESPONSE:

Dr. Foster explained the IHAF program and its history. He stated that he got the idea for it from a program he conducted which sought to provide as many health programs as possible at a single point for teens. In that study he found four major gaps: (1) Program did not reach drop-outs, particularly when there was a 50% student drop-out rate in inner-city schools; (2) Schools were closed during critical times since studies showed that most pregnancies were conceived during unchaperoned hours between 4-7 pm; (3) Schools are closed summers and weekends; (4) Difficult to get parental involvement in school, especially in the inner-city. These problems led Dr. Foster to get a grant to establish a program in a residential venue. By placing the services in the housing project, Dr. Foster said the program is more accessible and gets more parental involvement. One aspect of the program is parental empowerment. The program is designed to increase life options through education, services and life enhancement. The program teaches operative English, includes a jobs program, and seeks to involve community volunteers of all races to show harmonious relations among races. Dr. Foster stated that a disproportionate number of those involved are going to college. Of the 23 teens involved, 17 are going to college, including nine males.

The program also teaches the seven principles of Blackness, the Kwanza principles. Dr. Foster stated that these were strong principles for all cultures and that they were not presented in such a was as to exclude white participants.

As to "inappropriate" teen pregnancies, Dr. Foster stated that he was referring to pregnancies in the context where there was not adequate financial, emotional or social support for a baby.

PUBLIC RECORD VET:

On August 5, 1986, the UNITED PRESS INTERNATIONAL reported that a Governor's Task Force on Healthy Children, of which Dr. Foster was Chairman, concluded that teaching sex education in public schools was one way to reduce the rising death rate among babies born to high-risk women, such as African-American teenagers and African-

American women of all ages who have previously given birth to low-birthweight babies or who have medical conditions particularly associated with reproductive problems.

RESPONSE:

Dr. Foster said he was not Chairman of the committee but of a subcommittee on non-white infant mortality. As to sex education in schools, Dr. Foster stated that he believes that knowledge of human sexuality, in all phases, is important but that implementation needs the involvement of parents and children. He stated that he believes that there should be greater decentralization of schools to allow individual schools to decide on school programs, such as sex education, based on their needs and values. That way an inner-city school where sexuality is an issue, would be free to have a sex education program even though a suburban school in the same district would not want one. This would also allow different schools to structure programs to meet their needs and values.

Not Chosen as President of Meharry Medical College

PUBLIC RECORD VET:

According to the November 9, 1993 NASHVILLE BUSINESS JOURNAL, Dr. Foster, who was the Acting President of Meharry Medical College, was a candidate to replace the previous President. However, later articles disclosed that a different candidate was chosen. No article explained the reason Dr. Foster was not selected.

RESPONSE:

Dr. Foster stated that he was never given a reason by the search committee. He did say that he was late putting his name in for consideration.

Set #1

ABORTION AS CONTRACEPTION

Charge:

Dr. Foster advocates abortion as a method of contraception.

Response:

Dr. Foster recognizes that abortion can be used as a method of contraception, but believes that it should not be used that way. Dr. Foster believes in preventing abortions by preventing unplanned pregnancies. He has created innovative programs to fight unwanted teen pregnancy through education and building young women's self-esteem. However, Dr. Foster does believe that safe and legal abortion must be available.

Charge:

But Dr. Foster has specifically listed abortion as a method of contraception in his writings.

Response:

Dr. Foster has acknowledged that abortion is available as a method of contraception, but this does not mean that he advocates its use as a form of contraception. To the contrary, he has stated in his writings his preference that abortion be used for contraceptive purposes only when other methods of contraception fail.

Dr. Foster advocates abortion on demand.

Response:

Dr. Foster does not advocate abortion; he believes it should be available as an option. He believes that unwanted pregnancy should be avoided so that the use of abortion is rare.

Charge:

Dr. Foster believes in abortion as a method of contraception, but not abstinence.

Response:

Dr. Foster believes that abstinence is the best way of preventing pregnancy. This is apparent in his work with innovative programs to help teens avoid pregnancy through education and development of self-esteem.

Charge:

Dr. Foster has written that in counselling for abortion, "the overall objective is to decrease the patient's fears and anxieties."

Response:

Dr. Foster is a strong proponent of counselling to help women make their own decisions about abortion. Dr. Foster does not encourage his patients to undergo abortions.

Charge:

Dr. Foster advocates the development of in-home abortion to make it more available as a contraceptive.

Response:

Dr. Foster has researched non-surgical abortion methods using medications administered in hospitals, not in home settings. Although Dr. Foster believes abortions should be performed only as a last resort, he believes that they should be done in the safest manner possible. Therefore, he supports research into safer methods.

Charge:

Dr. Foster advocates abortion on demand for all nine months of pregnancy.

Response:

Dr. Foster does not advocate abortion but believes ~~they~~ it should be available as a last resort. Dr. Foster believes in preventing abortions by preventing unplanned pregnancies. Abortions in the third trimester are generally illegal, and Dr. Foster ~~would~~ opposes such abortions.

SOCIAL ENGINEERING

Charge:

Dr. Foster advocates abortion for any fetus that shows any abnormality.

Response:

Dr. Foster does not advocate abortion ~~in any case.~~ He believes that prospective parents are entitled to as much information as is available regarding the health of the fetus. He believes that abortion should be available as an option but has worked to minimize the use of that option by developing treatments for fetuses with health problems.

Charge:

~~Throughout his practice,~~ Dr. Foster has coerced women to get abortions.

Response:

~~Dr. Foster does not coerce his patients to have abortions, nor does he encourage them to have abortions.~~ He is a strong proponent of counselling to help women make their own decisions about abortion.

Charge:

Dr. Foster advocates genetic testing with an eye toward encouraging abortion.

Response:

Dr. Foster believes that prospective parents are entitled to as much information as is available regarding the health of the fetus. He believes that abortion should be available as an option but has worked to minimize the use of that option by developing treatments for fetuses with health problems.

HYSTERECTOMIES

Charge:

In an article, Dr. Foster states that he has performed hysterectomies on mentally retarded women for hygienic purposes.

Response:

The article was written over 20 years ago, and relies upon medical theory from that time, which has since changed significantly. Dr. Foster has always advocated informed consent.

Was charged?

Charge:

Dr. Foster has justified a hysterectomy on the basis that the woman had a "dismal social history," i.e., was unmarried, had four children, was unemployed, and received no welfare assistance. ["Meigs' Syndrome Complicated by Pregnancy," 1972]

Response:

Dr. Foster has acknowledged that that article contains a value judgment that he shouldn't have made at the time and would not make today. He believes that the decision about whether to undergo sterilization should be made by the patient after receiving thorough and accurate information. In this particular case, the pelvic organs were removed because of the presence of a tumor with a high probability of malignancy.

Set #2

ABORTION FOR CONTRACEPTIVE PURPOSES

Charge:

Dr. Foster advocates the use of abortion as a means of contraception. He has specifically referred to abortion as "a contraceptive measure." (Contraceptives in Sickle Cell Disease, Southern Medical Journal, 1981)

Response:

- Dr. Foster does not equate abortion and contraception. In his writings and speeches, Dr. Foster has used the words abortion and contraception to denote two very different concepts. Dr. Foster has never advocated that abortion be used in place of contraceptives.

- Although Dr. Foster acknowledged in his 1981 article that abortion is a type of contraceptive, he did not advocate the use of abortion as a contraceptive measure.

- Dr. Foster has not promoted the use of abortion solely for contraceptive purposes. In discussing its use as a contraceptive measure for women with sickle cell anemia, he stated that "clearly this would not be ideal."

- Instead, Dr. Foster has stated his preference that, even when the health of the mother is at issue, abortion should be used for contraceptive purposes only when other methods of contraception fail.

- Dr. Foster has not advocated the use of abortion. He specifically stated that the risks associated with abortion were too great, and his ultimate recommendation in the article was that barrier methods of contraception combined with timing should be used by women with sickle cell disease.

Charge:

Dr. Foster is cavalier and indifferent to the use of abortion.

Response:

- Dr. Foster believes that abstinence is the best contraceptive, and that abortion should be rare. (Nightline, Feb. 8, 1995)

- Dr. Foster has expressed his concern about reliance on abortions rather than on birth control measures. (Family Planning and the Black Community, 1975). Dr. Foster has focused much of his energy on promoting family planning in order to prevent unwanted pregnancies and abortions.

Charge:

Dr. Foster has promoted in-home abortions to make them more available as contraceptives. (Upjohn Study, 1985)

Response:

- Although Dr. Foster believes abortions should be performed only as a last resort, he believes that they should be done in the safest manner possible. Therefore, he supports research into safer methods.

- As Chairman of the Obstetrics Department at Meharry Medical College, Dr. Foster was the principal investigator for an FDA-approved clinical trial to test the efficacy and safety of an abortifacient suppository administered during early pregnancy. The trial was a research project conducted in an academic setting and all medical procedures were conducted in the hospital. All patients were volunteers who gave informed written consent.

Charge:

Dr. Foster's treatment of abortion as a contraceptive measure is evidence of the liberal mind set that promotes sexual promiscuity among young people and does not require them to take responsibility for their actions.

Response:

- Dr. Foster has devoted much of his life and career to the community, establishing such programs as "I Have A Future" (IHAF), which seeks to provide positive alternatives to teenage pregnancy. Through IHAF, Dr. Foster has helped build the self-esteem of young men and women by providing education and job opportunities.

- Dr. Foster anchored the IHAF program in the neighborhoods where the young participants were living to ensure that their parents were involved with their choices. One critical aspect of the program is parental involvement.

STERILIZATION

Charge:

Dr. Foster advocates hysterectomies as a means of sterilization. He has performed hysterectomies to sterilize severely retarded individuals.

> "Recently, I have begun to use hysterectomy in patients with severe mental retardation. Hysterectomy can be done either for sterilization or to eliminate the menses, which is of significant hygienic benefit to those severely handicapped individuals." (Removal of the Normal Uterus, Southern Medical Journal, 1976).

Response:

- Dr. Foster stressed in this article that "obstetricians and gynecologists must guard vigilantly against the injudicious and indiscriminate removal of the normal uterus."

- Nonetheless, he recognized that hysterectomy might be appropriate for some severely retarded women. Medical theory has changed in the intervening decades, and Dr. Foster no longer believes that hysterectomy is appropriate solely for sterilization of a mentally retarded woman, although medical reasons might justify such a procedure.

- Dr. Foster has always advocated informed consent by the woman or her legal guardian.

Charge:

Dr. Foster has routinely encouraged sterilization of patients with sickle cell disease after they have been able to deliver a child. (Clinical Management: Sickle Cell State and Pregnancy, Urban Health, 1977).

Response:

- Dr. Foster actively opposed routine sterilization of sickle-cell-disease patients. He encouraged counseling, screening, and patient management to enable women with sickle cell disease to have healthy children.

Charge:

Dr. Foster has justified a hysterectomy on the basis that the woman had a "dismal social history," i.e., was unmarried, had four children, was unemployed, and received no welfare assistance (Meigs' Syndrome Complicated by Pregnancy, Journal of the National Medical Association, 1972).

Response:

• The procedure was medically necessary to remove a tumor with a high probability of malignancy. Dr. Foster noted in the article, however, that the woman's situation made the medically necessary removal of her reproductive organs "a bit less difficult." This insensitive comment reflected a value judgment Dr. Foster believes he should not have made then, and he would not make today.

Charge:

Dr. Foster's work and writings show a cavalier attitude toward sterilization. For example, he stated in 1972 that the number of tubal sterilizations -- 193 -- performed in one calendar year in a rural county with a small population was "low and in need of improving." (A Rural Hospital and Family Planning, 1972).

Response:

• Dr. Foster is not at all cavalier about sterilization. In a textbook on Ambulatory Gynecologic Surgery, he wrote: "As with abortion, the psychosocial dynamics associated with sterilization are profound and require special counseling. Sterilization should be offered only to mature women with no further desire of pregnancy."

• Dr. Foster has consistently advocated only voluntary, informed family planning. Moreover, he views family planning as only part of an overall strategy to improve health care, including reduction in infant mortality. He has stressed his opposition to "coercive sterilization" (same 1972 source).

• Dr. Foster has eloquently stated on numerous occasions that he, the father of two children and the grandfather of __, considers the creation of a human being one of the greatest joys anybody can have.

SOCIAL/GENETIC ENGINEERING

Charge:

Dr. Foster has promoted radical social engineering by encouraging amniocentesis and eventual abortions where there are any indications of genetic defects. In numerous articles, he has advocated monitoring pregnancies through amniocentesis so that patients can choose abortions. Additionally, he has encouraged patients to choose abortions where the woman was sick or where the child might have a genetic defect.

> "The couple must be provided with genetic counseling and offered antenatal diagnosis, with the option of pregnancy termination." Thalassemia, Hematologic Problems in Pregnancy, 1987);
>
> "It should be recommended that subsequent pregnancies be monitored by amniocentesis in such cases [couples with recurrent miscarriages] so that abortion can be made available for genetically abnormal fetuses when found." (Reproductive Performance in Women with Sex Chromosome Mosaicism, Obstetrics and Gynecology, 1980).
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> "The presence of hemoglobin SS, SC, or sickle thalassemia, which constitute sickle-cell disease, should not be the sole justification for either abortion or sterilization. The procedures should be done on the basis of medical indications or patient desire, or both." (Transfusion Therapy in Pregnant Patients with Sickle Cell Disease, Annals of Internal Medicine, 1979);

Response:

- Dr. Foster has not and does not advocate aborting fetuses where there is a potential for genetic defects.

- Dr. Foster recognizes that his responsibility as a treating physician and health care academic is to inform patients and practitioners of medical options as those patients make difficult, often painful decisions regarding pregnancy and childbirth.

- Over the course of his career, Dr. Foster has devoted himself to preventing unwanted pregnancies and to improving the health of pregnant women and their fetuses, particularly in the case of sickle cell disease.

- Dr. Foster is dedicated to informing patients so they can make voluntary, educated choices about their medical options. For his valuable work in promoting greater knowledge on the part of patients he has received national recognition.

• Dr. Foster recommends antenatal diagnosis and genetic counseling for pregnant patients who are at risk for certain genetically transmitted traits, such as sickle cell disease. He has written that "proper counseling for pregnant patients is essential to provide education, reassurance, and optimal medical outcome." (Sickle Cell Disease in Pregnancy, Obstetrics and Gynecology Annual, 1982).

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February 9, 1995

To: John Podesta

From: Beth Nolan, Marvin Krislov

Re: Dr. Foster

We are leaving this for you to review. Please accept this in the spirit of the best we could do given the deadline. We know how much that excuse is worth.

There are two sets: (1) plain-language charges and responses, and (2) charges and responses with more detailed cites to articles, etc. HHS did (1) and we did (2), though we talked to each other and shared ideas. We can combine if you wish, or keep both sets for different purposes.

The most important thing is that Dr. Foster agree that his views (in both charges and responses) are not misrepresented.

It's 5 am, and we're going home. We will try to be back around 8, but feel free to start without us. Really.

Set #1

ABORTION AS CONTRACEPTION

Charge:

Dr. Foster advocates abortion as a method of contraception.

Response:

Dr. Foster recognizes that abortion can be used as a method of contraception, but believes that it should not be used that way. Dr. Foster believes in preventing abortions by preventing unplanned pregnancies. He has created innovative programs to fight unwanted teen pregnancy through education and building young women's self-esteem. However, Dr. Foster does believe that safe and legal abortion must be available.

Charge:

But Dr. Foster has specifically listed abortion as a method of contraception in his writings.

Response:

Dr. Foster has acknowledged that abortion is available as a method of contraception, but this does not mean that he advocates its use as a form of contraception. To the contrary, he has stated in his writings his preference that abortion be used for contraceptive purposes only when other methods of contraception fail.

Dr. Foster advocates abortion on demand.

Response:

Dr. Foster does not advocate abortion; he believes it should be available as an option. He believes that unwanted pregnancy should be avoided so that the use of abortion is rare.

Charge:

Dr. Foster believes in abortion as a method of contraception, but not abstinence.

Response:

Dr. Foster believes that abstinence is the best way of preventing pregnancy. This is apparent in his work with innovative programs to help teens avoid pregnancy through education and development of self-esteem.

Charge:

Dr. Foster has written that in counselling for abortion, "the overall objective is to decrease the patient's fears and anxieties."

Response:

Dr. Foster is a strong proponent of counselling to help women make their own decisions about abortion. Dr. Foster does not encourage his patients to undergo abortions.

Charge:

Dr. Foster advocates the development of in-home abortion to make it more available as a contraceptive.

Response:

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Charge:

Dr. Foster advocates abortion on demand for all nine months of pregnancy.

Response:

Dr. Foster does not advocate abortion but believes they should be available as a last resort. Dr. Foster believes in preventing abortions by preventing unplanned pregnancies. Abortions in the third trimester are generally illegal, and Dr. Foster would oppose such abortions.

SOCIAL ENGINEERING

Charge:

Dr. Foster advocates abortion for any fetus that shows any abnormality.

Response:

Dr. Foster does not advocate abortion in any case. He believes that prospective parents are entitled to as much information as is available regarding the health of the fetus. He believes that abortion should be available as an option but has worked to minimize the use of that option by developing treatments for fetuses with health problems.

Charge:

Throughout his practice, Dr. Foster has coerced women to get abortions.

Response:

Dr. Foster does not coerce his patients to have abortions, nor does he encourage them to have abortions. He is a strong proponent of counselling to help women make their own decisions about abortion.

Charge:

Dr. Foster advocates genetic testing with an eye toward encouraging abortion.

Response:

Dr. Foster believes that prospective parents are entitled to as much information as is available regarding the health of the fetus. He believes that abortion should be available as an option but has worked to minimize the use of that option by developing treatments for fetuses with health problems.

HYSTERECTOMIES

Charge:

In an article, Dr. Foster states that he has performed hysterectomies on mentally retarded women for hygienic purposes.

Response:

The article was written over 20 years ago, and relies upon medical theory from that time, which has since changed significantly. Dr. Foster has always advocated informed consent.

Charge:

Dr. Foster has justified a hysterectomy on the basis that the woman had a "dismal social history," i.e., was unmarried, had four children, was unemployed, and received no welfare assistance. ["Meigs' Syndrome Complicated by Pregnancy," 1972]

Response:

Dr. Foster has acknowledged that that article contains a value judgment that he shouldn't have made at the time and would not make today. He believes that the decision about whether to undergo sterilization should be made by the patient after receiving thorough and accurate information. In this particular case, the pelvic organs were removed because of the presence of a tumor with a high probability of malignancy.

Set #2

ABORTION FOR CONTRACEPTIVE PURPOSES

Charge:

Dr. Foster advocates the use of abortion as a means of contraception. He has specifically referred to abortion as "a contraceptive measure." (Contraceptives in Sickle Cell Disease, Southern Medical Journal, 1981)

Response:

- Dr. Foster does not equate abortion and contraception. In his writings and speeches, Dr. Foster has used the words abortion and contraception to denote two very different concepts. Dr. Foster has never advocated that abortion be used in place of contraceptives.

- Although Dr. Foster acknowledged in his 1981 article that abortion is a type of contraceptive, he did not advocate the use of abortion as a contraceptive measure.

- Dr. Foster has not promoted the use of abortion solely for contraceptive purposes. In discussing its use as a contraceptive measure for women with sickle cell anemia, he stated that "clearly this would not be ideal."

- Instead, Dr. Foster has stated his preference that, even when the health of the mother is at issue, abortion should be used for contraceptive purposes only when other methods of contraception fail.

- Dr. Foster has not advocated the use of abortion. He specifically stated that the risks associated with abortion were too great, and his ultimate recommendation in the article was that barrier methods of contraception combined with timing should be used by women with sickle cell disease.

Charge:

Dr. Foster is cavalier and indifferent to the use of abortion.

Response:

- Dr. Foster believes that abstinence is the best contraceptive, and that abortion should be rare. (Nightline, Feb. 8, 1995)

- Dr. Foster has expressed his concern about reliance on abortions rather than on birth control measures. (Family Planning and the Black Community, 1975). Dr. Foster has focused much of his energy on promoting family planning in order to prevent unwanted pregnancies and abortions.

Charge:

Dr. Foster has promoted in-home abortions to make them more available as contraceptives. (Upjohn Study, 1985)

Response:

- Although Dr. Foster believes abortions should be performed only as a last resort, he believes that they should be done in the safest manner possible. Therefore, he supports research into safer methods.

- As Chairman of the Obstetrics Department at Meharry Medical College, Dr. Foster was the principal investigator for an FDA-approved clinical trial to test the efficacy and safety of an abortifacient suppository administered during early pregnancy. The trial was a research project conducted in an academic setting and all medical procedures were conducted in the hospital. All patients were volunteers who gave informed written consent.

Charge:

Dr. Foster's treatment of abortion as a contraceptive measure is evidence of the liberal mind set that promotes sexual promiscuity among young people and does not require them to take responsibility for their actions.

Response:

- Dr. Foster has devoted much of his life and career to the community, establishing such programs as "I Have A Future" (IHAF), which seeks to provide positive alternatives to teenage pregnancy. Through IHAF, Dr. Foster has helped build the self-esteem of young men and women by providing education and job opportunities.

- Dr. Foster anchored the IHAF program in the neighborhoods where the young participants were living to ensure that their parents were involved with their choices. One critical aspect of the program is parental involvement.