

*M. Joycelyn Elders, M.D.
810 Marcia Court
Little Rock, Arkansas 72206*

July 22, 1993

The Honorable Edward M. Kennedy
Chairman
Senate Labor & Human
Resources Committee
315 Russell
United States Senate
Washington, D.C. 20510

The Honorable Nancy Landon Kassebaum
Ranking Minority Member
Senate Labor & Human
Resources Committee
302 Russell
United States Senate
Washington, D. C. 20510

Dear Senators Kennedy and Kassebaum:

I write in response to your request for answers to the following questions concerning the National Bank of Arkansas.

I welcome the opportunity to address these issues in response to your questions, and remain available to answer questions from the senators at the hearing as well.

QUESTION 1:

Was the National Bank of Arkansas ("NBA") ever subject to a formal enforcement action under 12 U.S.C. Section 1818?

ANSWER:

The NBA was subject to a formal enforcement action under 12 U.S.C. Section 1818 in the form of a formal written agreement between the Comptroller of the Currency and the Board of Directors of the bank.

QUESTION 2:

Did an Office of the Comptroller of the Currency ("OCC") examination report find that any directors of the NBA engaged in practices that violated national banking laws regarding either safety and soundness or criminal activity?

ANSWER:

I was briefed at Board meetings on the contents of examination reports by the OCC and the President of the Board. I was advised that all directors were cited in examination reports as having violated national banking laws and safety and soundness laws relating to their failure properly to supervise bank management. I was advised that the examination reports did not find their activity to be criminal.

QUESTION 3:

Did any directors of the NBA, including yourself, receive letters of reprimand from the OCC?

ANSWER:

I received a letter of reprimand solely in my capacity as a member of the Board of Directors of NBA. I believe that other directors who served on the Board also received letters of reprimand.

QUESTION 4:

Was any of your conduct cited specifically in any examination report?

ANSWER:

I believe that no conduct in which I personally engaged was ever cited specifically in any examination report.

QUESTION 5:

Were the directors ever informed by examiners that the bank management was engaging or had engaged in unsafe and unsound banking activities or violations of national banking laws?

ANSWER:

As a result of the examination reports, Board directors were informed that bank management had engaged in unsafe and unsound banking practices which were in violation of national banking laws.

QUESTION 6:

Did the directors take action to reasonably ensure that the activities cited in the OCC reports would not continue?

ANSWER:

I believe that although the examiners acknowledged that remedial actions were taken, the examiners did not view those actions as sufficient to correct the activities of bank management. Thus, a letter of reprimand was issued by the OCC to me and the other directors.

QUESTION 7:

Are you the target of further investigation?

ANSWER:

I believe that I am not the target of any further investigation.

QUESTION 8:

Did the Board grant each director a \$200,000 extension of credit?

ANSWER:

The minutes of the Board of Directors meetings indicate that the directors were given an extension of credit up to \$230,000. This extension of credit was not construed by me as "automatic loan approval" in that each loan was subject to the usual bank policies and procedures applied for by anyone else. I abstained from the Board vote granting me this extension of credit.

QUESTION 9:

If the directors received such an extension of credit, was this decision ever cited or criticized by the banking examiners?

ANSWER:

No.

QUESTION 10:

Did you ever borrow money from the NBA during the time you were a member of the Board?

ANSWER:

Yes.

QUESTION 11:

What was the purpose of (each) such loan?

ANSWER:

I borrowed from the bank on various occasions under terms and conditions available to other borrowers. The purpose of the loans was primarily for commercial ventures, including the purchase of real estate.

QUESTION 12:

Did you ever borrow any money from the bank at preferential rates not offered to other borrowers during the time you were a member of the Board?

ANSWER:

No.

QUESTION 13:

Did you recuse yourself from discussion or approval by the Board of any loan you had requested?

ANSWER:

I recused myself from voting on the extension of credit by the other members of the Board of Directors to myself.

QUESTION 14:

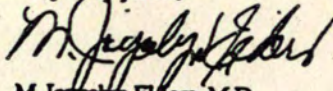
Does the Comptroller of the Currency have to approve or sign off on any settlement agreement involving litigation alleging violations of federal banking laws?

ANSWER:

Not to my knowledge.

I hope that the above responds to your questions in this area.

Very truly yours,



M. Joycelyn Elders, M.D.

American Medical Association

Physician and Surgeon General of the United States

James S. Todd, MD
Executive Vice President1515 North Dearborn Avenue
Chicago, Illinois 60610312 541-5000
312 541-5111 Fax

July 9, 1993

The Honorable Edward M. Kennedy
United States Senate
315 Russell Senate Office Building
Washington, DC 20510

Dear Chairman Kennedy:

On behalf of the American Medical Association (AMA), I would like to enthusiastically endorse the nomination of M. Joycelyn Elders, M.D., for the position of Surgeon General of the United States Public Health Service.

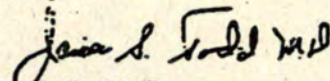
The Surgeon General presently serves as an advocate for the public and an advisor to the nation on matters of public health. In recent years, the role of the Surgeon General has greatly expanded. The Surgeon General has the opportunity to educate both the public and policy makers on critical health issues such as AIDS, smoking, immunization, violence, nutrition, and disease prevention.

In many ways, Dr. Elders, a pediatric endocrinologist, has trained extensively to fill the role of Surgeon General. As a pediatrician, Dr. Elders protected and cared for the nation's most vulnerable population, its youth. In 1937, then-Governor Bill Clinton appointed Dr. Elders to position of Director of the Arkansas Department of Health. During her tenure, Dr. Elders worked extensively to promote many public health issues, including greater immunization rates in preschool children, expanded services for pregnant women, increased AIDS testing and counseling, and improved access to health care providers in rural and underserved areas. In this position, Dr. Elders has provided exceptional leadership as an advocate for the health concerns of the public.

For her contributions to public health, Dr. Elders has earned numerous awards, including the AMA's 1990 Nathan Davis Award and the AMA's 1990 National Congress on Adolescent Health Award for Outstanding Efforts on Behalf of America's Youth. She currently serves as President for the Association of State and Territorial Health Officers. Dr. Elders is a graduate of Philander Smith College in Little Rock and the University of Arkansas Medical School.

Dr. Elders brings the requisite experience, knowledge and commitment to provide leadership as Surgeon General. The nation would be well served by her appointment to this critical position in the Clinton Administration. The AMA appreciates the opportunity to convey our full support for Dr. Elders and to urge you to confirm her to the position of Surgeon General. We look forward to working with Dr. Elders in the future.

Sincerely,


James S. Todd, MD

NATIONAL ENDORSEMENTS FOR DR. ELDERS
as of 27 July 1993 (12.00 pm)

9 to 5

A. Philip Randolph Institute
ActionAIDS
Adolescent AIDS Program
AIDS Action Council
AIDS National Interfaith Network
Alan Guttmacher Institute
Alliance for Young Families
Alliance to End Childhood Lead Poisoning
Alpha Phi Alpha Fraternity, Inc.
Ambulatory Pediatric Association
Ambulatory Pediatrics Association
American Academy of Child and Adolescent Psychiatry
American Academy of Family Physicians
American Academy of Pediatrics
American Association for World Health
American Association of Black Cardiologists
American Association of Dental Schools
American Association of Medical Schools
American Association of School Administrators
American Association of Sex Educators, Counselors, and Therapists
American Association of University Women
American Cancer Society
American Civil Liberties Union
American College Health Association
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Preventive Medicine
American Cyanamid Company (Lederle Laboratories)
American Dietetic Association
American Federation of Labor-Congress of Industrial Organizations
American Federation of Teachers
American Federation of State and County Municipal Employees, AFLCIO
American Fertility Society
American Foundation for AIDS Research
American Friends Service Committee
American Heart Association
American Home Economics Association
American Jewish Congress
American Library Association
American Lung Association
American Medical Association
American Medical Student's Association
American Medical Women's Association, Inc.
American Nurses Association
American Occupational Therapy Association, Inc.
American Orthopsychiatric Association
American Pediatric Society
American Psychiatric Association
American Psychiatric Society
American Psychological Association
American Public Health Association
American School Food Service Association
American School Health Association
American Schools of Public Health
American Social Health Association
American Society for Adolescent Psychiatry
American Society for Clinical Nutrition
American Society for Medical Technology
American Society for Parenteral and Enteral Nutrition

American Society of Public Health
 Americans for Democratic Action, Inc.
 Artemis Project
 Asian American Health Forum, Inc.
 Asian/Pacific AIDS Coalition
 Asians and Pacific Islanders for Reproductive Health
 Association for the Advancement of Health Education
 Association for Vital Records and Health Statistics
 Association of American Medical Colleges
 Association of Asian/Pacific Community Health Organizations
 Association of Black Cardiologists, Inc.
 Association of Black Sociologists
 Association of Faculties of Graduate Programs in Public Health Nutrition
 Association of Junior Leagues International
 Association of Local Health Liaison Officials
 Association of Maternal and Child Health Directors
 Association of Maternal and Child Health Programs
 Association of Reproductive Health Professionals
 Association of Schools of Public Health
 Association of State/Territorial Chronic Disease Program Directors
 Association of State/Territorial Dental Directors
 Association of State/Territorial Directors of Nursing
 Association of State/Territorial Directors of Public Health Educators
 Association of State/Territorial Health Officials
 Association of State/Territorial Local Health Liaison Officials
 Association of State/Territorial Public Health Education
 Association of State/Territorial Public Health Laboratory Directors
 Association of State/Territorial Public Health Nutrition Directors
 Association of State/Territorial Public Health Social Work
 Association of the Faculties of Graduate Programs in Public Health Nutrition
 Association of Women's Health, Obstetric, and Neonatal Nurses
 Associated Group
 B'Nai B'rith Women
 B'Nai B'rith
 Biotechnology Industry Organization
 Black Leadership Forum
 Black Women's Agenda, Inc.
 Business and Professional Women/USA
 Campaign for Fairness
 Campaign for Women's Health
 Catholics for Free Choice
 Catholics Speak Out
 Center for Population Options
 Center for Reproductive Law and Policy
 Center for Science in the Public Interest
 Center for Women Policy Studies
 Child Welfare League of America
 Children and Youth 2000
 Church Association for Community Services
 Church Women United
 Citizen Action
 Clinical Directors Network Region II, Inc.
 Coalition for Nutrition Services in Health Care Reform
 Coalition for School-Based Primary Care
 Coalition of 100 Black Women
 Coalition of Black Trade Unionists
 Consumer Federation of America
 Coalition of Labor Union Women
 Coalition on Smoking OR Health
 Commission on Pan-Methodist Cooperation
 Commissioned Officers Association of U.S. Public Health Service
 Committee for Education Funding
 Congressional Black Caucus

Congressional Caucus for Women's Issues
 Consumer Federal of America
 Consumer Federation of America
 Council for State and Territorial Epidemiologists
 Council of Chief State School Officers
 Council of Great City Schools
 Council of State/Territorial Epidemiologists
 Council of the Great City Schools
 Delta Sigma Theta Sorority, Inc.
 Doctors Ought to Care
 Drug, Hospital, and Health Care Employees Union
 Education/Training/Research Associates
 Environmental Defense Fund
 Family Planning Center, Inc.
 Food Research and Action Center
 Fund for the Feminist Majority
 Funders Concerned about AIDS
 Girls, Inc.
 Harvard School of Public Health
 Health Policy Institute
 Hetrick-Martin Institute for Gay and Lesbian Youth
 Hispanic Nurses Association
 Human Rights Campaign Fund
 ILGWU
 Institution for Advanced Study of Human Sexuality Alumni Association
 International Coalition of Women Physicians, Inc.
 Japanese American Citizens League
 Juvenile Diabetes Foundation International
 Kappa Alpha Psi Fraternity, Inc.
 Large Council Executive Director's Association
 Legal Defense and Education Fund
 March of Dimes, Birth Defects Foundation
 Martin Luther King Center for Nonviolent Social Change
 Maternal & Child Health Institute
 Maternal and Child Health Institute (Atlanta)
 Mexican American Women's National Association
 Minority Cardiovascular Disease Prevention Task Force
 Ms. Foundation for Women
 NAACP
 NAACP (Little Rock)
 NAACP Legal Defense Fund
 National Abortion Federation
 National Abortion Rights Action League
 National Alliance of State and Territorial AIDS Directors
 National Assembly of State Arts Agencies
 National Association of Secondary School Principals
 National Association for Equal Opportunity in Higher Education
 National Association for Sickle Cell Disease
 National Association of Black Psychologists
 National Association of Children's Hospitals and Related Institutions, Inc.
 National Association of Community Health Centers
 National Association of County Health Officials
 National Association of Ecumenical Staff
 National Association of Elementary School Principals
 National Association of Health Services Executives
 National Association of Labor Workers
 National Association of Pediatric Nurses and Practitioners
 National Association of People with AIDS
 National Association of Protection and Advocacy Systems
 National Association of School Nurses
 National Association of Secondary School Principals
 National Association of Social Workers
 National Association of State Alcohol and Drug Abuse Directors, Inc.
 National Association of State Boards of Education

National Association of WIC Directors
 National Black Caucus of State Legislators
 National Black Child Development Institute
 National Black Nurses Association (40 letters)
 National Black Women's Health Project
 National Catholic AIDS Network
 National Caucus and Center on Black Aged, Inc.
 National Coalition to Support Sexuality Education
 National Committee on Pay Equity
 National Community AIDS Partnership
 National Consumers League
 National Council of Jewish Women
 National Council of Negro Women
 National Council of Senior Citizens
 National Council on Alcoholism and Drug Dependence, Inc.
 National Council on Family Relations
 National Education Association
 National Education Association Health Information Network
 National Environmental Health Association
 National Episcopal AIDS Coalition
 National Family Planning and Reproductive Health Association
 National Federation of Business and Professional Women's Clubs, Inc.
 National Foundation for Infectious Diseases
 National Gay and Lesbian Task Force
 National Jewish Democratic Council
 National Lawyers Guild
 National Leadership Coalition on AIDS
 National Lesbian and Gay Health Foundation
 National Medical Association
 National Medical Political Action Committee
 National Minority AIDS Council
 National Multiple Sclerosis Association
 National Native American AIDS Prevention Center
 National Network of Runaway and Youth Services
 National Network of Runaway Services
 National Organization of Women (NOW)
 National Organization of Women Legal Defense and Education Fund
 National Organization on Adolescent Pregnancy, Parenting, and Prevention
 National Organization Responding to AIDS
 National Pan Hellenic Council
 National Pediatric HIV Resource Center
 National Political Congress of Black Women
 National Program to Prevent Unintended Pregnancy
 National PTA
 National Public Health Information Coalition
 National Puerto Rican Coalition, Inc.
 National Resources Defense Council
 National Rural Health Association
 National School Boards Association
 National Smoking Cessation Center for African American Women
 National Task Force on AIDS Prevention
 National Urban Coalition
 National Urban League
 National WIC (Women's Infants, and Children) Directors
 National Women's Law Center

National Women's Political Caucus
 Northwest AIDS Foundation
 Nutrition Coalition for Health Care Reform
 Older Women's League
 Omega Psi Phi Fraternity, Inc.
 Operation PUSH
 Organizacion Nacional de La Salud de La Mujer Latina
 Partnership for Prevention
 Pediatric AIDS Foundation
 Pension Rights Center
 People for the American Way
 Phi Beta Sigma Fraternity
 Philadelphia AIDS Coalition
 Physicians for Social Responsibility
 Planned Parenthood Federation of America
 Presbyterian Church USA
 Produce for Better Health Foundation
 Produce Marketing Association
 Public Citizen
 Public Health Foundation
 Public Health Information Services
 Public Voice for Food Policy and Health
 Religious Action Center of Reform Judaism
 Sara Lee Corporation
 Sex Information and Education Council of the U.S.
 Sigma Gamma Rho Sorority, Inc.
 Society for Adolescent Medicine
 Society for Nutrition Education
 Society for Pediatric Research
 Southern Christian Leadership Conference
 Southern Regional Project of Infant Mortality
 State Family Planning Administrators
 Therapeutic Communities of America
 Tobacco Free Heartland
 U.S. Conference of Local Health Officials
 U.S. Conference of Mayors
 UAW
 Union of American Hebrew Congregation
 Unitarian Universalist Association of Congregations
 United Church of Christ Office for Church in Society
 United Food and Commercial Workers International Union, AFL-CIO and CLC
 United Methodist Church and Society
 United Methodist Women
 Voters for Choice
 Wider Opportunities for Women, Inc. (WOW)
 Woman Activist Fund
 Women and Poverty Project
 Women's International League for Peace and Freedom
 Women's Legal Defense Fund
 World Federation of Hemophilia
 YWCA of U.S.A.
 Zero Population Growth

STATE/LOCAL ENDORSEMENTS

100 Black Women of Long Island, Inc.
 Adolescent AIDS Program of the Montefiore Medical Center
 AIDS Project Los Angeles
 AIDS Service of Dallas
 Alabama State Nurses Association
 Alaskans/Americans Living with HIV
 Alliance for Young Families
 American Association of University Women of Maine

American Lung Association of Illinois
 Arkansas Advocates for Children and Families
 Arkansas Baptist College
 Arkansas Chapter of the Society for Public Health Education
 Arkansas Children's Hospital
 Arkansas Department of Health
 Arkansas Hospital Association
 Arkansas Medical Dental Pharmaceutical Association
 Arkansas Medical Society
 Arkansas Minority AIDS Task Force
 Arkansas Minority Health Commission
 Arkansas PTA
 Arkansas Public Health Association
 Arkansas State Board of Health
 Atlanta Neighborhood Development Partnership, Inc.
 Black Nurses' Association
 Boston Women's Health Book Collective
 Broadway Cares/Equity Fights AIDS
 Brooklyn Pediatric AIDS Network
 California Teen Pregnancy and Parenting Coalition
 Care Planned Parenthood of New York City
 Central State University of Ohio
 Chicago Area Immunization Campaign
 Chicago Public School System
 Chicago Women's AIDS Projects
 Chicano/Latino Medical Association of California
 Children's Center
 Children's Diagnostic and Treatment Center of South Florida
 Children's Hospital of Columbus, Ohio
 City of Los Angeles AIDS Coordinator
 Coalition for School-Based Primary Care
 Coalition of 100 Black Women (of metropolitan Atlanta)
 Coalition of Black Trade Unionists
 Colorado Academy of Family Physicians, Inc.
 Community Health and Education Program of the Columbia University School of
 Community Health Connection of Wilkes, Inc.; NC
 Community United Methodist Church
 Community United Methodist Church of Brighton, MA
 Council of Black Nurses of Los Angeles
 Education/Training/Research
 El Centro del Pueblo of Los Angeles
 Englewood Health Department of New Jersey
 Family Planning Center, Inc.
 Family Health Council of Central Pennsylvania
 Family Health Council of Pennsylvania
 Family Planning Advocates of New York State, Inc.
 Family Planning Association of Maine
 Family Planning Center, Inc.
 Family Planning Council of Cayuga County
 Family Planning Council of Iowa
 Family Planning Council of New Hampshire
 Family Planning Council of Southeastern Pennsylvania
 Feminist Women's Health Center of Atlanta
 Green Hills Community Action Agency --
 Harbor Sweets
 Health First
 Hollywood Women's Political Committee
 Horta Pharm B.V. of the Netherlands
 Idaho Women's Network
 Illinois Maternal and Child Health Coalition
 Johns Hopkins University School of Medicine -- Department of Pediatrics and the
 Kalamazoo AIDS Resource and Education Services
 Kansas Department of Health and Environment
 Kansas Health and Environment Chronic Disease Control Division

Legal Action Center
 Life Foundation
 Lincoln County Nursing Service
 Little Rock Black Nurses' Association
 Los Angeles Immunization Coalition
 Los Angeles Regional Family Planning Council, Inc.
 Louisiana Department of Health and Hospitals
 Louisiana Office of Public Health
 Magic Valley Citizens for Choice
 Maine Chapter of NOW
 Maine Choice Coalition
 Maine Civil Liberties Union
 Maine Women's Lobby
 Massachusetts Committee for Children and Youth
 Massachusetts Nurses Association
 Massachusetts Nutrition Board
 Massachusetts Public Health Association
 Maternal and Child Health Coalition of Nevada
 Mecklenburg Council on Adolescent Pregnancy
 Medico-Chirurgical Society
 Memphis and Shelby County Health Department
 Mercy Family Medicine Residency Program; Denver, CO
 Mercy Medical Center
 Metropolitan Washington Public Health Association
 Minority Task Force on AIDS
 Mississippi Conference on Social Welfare
 Mississippi Health Advocacy Program
 Mississippi State Department of Health
 Missouri Health Council, Inc.
 Municipality of Anchorage Department of Health and Human Services
 NAACP (Little Rock)
 National Association of Children's Hospitals and Related Institutions, Inc.
 National Association of Fashion and Accessory Designers Inc
 National Association of Negro Business and Professional Women's Clubs, Inc.
 National Coalition of 100 Black Women, Inc. of Virginia
 New Hampshire Family Planning Council
 New Jersey State School Nurses Association
 New Mexico Community Foundation
 New Mexico Department of Health
 New York City Commission on the Status of Women
 New York State Department of Health AIDS Institute
 North Carolina Coalition on Adolescent Pregnancy
 North Dakota Department of Health, Division of Health, Promotion and Education
 North Dakota State Department of Health and Consolidated Laboratories
 North Jersey Medical Society
 NOW-San Francisco Chapter
 Ogala Sioux Tribe
 Oklahoma Sooner City Alumnae Chapter
 Oregon Department of Human Resources Health Division
 Pediatric AIDS Demonstration Project for Alabama
 People with AIDS Coalition of Tucson
 Philadelphia AIDS Coalition
 Philander Smith College
 Physicians Association of Louisiana, Inc.
 Planned Parenthood of Alaska
 Planned Parenthood of Broward County, FL
 Planned Parenthood of Buffalo and Erie County
 Planned Parenthood of Chester County of Pennsylvania
 Planned Parenthood of Delaware and Otsego Counties
 Planned Parenthood of East Central Illinois
 Planned Parenthood of Essex County
 Planned Parenthood of Greater Iowa
 Planned Parenthood of Greater Kansas City

Planned Parenthood of Greater Northern New Jersey
 Planned Parenthood of Greater Western Michigan
 Planned Parenthood of Lincoln
 Planned Parenthood of Memphis
 Planned Parenthood of Monmouth County
 Planned Parenthood of New York City

Planned Parenthood of Niagara County
 Planned Parenthood of Northern New England
 Planned Parenthood of Northern New York
 Planned Parenthood of Rochester and Genesee Valley, Inc.
 Planned Parenthood of San Mateo County, CA
 Planned Parenthood of Southern Tier, Inc.
 Planned Parenthood of Suffolk County
 Planned Parenthood of Summit, Portage and Medina Counties
 Planned Parenthood of Tompkins County
 Planned Parenthood of West Michigan
 Planned Parenthood of Wisconsin
 Pro-Choice Coalition of West Tennessee
 PROTOTYPES

Public Health

PWA (People with AIDS) of Jacksonville, FL
 Retired Senior Volunteer Program
 Sage United Methodist Church of Monterey Park, CA
 Shelby County Adolescent Pregnancy Prevention Council of Tennessee
 Southwestern Jefferson County Consolidated School Corporation of Indiana
 State of Alabama Department of Health
 State of Tennessee Department of Education
 State of Tennessee Department of Health
 Surry County Department of Health
 Texas Family Planning Association
 United Brotherhood of Carpenters and Joiners of America
 United Methodist Church of Harrisburg
 United Methodist Church of Little Rock
 United Methodist Church of Pine Bluff
 Upper Hudson Planned Parenthood
 Utah Public Health Association
 Violet-Cherry-Englewood Health Department, New Jersey
 Waianae Coast Comprehensive Health Center
 Washington State Department of Health
 Washington Urban League
 Women's Bar Association of Washington, D.C.
 Women's International League for Peace and Freedom

PERSONAL ENDORSEMENTS

Jo Ann Spees
 Lilla Natson
 Patricia A. Nolan
 Enid Hickman
 Anne Hess
 Diane Murray
 Sukey Wagner
 Suki Terada Ports
 Sheila G. Holden
 Malinda Miles

Executive Director of Colorado Department of Health

Iris House

Peter D. Relyea
 Deborah C. Francis
 Linda Haynie Green
 Audrey Opulski
 Mary Ellen Yamashita
 Dorothy Johnson
 Lorrie Luahnat Bellair
 Tonya Hall
 Catherine Saalfeld
 Beverly Ratter
 Petra Allende
 Linda Gang
 Bambi T. Magie
 Mary K. Richards and colleagues
 Peggy L. Kopf
 Myrta Cuadro
 Liat E. Applenhite
 Denice Williams Johnson
 Wei Lam
 Dave Cutler
 Yvette Green
 Debbie Dotson
 Mary N.D. Matanane
 Agnes Molnar
 Cynthia A. McKinney
 Electra Kimble Price
 Valyrie K. Laedlein
 Jeannette Bobst
 Terry M. Stone
 Ann Jueschke
 Rev. Richard A. Schlosser
 Diana Slutzman
 Carlton Newsome
 Ann Whitehead
 Gwen E. Bowman
 Diane Kujawa
 Hilary House
 Leslie J. Bille
 Carol A. Perhach
 Joan Fields
 James R. Miller
 LaShime McBride
 Debra Cooper
 Anthony Houston
 Grace E. Groves
 O'Neill Blacker-Hanson
 Martha Parry
 Susan Edwards
 Bonnie L. Solloway
 Dr. and Mrs. Charles P. Hadley
 Henry A. Waxman
 Irwin Redlener
 Roosevelt Brown
 Isadore Seeman
 Karen Heck
 Hannah Sidofsky
 Lois Moore
 Sandi von Scoyoc
 Margaret V. Todd
 John H. Stoner
 Nicole Simpson
 Douglas S. Lloyd
 J. Smith
 Ingrid Scott Weekley

Pima County Health Department

Sullivan County Regional Health Department
 Maternal Child Health Program of Guam

United States Representative

Lane County Public Health Services Manager

Josephine County, Oregon Health Department

Sullivan County Regional Health Department

Detroit Department of Health
 Onondaga County Health Department

WTLV-12

U.S. Representative

Kennebec Valley Community Action Program

Delta Sigma Theta
 Charlotte-Mecklenburg Schools

Jane Kravotil
 Mary E. Henry
 F. Herbert Skeete
 Marilyn W. Derig
 Julia Minoia
 Barbara Floyd
 Firms Barber
 Patricia D. Mail
 Willie E. Francis
 David L. White
 Dianne E. Christensen
 Michael H. Rhodes
 Maureen Homenick
 John F. Higdon
 Paul and Janet Haynes
 Gail G. Church
 Carolyn H. Stewart
 Patricia Barber
 James H. Littrell
 Michael Burkhardt
 Ronald Levine
 Michael Skeels
 Peter Somani
 Ed Thompson
 Coleen Kivlahan
 Christopher Alchison
 Dr. and Mrs. Glenn White
 Margaret Dionne
 S. P. Meyn
 Marie C. Meglen

Laverne Alves Snow
 Jeanee Seals; Margaret Major
 Johana Wiese
 Sadako S. Holmes
 John Lumpkin
 Sidney Alexander
 Jack Dillenberg
 Mimi Fields
 James Lieberman
 Faye Wilson
 T.W. Lewis, III
 Patricia Nolan
 Agnes Dolores Lattimer
 Elizabeth Karlin
 Laura M. Keefe
 Rice Leach
 Larry Hebert
 Lani Graham
 Nelson Sabatini
 David Mulligan
 Gregg Wright
 Allan Noonan
 Rod Beft
 Jan Carney
 Robert Strube
 Jane Sabes
 Cindy Howard
 Sheila J. Webb
 Rosemary M. Jones
 Ray Baker
 Amando I. Smith
 Harvey V. Fineberg
 Millicent Y. Cox

United Methodist Church of Boston

Jacobus Center for Reproductive Health
 Curry County Health Department
 Mississippi Human Services Agenda

Brunswick County Health Department
 The Momentum Project

National Political Congress of Black Women

Philadelphia AIDS Consortium
 New Mexico State Health Official
 North Carolina State Health Official
 Oregon State Health Official
 Ohio State Health Official
 Mississippi State Health Official
 Missouri State Health Official
 Iowa State Health Official

South Carolina Department of Health and
 Environmental Control
 Utah Public Health Association
 State of Tennessee Department of Health

Illinois State Health Official
 Lahey Clinic of Burlington, MA
 Arizona State Health Official
 Washington State Health Official
 Director of Health; Greenwich, CT
 General Board of Global Ministries
 Millsaps College
 Colorado State Health Official
 Medical Director of Cook County Hospital
 Women's Medical Center of Madison

Kentucky State Health Official
 Louisiana State Health Official
 Maine State Health Official
 Maryland State Health Official
 Massachusetts State Health Official
 Nebraska Passt State Health Official
 Pennsylvania State Health Official
 Utah State Health Official
 Vermont State Health Official
 Virginia State Health Official
 Wyoming State Health Official

Department of Health of New Orleans
 Tioga Opportunities Program, Inc.
 Kansas State Health Official

Harvard School of Public Health
 United Methodist Church

Erima J. Vaughan
 Consuelo Saragoza
 Charles F. Flagg
 Stella Reinstein
 Ann C. Hobson
 Christine A. Forester
 Mary Ann Oakley
 Louisa Woodward
 Cindy Goldstein
 Jane H. Lee
 Mary Parker
 Johanna Dwyer
 Peter D. Wilson
 Robert C. Harder
 Joan K. Leavitt, M.D.
 Jean G. Brown
 Sima D. Michaels
 Linda Polk
 Robert W. Johnson, Jr.
 Tom Dressler
 Anna Dillman
 Susan S. Addiss

Paul W. Nannis
 Barbara D. Martin
 Lynn Cooper Breckenmaker
 David R. Smith
 Elena Rios
 Beth E. Dozoretz
 Alan Blum
 Robert C. Harder
 Harold Wimmer
 Marion A. Humphrey
 Penni Eldredge-Martin
 Idella Washington
 John Lewin
 Ron J. Anderson
 Robert Cunningham
 Jeanne Kefner
 Margaret and Peter Strumpf
 Kimberly D. Jones
 Tom Brown
 Joan Campbell
 Barbara Debuono
 Larry Herbert
 Dr. C. Everett Koop
 Paul Nannis
 Samuel Rogers
 Alex Vinson
 Bernard Barth
 Tonie Fleming
 Samuel H. Thomas, III
 Nichelle Schoutz
 Damon Green
 Sharon McGill
 Kim Williams
 Frances Grace Block
 Mark and Claudia Washburn
 Sheila Maloney
 Arthur and Anne Johnson
 Hermann Mendez
 Virginia Benker-Beck
 Christina Lightbourne
 Martha C.

New England Medical Center
 National Association of Children's Hospitals
 Department of Health and Environment of
 Former Health Official of Oklahoma; Past
 Family Guidance Center (Missouri)
 Los Angeles Regional Family Planning Council

Commissioner of Connecticut Department of
 Public Health and Addiction Services
 Commissioner of Health of Milwaukee

Family Health Council of Central Pennsylvania
 Texas Department of Health
 The Chicano/Latino Medical Association of
 First Hospital Corporation (Virginia)
 Baylor College of Medicine/Doctors Ought To
 Kansas Department of Health and Environment
 American Lung Association of Illinois
 Circuit Judge of Little Rock

Alpha Kappa Alpha
 Hawaii State Health Official
 Parkland Memorial Hospital; Texas Board of Health

NASN Director of New Jersey

State Health Official of South Carolina
 General Secretary, National Council of Churches
 State Health Official of Rhode Island
 State Health Official of Louisiana

Milwaukee Department of Public Health
 Community Health Center, Kansas City, MO

Children's Medical Center of Brooklyn
 Erie Medical Center

Tracee N. Murphey	
Dr. E.B. Johnson, Jr.	
Julie L. Webster	
Pat Donze Shae	
Jonathon Makepeace	
Pamela T. Wright	
Beth Teubert	
Ian Thompson	
Lynne Mohe	
Dorothy Morris	
Kara C. Mariaca	
Mr. and Mrs. Robert W. Schafer	Morse Enterprises, Inc.
Mildred S. Morse	
Mr. and Mrs. Simon L. Cohen	
Deanna Durica	Yukon-Kuskokwim Health Corporation
Mark B. Horton	Director of Department of Health of Nebraska
Donald Kwalick	Nevada State Health Official
Bruce Siegel	New Jersey State Health Official
Mr. and Mrs. Foster Brandt	
Robert W. Dunn	
Vivian O. Lee	
Lee R. Heck	Director of Revenue Development of Dallas
Lawton Chiles	Governor of Florida
James D. Thomas	
Lessie F. Laris	
Summiya Wimbish	
Elica Ware	
Sandra Soule	
Carolyn Barge	
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Human Services

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Susan G. Komen Breast Cancer Foundation

American College of Physicians

Paul F. Griner, MD, FACP
President

July 12, 1993

The Honorable Edward M. Kennedy
U.S. Senate
Washington, DC 20510

Dear Senator Kennedy:

The American College of Physicians, representing more than 80,000 physicians practicing internal medicine and its subspecialties, strongly supports the confirmation of M. Joycelyn Elders, M.D., as U.S. Surgeon General.

Dr. Elders is a board-certified pediatric endocrinologist, holds a Master of Science degree in biochemistry, and is author of more than 150 scientific articles for medical publications. Prior to becoming Arkansas Director of Public Health in 1987, she served as President of the Association of State and Territorial Health Officers, and has served on numerous distinguished panels, such as the National Advisory Committee on Rural Health. She is the recipient of more than a dozen awards for her achievements, including the AMA National Congress on Adolescent Health Award, the National Education Association's Award for Creative Leadership in Women's Rights, and the National Governor's Association Distinguished Service Award.

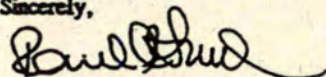
As Director of the Arkansas Department of Health since 1987, Dr. Elders tackled difficult public health challenges and amassed a record of achievement through innovative approaches to difficult problems. She initiated a plan to expand home health care in Arkansas allowing senior citizens or medically fragile patients to remain in their communities. In 1990, Dr. Elders instituted a new born sickle cell screening program that now covers 40,000 infants. Under Dr. Elders' leadership, the number of children screened in the EPSDT program went from just over 4,000 in 1988 to over 45,000 in 1992.

One of Dr. Elders' most notable and widely praised achievements was the establishment of innovative school-based clinics in Arkansas, raising the number from one to twenty-six during her tenure. Linking public schools with the Arkansas health department, Dr. Elders was able to successfully bring to those who most needed them services that increased childhood immunization and early childhood screening and reduced teen pregnancy, substance abuse, sexual abuse, and sexually transmitted diseases.

As Surgeon General, Dr. Elders will bring new focus to health care toward health promotion and disease prevention. New initiatives are essential to control infectious diseases such as tuberculosis and measles. Health promotion is also a priority of Dr. Elders, including nutritional information, counseling on tobacco and alcohol use, and education about avoiding injury and violence. She is dedicated to making primary care available and accessible to all Americans.

The role of Surgeon General requires a forceful and resourceful advocate for health care. The College believes that Dr. Elders' record supports nomination to this key position. We encourage you to strongly support her confirmation.

Sincerely,


Paul F. Griner, MD, FACP
President

ARKANSAS PTA

State Office / 2200 N. Poplar / N. Little Rock, AR 72114 / (501) 753-5247

State President Don Johnson
4312 Ardmore, Springdale, AR 72764
Phone (501) 751-9881
b) 750-8858

July 1993

The Honorable Bill Clinton
President of the United States
1600 Pennsylvania Avenue
Washington DC, 20500

Dear President Clinton,

In keeping with PTA's non-partisan policy, Arkansas PTA strongly supports Dr. Joycelyn Elders efforts on behalf of the health and welfare of all children.

During Dr. Elders tenure as Arkansas State Health Director, she was instrumental in the passage of many legislative issues supported by the National PTA such as the School Based Health Clinics. These clinics provide services to many children who, otherwise, would be denied services such as family planning, periodic early health screening, diagnosis, and treatment.

In 1991, Dr. Elders worked tirelessly, not only during her business hours but during her personal time as well, along with the many hours of her staff, in the testing for and educating the public about the current dangers of lead poisoning in preschool and school aged children. The immunization of children continues to be an on going personal battle of hers, which is another issue that is close to the heart of PTA.

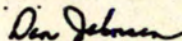
During the 1992 Legislative Session of the Arkansas General Assembly, Dr. Elders, along with the Arkansas PTA, formed a coalition to increase the sales tax on cigarettes with the majority of the funds to be designated for children's health services.

Dr. Elders is a tireless advocate for all health issues, especially those relating to children. One of her famous quotes is, "All children are at risk of becoming members of the S-H Club, that is homeless, hopeless, hungry, helpless, and hugless." It is up to us to put in place those measures that will void that membership forever.

Because of Dr. Elders devotion and commitment to children, Arkansas PTA bestowed upon her the highest honor PTA can award, an Honorary Life Membership in Arkansas PTA. Joycelyn Elders truly cares for children. It is not out of the ordinary for her to drive for hours to visit with a teenage mother concerning the health of the mother and/or her child.

We have been privileged to have had the opportunity to have worked with Dr. Elders and we continue to applaud her efforts. We, sincerely, hope that Dr. Joycelyn Elders receives the necessary support to become Sergeant General of the United States.

Sincerely,



Don Johnson, President
Arkansas PTA

cc: Office of Governmental Relations
National PTA



CHILD WELFARE LEAGUE OF AMERICA, INC.

440 First Street, NW, Suite 310, Washington, DC 20001-2085 • 202/638-2952 • FAX 202/638-4004

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Sandra G. Smith
Director

July 8, 1993

*Support for
Elders
Sug Gen.*

The Honorable Edward Kennedy, Chairman
Committee on Labor and Human Resources
U.S. Senate
Washington DC 20510

Dear Mr. Chairman:

Please accept my enthusiastic recommendation of Dr. M. Joycelyn Elders for the position of Surgeon General of the United States. From my perspective, Dr. Elders is the ideal candidate for this position.

Throughout her long and distinguished career as a physician, public servant, and children's advocate, Dr. Elders has demonstrated an unwavering commitment to the welfare of children, youth, and families. Her work as Professor in Pediatrics at the University of Arkansas Medical Center indicates both a profound concern for, and extensive knowledge of, the health needs of the nation's children.

She also brings outstanding public leadership credentials to this position. As director of the Arkansas State Health Department since 1987, she has helped to raise the immunization rates of pre-school children in the state. Her programs have also led to a reduction in infant mortality and the rate of increase in teenage pregnancy. Dr. Elders' service on several national health commissions, including the Secretary's Advisory Committee for Infant Mortality, means that she will bring a broad national perspective to the Surgeon General's post.

In addition, her impressive record of civic service, which includes terms as a board member of the Elizabeth Mitchell Children's Home and Youth Homes Inc. demonstrates her knowledge of the needs of vulnerable and at-risk children and families.

Dr. Elders will make a superb advocate for the health of our nation's children and for enduring changes to improve the health of all Americans. I heartily endorse her nomination.

Sincerely,

David

David S. Liederman
Executive Director

cc: Members of the Senate Committee on Labor and Human Resources

TO: Interested Persons DATE: July 7, 1993

FROM: Wade Henderson, Director *WH*

RE: Nomination of Dr. Joycelyn Elders for Surgeon General

Call, write, and send telegrams to your Senators and urge them to support the nomination of Dr. Joycelyn Elders for U.S. Surgeon General. Contact these members of the Committee on Labor and Human Resources: Edward M. Kennedy-MA (Chairman), Claiborne Pell-RI, Howard M. Metzenbaum-OH, Christopher J. Dodd-CT, Paul Simon-IL, Tom Harkin-IA, Barbara A. Mikulski-MD, Jeff Bingaman-NM, Paul David Wellstone-MN, Harris Wofford-PA, Nancy Landon Kassebaum-KS, James M. Jeffords-VT, Dan Coats-IN, Judd Gregg-NH, Strom Thurman-SC, Orrin G. Hatch-UT, Dave Durenberger-MN. You may reach your Senators by calling the Capitol Switchboard at (202) 224-3121.

Immediately. NAACP members are urged to call their Senators and request their support for Dr. Joycelyn Elders' nomination. It is imperative that the NAACP's vigorous support for Dr. Elders be heard.

Dr. Joycelyn Elders is the first African American woman to be nominated for the position of U.S. Surgeon General. Presently, Dr. Elders is the director of the Arkansas Health Department. In December of 1992, President Clinton selected Dr. Elders as his choice for U.S. Surgeon General; however, Dr. Antonia Novello, outgoing Surgeon General, requested to remain in position until June 30, 1993. Several conservative groups and Christian fundamentalists have attacked Dr. Elders because of her progressive views on health care for all Americans. Leading the attack is the Concerned Women of America, who call Dr. Elders "a very, very dangerous woman," and vow to defeat her nomination.

Dr. Elders graduated from Philander Smith College in Little Rock. She then served as physical therapist in the Army before earning her medical degree, and a Masters Degree in biochemistry, from the University of Arkansas School of Medicine. Dr. Elders then trained in pediatrics at the University of Minnesota hospitals and became chief pediatric resident at the University Hospital in 1961. For the next 20 years, Dr. Elders combined research in pediatric endocrinology with a university clinical practice that specialized in the treatment of juvenile diabetes.

Dr. Elders believes that discussions of "public health" must include everything from the impact of poverty, the plague of violence, medical assistance to the elderly, nutrition, preventive medicine and treatment of disease. In her capacity as director of public health in Arkansas, Dr. Elders has already battled right-wing forces who opposed her efforts to combat AIDS, child sex abuse, and adolescent pregnancy through public education. These groups became particularly angry over her attempts to reduce teen pregnancy and combat AIDS through school-based clinics and education in public schools. Though personally opposed to abortion, Dr. Elders is pro-choice.

Dr. Elders' life and career have enabled her to appreciate the harsh realities of health problems in the African American community, and have led her to tackle hard issues with vigor. The African American community cannot afford to lose the important opportunity to have Dr. Joycelyn Elders as our nation's Surgeon General. We need to have a Surgeon General who is not afraid to speak candidly about the difficult health care problems facing the nation.

The NAACP must urge Senators to confirm Dr. Elders as U.S. Surgeon General. Senator Edward (Ted) Kennedy, Chairman of the Committee on Labor and Human Resources, has voiced his support for Dr. Elders and will prove helpful in guiding her nomination through the confirmation hearings. Dr. Elders' confirmation hearing has been set for Friday, July 16, 1993.

The NAACP must show a strong, independent voice in support of Dr. Elders. The African American community, and this country as a whole, needs both her medical experience and willingness to confront some of the most distressing health problems of our times.

March of Dimes
Birth Defects Foundation
National Government Affairs Office
1001 L Street, N.W., Suite 200
Washington, DC 20036
Telephone 202 658 1800
Fax 202 295 2564

July 14, 1993

The Honorable Edward M. Kennedy
Chairman
Labor and Human Resources Committee
U.S. Senate
Washington, D.C. 20510

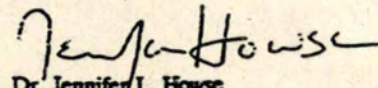
Dear Mr. Chairman:

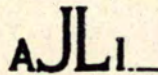
The March of Dimes Birth Defects Foundation greatly appreciates your enthusiastic endorsement of Joycelyn Elders, M.D. for U.S. Surgeon General. As a pediatrician and a leader in public health, Dr. Elders has been a strong advocate for improving the health of mothers and babies. Your leadership will be key in securing her confirmation.

In her capacity as the director of the Arkansas State Health Department, Dr. Elders has supported and worked jointly with the March of Dimes in our Campaign for Healthy Babies. She has also helped raise the immunization rates of pre-school children in the state and has been instrumental in attracting more health professionals to serve pregnant women and children in the underserved rural areas. Furthermore, she has forged important linkages between the education and health communities to encourage comprehensive school health education and to promote the healthy development of our nation's youth.

The March of Dimes believes that the confirmation of Dr. Elders as U.S. Surgeon General will help ensure that preventive and primary health for mothers and babies is a priority of this nation. Again, I thank you for your efforts in support of her confirmation.

Sincerely,


Dr. Jennifer L. Howse
President



THE ASSOCIATION OF JUNIOR LEAGUES INTERNATIONAL, INC.

July 8, 1993

President William Jefferson Clinton
The White House
Washington, DC 20500

Dear President Clinton,

On behalf of the Association of Junior Leagues International (AJLI) it is with great pleasure we add our support for the nomination of Dr. Jocelyn Elders to the position of U.S. Surgeon General. Through her work as the Director of the Arkansas Department of Health, we have experienced first hand Dr. Elder's vision, compassion, commitment and the difference she has made in the lives of children throughout Arkansas.

The Association of Junior Leagues International is an organization of women committed to promoting volunteerism and to improving the community through the effective action and leadership of trained volunteers. Representing 190,000 women in 283 Junior Leagues, AJLI has over ninety years of experience in working to ensure the adequate health of all children, youth, and pregnant women. In 1991, the Association's Board of Directors adopted Child Health as a priority, with the following goal: *All children, youth, and pregnant women should be guaranteed availability and access to appropriate preventive primary health care.* The work of Dr. Elders clearly and effectively supports the Association's position on Child Health and will bring leadership and attention to an issue critical to the health of our country. The children of the United States will be in good hands with Dr. Elders. She will serve us well.

Sincerely,

Mary Berrus Babson
President
Association of Junior
Leagues International

Sherrye McBryde
President
Junior League of
Little Rock

Elvada Ward
President
Junior League of
North Little Rock

Janie Goins
President
Junior League of
Fort Smith



NATIONAL EDUCATION ASSOCIATION

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Marlene McMahon, Executive Director
Don Garmann, Executive Director

1201 16th Street, N.W.
Washington, D.C. 20036-3290
(202) 822-7000 Fax (202) 822-7974

EXECUTIVE OFFICE

July 12, 1993

The Honorable Edward M. Kennedy
Chairman
Labor and Human Resources Committee
U.S. Senate
Washington, D.C. 20510

Dear Mr. Chairman:

The National Education Association supports the quick confirmation of Joycelyn Elders M.D. as U.S. Surgeon General. Dr. Elders has extensive experience and knowledge in the field of public health and is dedicated to tackling tough issues. While Director of the Arkansas State Health Department, Dr. Elders was instrumental in raising the immunization rates of preschool children, reducing the teenage pregnancy rate, and helping to lower the state's infant mortality rate.

Throughout her career she has demonstrated an unwavering commitment to improve public health and has dedicated herself to educating the public on important health issues. As a professor of pediatrics at the University of Arkansas Medical School and a researcher into the causes and treatment of hormone-related illness, she published more than 150 articles for medical research publications. She is a board certified pediatric-endocrinologist, served as a first Lieutenant in the U.S. Army, and has received the American Medical Association's National Congress on Adolescent Health Award for outstanding efforts on behalf of American Youth.

America needs strong leadership to help conquer the AIDS epidemic, curb alcohol and drug abuse, and fight the spread of diseases. Dr. Elders is clearly the person to provide that leadership. I am confident that as she works to educate Americans on key health issues, she will also inspire a new generation of health care professionals to serve with the same compassion and dedication that she has displayed throughout her career. We urge you to vote for her confirmation as soon as possible.

Sincerely,

Keith Geiger
President



July 14, 1993

Honorable Edward M. Kennedy
United States Senate
Washington, D.C. 20510-2101

Dear Senator Kennedy:

The YWCA of the U.S.A. enthusiastically supports President Clinton's nomination of Dr. Joycelyn Elders to the position of U.S. Surgeon General. She is a highly skilled pediatrician, public health professional, and outstanding advocate for children. She understands the need for preventative services in regard to adolescent pregnancy and screenings for cervical and breast cancer, HIV, and children, all priorities in the public policy recommendations of our constituents.

As a professor of pediatrics and researcher at the University of Arkansas Medical School, Dr. Elders authored more than 150 scholarly articles for medical publications. Her distinctions include the American Medical Association Awards for Outstanding Efforts on Behalf of American Youth and for Outstanding Public Health Professional, the National Education Association's Mary Futrell Award for Creative Leadership in Women's Rights, the National Governor's Association Distinguished Service Award, and the National Coalition of 100 Black Women's Candace Award for Health Science.

Confirmation of Dr. Elders will ensure an increased dedication to the health status of all Americans. We urge you to strongly support her confirmation.

The YWCA of the U.S.A. is a women's membership organization. Founded in 1858, it is committed to the empowerment of women and the elimination of racism. Currently, it serves over two million girls, women and their families through 4,000 locations across the nation.

Sincerely,

Ann Stallard
National President

GCS:bab

Gwendolyn Calvert Baker
National Executive Director

Washington Office
6th Floor
624 8th Street, N.W.
Washington, D.C. 20001
202-638-0528
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General Board of Church and Society of The United Methodist Church
100 Maryland Avenue, N.E., Washington, D.C. 20002 • (202) 488-5600

July 7, 1993

United States Senate
Washington, DC 20510

Dear Senator:

The General Board of Church and Society of The United Methodist Church is proud of Dr. Joycelyn Elders' commitment to health and wholeness for all. A life-long member of our denomination, she exemplifies, through her words and actions, the church's dedication to healing ministries. Her career as a pediatrician and public health professional characterizes her religious devotion to the needs of others.

Dr. Elders has the strength of will and mission to confront the difficult and complex health care issues facing our nation. As Surgeon General, she will lead us in reform by focusing the debate on the concerns of prevention and accessibility. One of her major goals will be improving the health and well-being of all, especially adolescents. She will address the issues of infectious disease, nutrition, tobacco and alcohol use, as well as the prevention of injury and violence. Her leadership, anchored in her faith commitment, is urgently needed in this era of failing health care systems and polarized vested interests.

Dr. Elders is a board-certified pediatric endocrinologist. As professor and researcher at the University of Arkansas Medical School, she has authored more than 150 scholastic articles for medical publications.

Among numerous distinctions, she has received the American Medical Association's awards for Outstanding Efforts on Behalf of American Youth and Outstanding Public Health Professional, the National Governor's Association's Distinguished Service Award, and the National Education Association's Award for Creative Leadership in Women Rights.

She currently serves on the boards of a dozen councils and commissions in the public and private sectors, including the National Institute of Medicine's Health Promotion Disease Prevention Committee and the Council on Government Affairs for the Academy of Pediatrics.

In the five-and-a-half years since she became director of the Arkansas State Health Department, she has helped raise the immunization rates of pre-school children in the state and has been instrumental in attracting more health care professionals to practice in underserved areas.

Confirmation of Dr. Elders will help ensure that an improved health status for all becomes a priority of this nation. I encourage your strong support in her behalf.

Sincerely,

Jane Hull Harvey
Assistant General Secretary
Ministry of God's Human Community

- Why the Government Urges- Abstinence and Condoms

Health: The public interest in curbing sex-related disease is also served in encouraging moral, or at least more responsible, sex-related behavior.

By JAMES O. MASON

A couple I know tells what the heavy state they made in a physician and a summer before they were married. The doctor counseled them about the importance of going to church and seeing their parents, while the minister recommended a new book he had heard about, "The Joy of Sex."

I am a physician, and I believe in all of the above—family values, the blessing of church and the joy of sex, with marriage. Like many others, some teachers that emphasized an emphasis on their important relationships, including our all-important relationship with God.

Two days later by visiting, somewhat like the couple, "Which side does your preaching go to?" So he did not exactly that I am convinced by my experience in the Public Health Service that sexual behavior that I would consider young people doing on their parents are also a clear and serious health risk, creating, for example, about 60,000 to 80,000 deaths each year.

Of course, physicians in public health must do more than tell people such out-lets. When we cannot eliminate drug addiction, we must attempt to modify and control them and their consequences.

Promiscuity—casual and irresponsible sex, whether between homosexuals or heterosexuals—is a root cause of many of the deaths, disability and anguish of AIDS.

This public-health risk is what brought a conservative senator, C. Everett Koop, our former surgeon general, to become an outspoken advocate of abstinence.

He didn't change his mind there, but his public-health view reflected a shift in which AIDS to the No. 1 cause killing American youth and a world in which many kids are likely to experience with their bodies and may start having intercourse between the ages of 13 and 16.

This tension between what some of us would prefer that children and adults do and what they sometimes actually do is why the Public Health Service continues to urge abstinence in some programs and yet promotes condom education. To experience education, the goal is to avoid health risks and also lead us to understand to give men certain confidence of sexual protection that, under other circumstances and with other partners, many of us would think inadequate.

Yes, while we need to reach out to the way to encourage and encourage promiscuous heterosexuals, I think we must also point out, again and again, that it is promiscuity that has created AIDS and other sexually transmitted diseases to ravage many of our people and society. We must not forget, from 1972 to 1978

we are in. Promiscuity—casual and irresponsible sex, whether between homosexuals or heterosexuals—is a root cause of many of the deaths, disability and anguish of AIDS.

... From Love, the Malibu-based survivor and activist, says, "When we know how to reject the current, but do not do it, then we become the current." I believe that this is true. I believe that we must move forward with HIV and such common and moral, but we must also speak out about the destructive behaviors that affect individuals and society. We must do this without fear of whatever editors Playboy and other voices of "sensationalism" may throw at us.

Condom use and promiscuity are responsible for spreading AIDS, herpes, hepatitis and other painful, crippling and deadly conditions.

Condom use and promiscuity also limit fertility, test pregnancy and reproductive potential.

Every pregnant woman should receive early and continued prenatal care, but good doctors and midwives are not enough. Freely because of the irresponsible use of drugs, cigarettes and alcohol during pregnancy, 40,000 babies born in the United States this year will die before their first birthday, and 220,000 will live but will have, born with or will develop disabling, chronic conditions that will deprive them of some independence, throughout their lives.

There are the crack babies, the low-weight babies in much poverty of drug-using mothers and this such fatal alcohol syndrome, a devastating and permanent handicap.

We know, too, in this AIDS era, that there is no more lethal cause of women than promiscuity. Do we have the courage to do our duty in this behavior?

We in the Public Health Service have sent out a loud message to Americans that they should modify some of their habits. We tell kids they need to say, swim, play sports and like bicycling. We've advised them to limit their intake of saturated fats and increase the fiber in their diets. We've told them to get their car checked and not to use alcohol or drugs. We've said that women should get mammograms and that men and women should have their cholesterol and blood pressure checked.

But we have been somewhat shy in speaking out against casual sex, early-onset pregnancy and childbearing out of marriage. Without sufficient power, we have sometimes offered the concept of fatherhood to a generation too "open-minded."

I regret the times that behavior is an entirely individual matter, especially in our present circumstances. It is the public's business—namely, at least, a matter requiring public discussion—when one person's smoking impairs the health of another, when a mother's alcohol use causes permanent damage to her child and when alcohol, drugs and promiscuity destroy promising young lives.

We, as physicians, know when we can tell what the conditions we cannot prevent. We make some decisions when we can and refuse the best way we choose. But there are times when the best we can do is advise, urge and recommend—and do it we must.

End of column.

Dr. James O. Mason is assistant secretary for health in the Department of Health and Human Services and head of the U.S. Public Health Service.

PERSPECTIVE ON AIDS
L.A. Times: 7-20-92

How Do You Know You're Safe?



Women must get serious about protecting themselves, for the epidemic is spreading, especially among teens.

By ANTONIA C. NOVELLO

As the nation's first female surgeon general, I'd like to speak to women in this country about a health problem that makes me fear for all of us: the alarming spread of AIDS among sexually active women.

In the second decade of this epidemic, the female face of AIDS is still largely unfamiliar. We do not yet see ourselves from this new and unsettling vantage point, and we are letting this killer claim more and more of us and our children.

We cannot expect to have any real power over our health and well-being until we are empowered with knowledge. If we have learned anything from the solidarity of the women's movement, it is this: To know is to care, and to care is to act.

Let me share with you some facts about women and AIDS, so that you begin to see the problem as it really is.

The Centers for Disease Control estimates that 111,000 women can be counted among the 1 million Americans who are infected with the virus but do not yet show major symptoms. Although men still account for most of the reported cases of AIDS in the United States, women and perinatally infected children are the fastest-growing groups of people reported. Out of more than 214,000 reported cases, roughly 22,000 have been reported in women, almost half of them in the past two years.

HIV infection and AIDS are now among the five leading causes of death for women 25 to 44, an age group that accounts for nearly half of all the women in this country. In New York City and New Jersey, AIDS is already the leading cause of death in women of childbearing age.

About half of the women now sick with AIDS acquired the virus by injecting drugs, but at least 34% got AIDS through heterosexual sex, and it is this risky behavior that endangers the greatest number of women. If we compare the first half of the epidemic to the second half, heterosexual transmission has jumped by 44%. Among teen-age women, the situation is even more

pronounced: 50% of adolescent females diagnosed with AIDS in 1990 reported contracting the virus through heterosexual contact.

Although the data on transmission through vaginal intercourse are still limited, a number of studies have suggested that an infected man may be 2 to 3 times more likely to pass the virus to a woman than a woman is likely to pass it to a man; one study estimated a 20 times higher risk.

Any woman who risks having unprotected sex with just one man is taking the incredible risk of exposure to all of his partners. Remember the partners you have had in the last 10 years, now think about what that means to you and your children, even those yet unborn.

It is widely assumed that women who get AIDS through sex are part of the drug culture. Indeed, 62% of women who acquire the virus heterosexually report that their partners injected drugs. But an increasing proportion of AIDS cases is being attributed to sexual contact with a man whose risk factors were unknown to the woman. This category has increased from 6% in 1985 to about 15% in 1991. Also increasing is the number of cases among women who report sexual contact with bisexual men. 5% fall into this category, and they tend to be older women, between 30 and 49.

I cannot stress enough the far-reaching, deadly consequences of drug abuse. Drug injection transmits HIV through blood in and on shared needles and syringes. This practice involves a twofold risk: direct transmission through shared needles and sexual transmission from men who inject drugs. Alcohol, crack cocaine and other drugs alter judgment about sexual contact and may put users of these drugs at higher risk for infection.

We must stop taking chances and begin to take greater charge of our lives. We must take the initiative to protect our health, to shield ourselves and our children from all sexually transmitted diseases, including HIV.

The first step in prevention is being aware of the risks, then the challenge is to change behavior. This means refraining from sex altogether, or demanding and maintaining a truly monogamous relationship, or negotiating for safer sex through the use of condoms.

Taking such action can be very hard for some women. We have been telling sexually active women that abstinence

works and that those who cannot abstain should change the race and insist that their partners wear condoms. But for women in some communities this can seem impossible. We have also been telling women that monogamy—sex with one uninfected partner—is safe—but realistically speaking, can every woman be sure that she is in a truly monogamous relationship? Because of social, cultural and religious beliefs in some communities, women who insist on bargaining for their protection may be abandoned, abused or thrown out on the streets.

Of equal concern is the fact that many women, especially those associated with the drug culture, are not inclined to seek health services. In many cases, women's unbridled role of caretaker leads them to put others first. They may be diagnosed too late and thus appear to die faster.

AIDS diagnosis may also be complicated by the fact that women with HIV often present slightly different symptoms than men. Like their male counterparts, they suffer from diarrhea, weight loss and pneumocystis carinii pneumonia. In addition to these well-known AIDS manifestations, women with the virus are prone to gynecological disorders such as cervical dysplasia (abnormal cells of the cervix) and severe, difficult-to-treat yeast infections. Owing to these gender differences in the manifestation of the disease, I urge women to consult thoroughly with their health-care providers.

Woman to woman, I urge each of you in all sincerity, that if you have any reason to believe that you may have contracted HIV, the time to act is now. Contact your doctor or visit a public health clinic or testing site right away for counseling and testing.

And don't panic. Remember, you are not alone. AIDS has become a women's disease. And there is a cure, we must encourage one another to do what is necessary to take care of ourselves. It is not egotistical to give our own health priority; it is life-affirming in the face of AIDS. For once put your own health first. Your family will have a lifetime to be glad you did.

For more information, call the Center for Disease Control National AIDS Hotline 1-800-342-AIDS, or 1-800-342-SIDA (Spanish).

Dr. Antonio C. Novello is the surgeon general of the United States.

Teen-agers' high-risk behavior courts AIDS

COMMENT

While AIDS experts confer in Amsterdam, the USA needs to focus on curbing the spread of the virus among adolescents.

The fresh young faces of our adolescents are increasingly becoming the new faces of AIDS — and as a nation we have not yet begun to recognize that fact.

The plain truth is that today, in this country, millions of high school and college-age students may be at dire risk of contracting the human immunodeficiency virus and AIDS.

Through June, 572 cases of adolescents with AIDS were reported in the United States. This deceptively small number obscures the fact that over 44,000 young adults ages 20-29 have been reported with AIDS, many of whom may have been infected during their teen-age years. In 1989, HIV/AIDS became the sixth leading cause of death among young people ages 15-24.

AIDS cases reported among adolescent females have more than doubled — from 13% of all adolescent cases in 1987 to 34% in 1991 — and more than half are due to heterosexual contact. While the overall ratio of males to females reported with AIDS is 4 to 1 in adults, it is 2.7 to 1 among teen-agers.

Studies indicate the average age of first sexual experience among U.S. adolescents is 16. A 1989 survey of adolescents by the Centers for Disease Control reported that 54% were sexually active before finishing high school and 19% had four or more partners.

I must stress this is usually unprotected sexual activity. Of the students surveyed who had sex in the three preceding months, 67% reported using condoms. Condom use dropped significantly as age increased.

Also, 8 million cases of sexually transmitted diseases occur annually among persons under the age of 25 — the equivalent of a teen-ager contracting a sexually transmitted disease

every 20 seconds.

Young people must understand the links in the chain of alcohol and other drugs, risky sex practices, multiple sex partners, unprotected sex and sexually transmitted diseases which can lead to transmission of HIV and AIDS. Too many young people fail to recognize these risks and obtain professional guidance and support. Of the adolescents who did seek AIDS/HIV counseling and testing last year, fully 50% did not return for their test results.

As surgeon general, I cannot allow the spread of HIV in adolescents to continue unchecked. We must impress upon our young people that abstinence is the only sure way to protect themselves from acquiring a sexually transmitted disease or HIV. But being realistic, I believe we must also educate our youth about the best ways to protect themselves if they choose to be sexually active. For them, we must not fail to provide adequate instruction on correct use of condoms and alert them to their obligations and responsibilities toward their sexual partners. Above all, we must foster in them a confident, sensible and realistic approach to sex.

As caring adults, we must remember that most of them will find themselves in risky situations, looking for perhaps no more than a few minutes but having perhaps a lifetime of consequences.

Health-care providers and government officials have to



By Antonio C. Novella, Surgeon General of the Public Health Service.

Who is getting AIDS

Cases by age (Through June 1992)

Age at diagnosis	Number of cases
Under 12	3,988
13-19	1,672
20-29	44,483
30-39	105,657
40-49	51,823
50 or older	22,471

How teens contract it

Increasing numbers of teens are at risk. Breakdown by categories in 13-19 age group. (Through June 1992)

Exposure category	Cases	Percent
Males who have sex with males	213	24%
Injecting drugs	112	13%
Males who have sex with males and inject drugs	37	4%
Homosexual/lesbian contact*	267	31%
Heterosexual contact	124	14%
Recipient of blood transfusion, organ transplant or tissue	55	6%
Undetermined	64	7%

How teens rate AIDS

Gallup surveyed more than 500 teen-agers on the most important problems facing the teen generation. Some teens named more than one problem.

Drug abuse	49%
Peer pressure	15%
AIDS	11%
Teen pregnancy	6%
Alcohol abuse	7%
Education	7%

* Defined as receiving transfusion from hundreds of blood donors.

Source: Centers for Disease Control, Gallup poll, Nov 1991.

Old Version, USA 10047

deal with complex problems when attempting to balance parental rights with the autonomy of the young person. Issues like consent to be tested, notification of partners who test positive, and disclosure of results to parents and/or sexual and drug partners who may be at risk will have to be addressed — all while respecting confidentiality. We must ensure that adolescents have access to testing and counseling that they will feel comfortable going to.

The importance of raising adolescents' awareness of the dangers of HIV/AIDS cannot be overstated. But we must be watchful that our struggle to educate them is not rendered

helpless by failure to provide humane, respectful and confidential services to all adolescents.

The success or failure of our efforts to address HIV infection in adolescents depends less on the competence of our universities than on the will needed to carry them out. We cannot permit the ultimately diverse effects of adolescent development to hinder our efforts. The time has come to open our eyes to the changing faces of AIDS, to do away with blame and to share, instead, in the wisdom and experience that will protect our children — and theirs — from the tragedy of AIDS.

— AIDS conference, 1A, 4D

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
Atlanta, GA 30333

SEP 15 1989

The Honorable Edward M. Kennedy
Chairman
Committee on Labor and Human Resources
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

You have inquired about the use of Centers for Disease Control (CDC) sexually transmitted disease (STD) and human immunodeficiency (HIV) prevention funds, for condoms. When asked, we have provided the following guidance:

The Centers for Disease Control (CDC) supports public health activities that can prevent the spread of human immunodeficiency virus (HIV) infection among adults and young people. Prevention messages targeted to these populations strongly emphasize postponing sexual activity for young people, and mutual monogamy with an uninfected partner for sexually active adults. From a public health perspective, both approaches will help prevent infection with HIV or other sexually transmitted diseases (STDs). For those persons whose sexual behavior puts them at risk, proper use of condoms is an effective means of reducing the risk of HIV or STD infection.

Cooperative agreements with state education agencies funded by CDC's Division of Adolescent and School Health are used to support HIV education as part of comprehensive school health education. These programs are designed to help young people develop the skills they will need to avoid HIV infection, other STDs, and other related health problems. These cooperative agreements provide support for the implementation of HIV education within comprehensive school health education programs, but not for the purchase or provision of condoms.

The CDC also supports state and local health departments as well as community-based organizations to implement HIV prevention programs. These grantees are authorized to purchase condoms with funds awarded to those agencies by CDC. These funds are different from those awarded to state education agencies. Health departments are authorized to use funds from both the STD grants and the HIV prevention cooperative agreements for purchase of condoms, for distribution in STD clinics or as part of other health department programs.

Decisions about the role of condoms in any program of HIV and STD prevention are best made locally, with careful attention to the context in which they are presented. The CDC recognizes and supports the right of each affected community to determine the course of action most appropriate to prevent HIV infection under local circumstances.

I hope this information is helpful to you.

Sincerely,

William L. Roper

William L. Roper, M.D., M.P.H.
Director

From the CDC

CONDOMS FOR PREVENTION OF STD/HIV

Overview

- Bacteria and viruses cannot pass through an intact latex condom
- Multiple studies have demonstrated that condom use protects against STD
- Several studies in persons continuously exposed to HIV+ partners show that condoms protect them against HIV infection
- Contraceptive failure rates are very low among experienced users
- Condoms are manufactured with high standards of quality
- Breakage rates attributable to poor quality are very low

Effectiveness

Laboratory studies

- Condoms provide a mechanical barrier which prevents direct contact with semen, genital discharge, genital lesions, or infectious secretions
- Bacteria and viruses cannot pass through intact latex condoms
- Viruses occasionally pass through natural membrane ("skin" or lambskin) condoms under laboratory conditions

Human studies

- Multiple studies show condoms protect users and their partners against gonorrhea and infection with ureaplasma, herpes simplex virus, and HIV
- Several studies show 100% effectiveness against STD and HIV

Condom Quality

- Condoms are classified as a medical device regulated by the FDA
- Condoms are manufactured according to national standards
- Each condom is individually tested for pinholes and areas of thinning

Condom Failure

Incorrect use or nonuse

- Condoms are highly effective only when used consistently and correctly
- Most experts agree that condoms fail most often due to incorrect and/or inconsistent use
- Typical contraceptive failure rates of 10-20% include persons who did not use condoms consistently
- Studies show that only 30-60% of men who claim to use condoms for contraception actually used them for every act of intercourse
- Contraceptive effectiveness increases with experience--failure rates as low as 0.6% have been documented in experienced users

Condom breakage

- Most studies in the U.S. show breakage rates are less than 1% (1 break per 100 acts of intercourse)
- Incorrect use (oil-based lubricants, fingernail tears) accounts for many condom breakages
- Broken condoms do not always lead to infection or pregnancy--one study showed that more than half of breaks occurred prior to ejaculation

Thank you for your recent inquiry regarding effectiveness of condoms to prevent sexual transmission of HIV. Enclosed are a bibliography of references and a review from the Morbidity and Mortality Weekly Report.

Condoms provide a mechanical barrier which prevents direct contact with semen, genital discharge, genital lesions, or infectious secretions. To be effective, condoms must be placed on the penis prior to any genital contact, must remain intact, and, most importantly, must be used consistently and correctly. Effectiveness of condoms to prevent sexually transmitted diseases has been documented in many laboratory and clinical studies.

Multiple laboratory studies, some of which attempted to simulate the mechanical friction of coitus, have clearly demonstrated that a latex condom is a continuous, impervious barrier to sexually transmitted bacteria and viruses, including HIV. Natural membrane ("skin") condoms, however, have been shown to contain small pores which allow passage of HIV in laboratory tests.

Multiple studies conducted among sexually active persons have shown that condoms protect users and their partners against gonorrhea, ureaplasma infection, herpes simplex virus infection, and HIV infection. As with contraceptive studies, effectiveness varies among studies. Several studies show 100% effectiveness, but others show that some individuals became infected despite self-reported condom use. Some of these individuals may have become infected prior to starting consistent condom use. Condoms are highly effective only with consistent and correct use, which cannot be easily confirmed by researchers. Condom failure is due to nonuse, incorrect use, breakage, or leakage. Although the "typical" failure rate of condoms as contraceptives is approximately 18-20%, this figure reflects failure of the user (to use the condom) in addition to failure of the condom itself. Indeed, condom effectiveness as a contraceptive increases with experience, and failure rates as low as 0.6% have been documented (Vessey). Most data suggest that the individual, not the condom, is usually responsible for infections and unwanted pregnancies, and inconsistent use accounts for a large proportion of unwanted pregnancies among condom users (Sophocles). For example, studies in Bangladesh (Ahmed 1990), and Barbados (Russell-Brown) showed that only 60% and 30%, respectively, of men who said they used condoms for contraception actually used them for every act of intercourse.

Incorrect use also accounts for some condom failures and breakage. In one study, men who acquired gonorrhea despite condom use reported putting the condom on the penis after sexual activity had begun (Darrow). Most studies in the United States have shown breakage rates are less than 1 break per 100 acts of intercourse, and incorrect use accounts for a large proportion. One Australian study (Richters) reported 8 breaks in 1269 acts of vaginal and anal sex (a rate of 0.6%); seven of the breaks were related to fingernail tears or use of oil-based lubricant (which weakens the latex).

Manufacturing defects are quite uncommon, since national standards are used and samples are tested to assure high quality. Each condom is individually tested for pinholes or areas of thinning. Moreover, condoms are classified as medical devices by the Food and Drug Administration, which actively monitors condoms manufactured in and imported into the United States.

It is important to remember that a broken condom does not always lead to pregnancy or infection (Liskin). A woman's chances of pregnancy from a single act of intercourse have been estimated to average 2-4% (Tietze). In one U.S. survey, pregnancy occurred in only 4% of women who reported condom breakage (Hatcher). Although infection with a sexually transmitted disease can occur at any time, most exposures do not in fact lead to infection. The chances of infection with HIV after a single sexual exposure has been estimated to be as low as 0.001 and as high as 0.1 (Liskin). Also, not all condom breaks are equally risky. In one study (Piedrahita), more than half of the breaks occurred while the condom was being put on or taken off. In another study, all breaks occurred prior to ejaculation (Richters).

In summary, we regard condom use as "highly effective" for the following reasons: (1) bacteria and viruses cannot pass through intact latex condoms, (2) multiple studies have demonstrated that condom use protects against sexually transmitted diseases, (3) several studies have shown that persons exposed to HIV who used condoms remained free of infection over many months, (4) extremely low contraceptive failure rates have been demonstrated among experience condom users, (5) condoms are manufactured with high standards of quality, and (5) breakage rates attributable to poor quality are quite low.

I hope this information is useful. Thank you for your concern about this important public health issue.

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Priority Area 18 HIV Infection

Risk Reduction Objective:

Reduce the proportion of adolescents who have engaged in sexual intercourse to no more than 15 percent by age 15 and no more than 40 percent by age 17.

	1988 Baseline	2000 Target
Adolescents Age 15		15%
Adolescents Age 17		40%
Girls Age 15	27%	
Boys Age 15	33%	
Girls Age 17	50%	
Boys Age 17	66%	

138

Lead Agency: Office of Population Affairs

Contributing Agency: Centers for Disease Control

Status of Data:

- National Survey of Family Growth - next survey scheduled in 1995 three follow-up interviews at 20 month intervals of same cohort. New survey in 1999.
- National Survey of Adolescent males - A unique survey in 1988. There was a repeat interview in late 1990 and early in 1991; data will be available in 1992. No plans to repeat survey.

Strategy:

- Provide HIV prevention education in comprehensive school health program;
- Support prevention research to develop, implement and evaluate behavioral interventions;
- Train peer educators to motivate behavior change.

Cross-References:

- Commentary in Family Planning Objective 5.4.
- Objective reported in Sexually Transmitted Disease Objective 19.9.

Priorit. Area 18
HIV Infection

Risk Reduction Objective:

Increase to at least 50 percent the proportion of sexually active, unmarried people who used a condom at last sexual intercourse.		
	1988 Baseline	2000 Target
Unmarried Women Age 15-44	19%	50%
Special Population Targets		
Use of Condoms		
18.4a Sexually active young women age 15-19 (By their partners)	26%	60%
18.4b Sexually active young men age 15-19	57%	75%
18.4c Intravenous drug users	—	60%
Notes: Strategies to achieve the objective must be undertaken sensitively to avoid indirectly encouraging or condoning sexual activity among teens who are not yet sexually active.		

Lead Agency: Office of Population Affairs

Contributing Agency: Alcohol, Drug Abuse and Mental Health, Centers for Disease Control, Food and Drug Administration

Status of Data: See Status of Data for 18.3.

Strategy:

- Develop, implement, and evaluate behavioral strategies to increase condom use among unmarried people who are sexually active;
- Counseling and condom distribution in health care and community settings;
- Support community leadership and infrastructure for community-based health education and risk reduction services;
- Prevention programs to use condoms and maintain behavior change;
- Build more effective partnerships with the media;
- Train peer educators to motivate behavior change;
- Train health care professionals, state officials, community leaders, and drug counselors in effective prevention strategies;
- Disseminate critical information regarding effective prevention strategies to communities, state and national organizations.

Cross-Reference:

- Commentary in Sexually Transmitted Disease Objective 19.10.

Priority Area 18 HIV Infection

Services and Protection Objective:

Increase to at least 95 percent the proportion of schools that have age-appropriate HIV education curricula for students in 4th through 12th grades, preferably as part of quality school health education.		
	1989 Baseline	2000 Target
Students grades 4th through 12th		95%
Students grades 7th through 12th	5%	
Note: Strategies to achieve this objective must be undertaken sensitively to avoid indirectly encouraging or condoning sexual activity among teens who are not yet sexually active.		

Lead Agency: Centers for Disease Control

Status of Data:

- 1989 survey - 67% total school districts require HIV education;
- A national probability sample is planned, by CDC, for spring 1993 (data available 1994), which will provide data which exactly match the objective.

Strategy:

- Assess the extent to which HIV education is being provided to youth;
- Support evaluation studies of HIV education programs in the areas of teacher training, policy development, and curricula;
- Support national organizations, state agencies, and local communities, including parents, to develop locally acceptable HIV prevention education approaches;
- Conduct and support research projects to develop, implement, and evaluate educational strategies for HIV education.

Statements of Support for Dr. Joycelyn Elders Received by Senator
Paul Wellstone as of July 23, 1993

Adolescent AIDS Program
Becker, ME (individual)
AIDS Action
AIDS National Interfaith Network
AIDS Service of Dallas
AJ Congress
American Academy of Child and Adolescent Psychiatry
American Assoc. of University Women
American Cancer Society
American College of Physicians
American College of Preventive Medicine
American Dietetic Association
American Federation of Labor and Congress of Industrial
Organization
American Heart Association
American Medical Women's Association
Ambulatory Pediatric Assoc.
American School Health Association
American Social Health Assoc.
American Society for Medical Technology
American Public Health Assoc.
Association of Maternal and Child Health Programs
Association of Schools of Public Health
Association of State and Territorial Health Officials
Association of State and Territorial Directors of Nursing
Catholics Speak Out
Child Welfare League of America
Citizen Action
Coalition of Labor Union Women
Coalition for Nutrition Services in Health Care Reform
Commissioned Officers Assoc of U.S. Public Health Service
The Council of the Great City Schools
Municipality of Anchorage Dept of Health and Human Services
Englewood Health Dept
Environmental Defense Fund
Education Training Research
The Faculties of Graduate Programs in Public Health Nutrition
Family Planning Council, Inc (Los Angeles Regional)
State of Georgia Governor's Special Council on Family Planning
International Union, United Automobile, Aerospace & Agricultural
Implement Workers of America - UAW
The Interreligious Response
National Abortion Federation
National Community AIDS Partnership
Mercy Medical Center
Mississippi Conference on Social Welfare
National Association of Social Workers
National Association of State Boards of Education
National Coalition to Support Sexuality Education
National Public Health Information Coalition
National Medical Association

142

RESPONSES OF M. JOYCELYN ELDERS, M.D.
TO
QUESTIONS SUBMITTED BY THE
SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

JULY 28, 1993

M. Joycelyn Elders, M.D.
810 Marcia Cove
Little Rock, Arkansas 72206

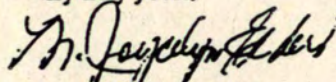
July 29, 1993

The Honorable Edward M. Kennedy
Chairman
Senate Labor & Human
Resources Committee
315 Russell
United States Senate
Washington, D.C. 20510

Dear Senator Kennedy:

Attached please find my responses to the written questions submitted by
Senator Dan Coats, Senator Nancy Landon Kassebaum, Senator Judd Gregg, Senator
James M. Jeffords, yourself and Senator Paul Wellstone.

Very truly yours,


M. Joycelyn Elders, M.D.

Attachment

RESPONSES OF M. JOYCELYN ELDERS, M.D.
TO
QUESTIONS SUBMITTED BY
SENATOR DAN COATS

ABORTION

1. What is your position on abortion?

A: I have repeatedly stated that I am not about abortion. I believe in preventing unplanned, unwanted pregnancies. If you do that, then there would not be a need for abortion. However, I do believe in a woman's right to choose as set forth in the U.S. Supreme Court decision of Roe v. Wade.

2. Do you believe a woman should have a right to an abortion, for any or no reason, throughout the entire duration of pregnancy?

A: See response to 1 above.

3. Do you support reasonable restrictions on abortion such as parental consent or notification for minors?

A: It is my understanding that the Administration opposes any Federal attempts to limit access to abortion through mandatory waiting periods or parental or spousal consent requirements. The Administration does not oppose State efforts to require some form of adult counseling or consultation for underage girls who choose to have an abortion -- as long as workable and effective bypass provisions are attached to such laws.

I fully support these views.

4. What is your position on the Freedom of Choice Act?

A: I support the principle embodied in the Freedom of Choice Act which would codify the tenets of Roe v. Wade. It places priority on the health of women, which is the standard by which any effort to regulate abortion must be measured.

5. Do you support the "Hyde" amendment which prohibits the expenditure of federal funds for abortion except in those cases where the mother's life would be endangered if the fetus was carried to term?

A: The Administration does not support the "Hyde" amendment and is working with congressional leaders to facilitate an approach that is consistent with both Federal and State law.

My views on the Hyde amendment are consistent with the Administration's position.

6. What is your position on RU-486?

A: I believe that we should work to make RU-486 available to women in the United States when it is proven to be safe and effective. However, I understand that a number of steps must be taken before an application can be filed, and FDA approval can be achieved.

7. Is it true that you once described pro-lifers as "very religious non-Christians" saying, "Yeah, they love little babies, as long as they're in somebody else's uterus"? (Washington Post, 2/16/93)

A: As I stated during the hearing, I probably referred to them as "the right to life" groups since I do not use the term "pro-lifers" and I probably called them the "very religious non-Christian right."

8. Is it true that you later said pro-lifers don't support programs to help children because they believe: "... a baby is God's just punishment for fornication?" (Los Angeles Times, 3/8/93) And that you authored an article appearing in the Berkeley Women's Law Journal in which you wrote: "We have refused to make a commitment to solving the crisis of teenage motherhood because we view pregnancy as just punishment for the sin of premarital sex?"

A: The Los Angeles Times quotes me as saying: "Most of our society believes a baby is God's just punishment for fornication. Their attitude is, I'm not going to invest in this baby growing up healthy, educated, motivated and with hope. I'm going to keep using him to grind in that punishment for you." As I stated during the hearing, I believe I restricted it to a narrow group.

The quote from the law journal article is accurate.

9. Did you also refer to persons who disagree with your position on abortion as "non-Christians with slave-master mentalities"? (American Medical News, 1/11/93)

A: To the best of my recollection, I never made such a statement.

10. At a pro-choice rally did you tell pro-lifers to: "get over their love affair with the fetus and start supporting the children?"

A: As I responded during the hearing to this question, I did make this statement. The reason I used the reference of the "love affair with the fetus" is because I look upon it as an affair, a short-term commitment; whereas when a child is born, it is a lifetime commitment.

11. Did you refer to the Catholic Church as being a "celibate, male-dominated church"? (Arkansas Democrat Gazette, 1/19/93)

A: Yes. I made the statement in referring to groups fighting the Roe v. Wade issue. After this statement drew some attention in the media in Arkansas, I went to meet with Bishop Andrew McDonald to explain that I did not have any preconceived malice or intent to blaspheme the Roman Catholic Church. It was agreed that in the future I would refer to the church as "male-governed" rather than "male-dominated." I later sent a letter of apology to Bishop McDonald to that effect.

12. During a December 30, 1992 interview with Bryant Gumble you are quoted as saying that you don't feel any of us are "good enough, know enough, or love enough to make the abortion decision for anybody else."

Yet you have previously stated that as a physician to diabetic teenagers you decided that if you wanted to keep those kids healthy you "had no choice but to take command of their sexuality at the first sign of puberty. I'd tell them, 'You're gonna have two good babies, and I'm gonna decide when you're gonna have them.'" (New York Times, 10/15/89). Could you please explain that statement?

- A: As I explained during the hearing, these two statements were never stated together.

The first statement accurately reflects my personal opinion on the abortion issue. Mr. Gumble had asked me about my beliefs on abortion.

The second statement concerns my work as a pediatric endocrinologist with juvenile patients with insulin-dependent diabetes. It was in this work that I recognized the importance of being candid with the patient and their parents about sexual matters. A diabetic female is a hazard to herself and her offspring if she becomes pregnant at too early an age, before her runaway endocrine system has stabilized and her diabetes is in good control. I wanted to help my patients have healthy, happy babies when they were medically ready to have them. This statement concerned family planning, not abortion.

13. If medicaid does not pay for abortions, does not pay for family planning, but pays for prenatal care and delivery, that is equivalent to saying that "I'll pay for you to have another good, healthy slave, but I won't pay for you to use your brain and make choices for yourself...It's a way to keep people poor, ignorant and enslaved. If you are poor and ignorant, you are a slave." Would you please explain what you meant by that statement? (American Medical News, January 1993)

- A: I am a proponent of access to family planning services for poor women and preventing pregnancy. We as a nation focus time and resources on health care for pregnant women and their children, yet do not focus enough on preventative health measures such as family planning that can assist women in planning or delaying their pregnancies until they are best able to care for their children.

14. Many of us feel a great sense of sorrow at the prevalence of abortion in our society. We understand how difficult a choice it is for many women, and also recognize how this decision can permanently affect the rest of their lives. Most believe abortion is an unfortunate occurrence. Yet you stated during your testimony before this committee on the Freedom of Choice Act that: "In the 17 years that abortion has been legal nationwide, it has had an important and positive public health effect." Do you really believe abortion has had a positive effect?

- A: After I made that statement, I explained my reasoning: abortion is extremely safe; now that abortions are legal, women are having them earlier - thus, more safely; and abortion provides an option to families at high risk for genetic defects. I concluded my testimony by stating that "it is an important component of a comprehensive public health strategy to protect and promote the health of women - the standard by which any effect to regulate abortion must be measured."

Let me reiterate that abortion is part of a comprehensive health strategy for women.

15. During your 1990 testimony before this Committee on the Freedom of Choice Act you commented: "Many families at high risk are willing to become pregnant only because of the option of abortion. Further, abortion has reduced the number of children afflicted with severe defects: the number of Down's syndrome infants in Washington state in 1976 was 64 percent lower than it would have been without legal abortion." (FOCA hearing, Elders's prepared statement, May 23, 1990).

to response to this statement, the National Down's Syndrome Congress has expressed concern and believes statements of this sort "raise some important questions in our minds as to her qualification for the position of Surgeon General It would appear from her testimony and written statements that her concern is more toward the cost of an individual's life as opposed to the value of the human life. It would not be a good choice to have the Surgeon General of the United States of America espousing such ideals."

Do you really believe, as your statement appears to indicate, that abortion has had a positive effect in that it has reduced the number of children with Down's Syndrome and other severe defects?

A: As I stated at Friday's hearing, "As a physician, I value all human life." I very much support these children and their families. As a doctor I have cared for Down's Syndrome children, and I have a beloved Down's Syndrome nephew. I know that these children are delightful and lovable - and that they thrive in families who have the resources and wherewithal to care for them.

However, I was testifying for the Freedom of Choice Act - and I feel strongly that all parents should have the choice in this instance. I am not wise enough, I am not good enough, and I cannot love enough to make this choice for them.

16. Would you explain what you meant when you said: "Abortion was the single most important factor in the significant decrease in neonatal mortality between 1964 and 1977?"

A: I was citing information from a 1981 article in Family Planning Perspectives that found that "increased availability of legal abortion, which followed the reform of restrictive state abortion laws in the late 1960s and the 1973 Supreme Court decision, was the most important factor in the large decreases in neonatal mortality that occurred between 1964 and 1977."

The article then stated that "the neonatal death rate (the number of deaths in the first 27 days of life per 1,000 live births) fell by 7.5 among white and by 11.8 among blacks." It also explained that neonatal mortality during the 1964-1971 period was "fueled by the increase in the percentage of low-income women who used subsidized planning services between 1965 and 1971 and by the dramatic increase in the legal abortion rate between 1969 and 1971 (emphasis added). The acceleration of this [trend] ... during the 1971-1977 period was due to the ... explosion of the abortion rate during that period."

17. In July 21, 1993 the New York Times ran an article entitled "The Chosen Sex--a Special Report". In it, the Times reports on a growing problem in China concerning sex-selection abortions. The article speaks of how women go into clinics and through the use of ultrasound, determine the sex of their child. Approximately 12% or 1.7 million fetuses are being aborted every year in China, simply because the child happens to be the wrong sex, a female.

Since you have on occasion stated that you oppose restricting a woman's access to abortion for reasons other than "medical necessity" would you support a woman's right to terminate her pregnancy simply because the child was the wrong sex? Do you consider this a legitimate form of family planning?

- A: I support the principles set forth in Roe v. Wade concerning a woman's right to choose.

I have never considered abortion as a means of family planning. To me, an abortion is a failure in our system to provide women with sufficient tools to control their reproductive cycles. I believe in preventing unplanned pregnancies, therefore, eradicating the need for abortion.

ADDRESS TO ARKANSAS COALITION FOR CHOICE

1. Did you address the Arkansas Coalition for Choice on January 18, 1992? If so, did you do so as Director of the Arkansas Health Department?

- A: Yes, I did address the Arkansas Coalition for Choice on Saturday, January 18, 1992. I did not do so in my capacity as Director of the Arkansas Department of Health.

2. Have any complaints been filed against you for violation of Arkansas laws which prohibit such actions by state officials? If so, what was your response?

- A: On February 17, 1992 Westark Christian Action Council filed a written complaint alleging that I had addressed the Arkansas Coalition for Choice in my capacity as director of the Arkansas Health Department, and therefore violated the Arkansas State Political Practices Act. On March 13, 1992 County Prosecutor Mark Stodola completed an investigation of the matter and announced that there had been no violation of state law. On March 17, 1992 the Westark Christian Action Council filed a petition in the Circuit Court of Pulaski County seeking the appointment of a special prosecutor to investigate the circumstances of the January 18, 1992 address. On May 26, 1992, upon joint motion of both petitioner, Westark Christian Action Council and myself, I was dismissed as a party to the proceeding. The request for a special prosecutor was dismissed by the Circuit Court of Pulaski County. Petitioners appealed to the Supreme Court of Arkansas, but the appeal was dismissed because the case was moot.

3. In responding to any suits alleging that you violated Arkansas law by addressing the Arkansas Coalition for Choice on January 18, 1992, did you use attorneys paid for by the state of Arkansas to defend you?

- A: Yes, because I was served in a civil action alleging that I had acted improperly under color of my office I did use the services of attorneys employed by the Arkansas Department of Health in responding to the action initiated on March 17, 1992.

4. What is the status of any suit pending against you alleging you violated Arkansas law for speaking to the Arkansas Coalition for Choice on January 18, 1992?

- A: On April 19, 1993 Westark Christian Action Council filed a second petition in Pulaski County Circuit Court seeking appointment of a special prosecutor. The second petition was substantially similar to the petition that was dismissed in 1992. It is my understanding that no parties have been served in this action, and I have no personal knowledge of the status of this proceeding.

5. Have petitions been filed requesting the appointment of a special prosecutor to bring suit against you for alleged violations of Arkansas law because of your address to the Arkansas Coalition for Choice? If so, what is the status of this request?

A: On March 17, 1992 the Westark Christian Action Council, filed a petition seeking the appointment of a special prosecutor to investigate the circumstances of the January 18, 1992 address. On May 26, 1992, upon joint motion of both petitioner, Westark Christian Action Council and myself, I was dismissed as a party to the proceeding. The request for a special prosecutor was dismissed by the Circuit Court of Pulaski County. Petitioners appealed to the Supreme Court of Arkansas, but the appeal was dismissed because the case was moot.

On April 19, 1993 Westark Christian Action Council filed a second petition in Pulaski County Circuit Court seeking appointment of a special prosecutor which was similar to the petition that was dismissed in 1992. It is my understanding that no parties have been served in this action, and I have no personal knowledge of the status of this proceeding.

6. During your address to the Arkansas Coalition for Choice on January 18, 1992, did you make the following statement:

"... and there the Church was silent when we talked about... the first 400 years black people had their freedom aborted, and the Church said nothing. The way of life for Native American was aborted; the Church was silent. We attempted to eradicate a whole race of people through the Holocaust, and the Church was silent.... Women had no right to vote for years. We ask why? Why do these things go on?... Any time the right of choice is taken away from all of us and put into the hands of a few, these kinds of things will happen, over and over again. Look at who's fighting the pro-choice movement: a celibate, male dominated church...."

A: Yes.

7. Were you ever asked to publicly apologize for the above statement? If so, did you publicly apologize? When and where?

A: Yes, I was asked to apologize by a priest. I discussed this with Bishop Andrew McDonald and my brother (who is a minister). I explained that I did not have any preconceived malice or intent to blaspheme the Roman Catholic Church. It was agreed that in the future I would refer to the church as "male-governed" rather than "male-dominated." I later sent a letter of apology to Bishop McDonald to that effect.

CONDOM ADVERTISEMENTS

1. Do you support advertising condoms on television?

When asked if as Surgeon General you would target networks for their continued refusal to air condom ads, you responded, "I most certainly will. You know, I feel we air everything else and I feel that the media - I feel that the media can make very, very significant impact on the attitudes of America." The Reuter Transcript Rept. December 30, 1992.

- A: I do support advertising condoms on television. I believe if we advertise feminine napkins and douches, we can also tastefully advertise condoms. We need to make condoms an every day item of personal hygiene for people who choose to be sexually active outside of a monogamous relationship. Otherwise, we are never going to successfully fight the spread of AIDS.

During my time in Arizona, one of the television stations devoted all of its public services announcements to the issue of teen pregnancy. Its campaign was very tastefully done and had a major impact on the public perception of this issue. The station received a Regional Emmy Award, the George Peabody Award and the Edward R. Murrow Award for their work.

We are not doing a very good job at promoting condoms. If confirmed, I will work to increase the acceptability of condoms among all populations within our country by using every tool available, including the media. I feel very strong about this.

CONTRACEPTIVES

1. You have had a lot to say about condoms. Given the fact that condoms have been promoted, distributed and made available more in the last several years than in their entire history, why is it that sexually transmitted diseases, teen pregnancies, and AIDS continue to increase?

- A: Yes, adolescent pregnancies, sexually transmitted diseases, and AIDS continue to be problems. And yes, condoms are promoted, distributed and made available more than ever. However, 1) condoms are not used by all couples, 2) condoms are not used properly or consistently by all couples, and 3) condoms can be defective or break. No form of contraception is 100% effective except abstinence, and I do support abstinence, especially for adolescents. However, for those persons who choose to be sexually active, I have advocated the use of condoms in promoting "safer sex."

2. Grady and Coworker report that condoms have an 18% failure rate for pregnancy among teenagers (and this doesn't even count all the pregnancies that were aborted). This means that when the failure rate is that bad, one in five girls who depend on condoms ends up pregnant. An editorial appearing in *Postgraduate Medicine*, written by its editor-in-chief, Glen C. Griffin, MD states, "The only really safe sex is between two faithful marriage partners who are free of sexually transmitted diseases." Dr Griffin says kids need to know that "this no-risk sex is worth waiting for." Do you agree with his statement? If so, how will you promote truly "safe sex" as surgeon general?

- A: I agree that "no-risk sex" is worth waiting for." However, I believe in facing facts, and the reality is that some persons choose to have sex in other than mutually monogamous relationships. For those persons, I would offer the same advice as my predecessor, Dr. Koop. That is, in the absence of such a relationship, both parties should protect themselves and use condoms.

3. Is the transmission of Chlamydia infection prevented by condoms? What is the rate of Chlamydia infection among teenagers? What are the consequences of a Chlamydia infection for a teenager?

- A: The transmission of Chlamydia trachomatis infection is prevented by latex condoms used correctly and consistently. Judson, et. al. found no leakage

when 50 unlubricated standard latex condoms with a receptacle end with 10 ml pooled suspensions of Chlamydia Trachomatis were subjected to vigorous simulated "intercourse" in an *in vitro* setting. (Condoms in the Prevention of Sexually Transmitted Diseases, American Social Health Association, December 1989.) The CDC, Division of Sexually Transmitted Disease and HIV Prevention concurs that latex condoms prevent transmission of Chlamydia trachomatis.

The rate of Chlamydia trachomatis infection is 10-15 percent nationwide. Data is not recorded nationally in an age specific manner.

Infection with Chlamydia trachomatis can result in pelvic inflammatory disease (PID), sterility, ectopic pregnancy, and neonatal pneumonia.

4. What is the human papilloma virus and its associated consequences? Is this transmission of human papilloma virus prevented by condoms? What percent of sexually active teens carry this virus? Is it curable?

A: There are many types of the human papilloma virus (HPV). Types 6 and 11 are associated with what is commonly known as genital warts, which may be permanently removed in an office setting. HPV types 16 and 18 have been associated with cervical dysplasia and malignancies. There are many procedures and treatments for cervical dysplasia and early stages of malignancies which attain cure. Transmission of HPV is prevented by condoms, according to the Division of STD/HIV Prevention, CDCP. Ten to fifteen percent of sexually active teens carry HPV.

DEFECTIVE CONDOMS

1. According to documents obtained from the FDA, the Arkansas Department of Health had repeated problems with condoms that it was obtaining from its sole supplier, Ansell, Inc. When did your agency begin purchasing condoms from Ansell?

A. The relevant Arkansas Department of Health records are not available prior to 1988, by which time the Department was purchasing condoms from Ansell. I believe that the Department had been purchasing Ansell condoms for several years before 1988.

2. Did any problem with the condoms surface before December 1990?

A. I know of no reported or documented complaint about the Ansell condoms at the Arkansas Department of Health prior to December, 1990.

3. In December 1990, a high school clinic in your state returned 50 condoms to your department. These condoms had been supplied to the school by your health department and were returned by the school because of complaints of breakage. An official with your agency sent the condoms back to the manufacturer. What efforts did your department make to notify high school children who had received condoms from that batch of the problems that had been detected? Were the students asked to return the condoms to the school-based clinic and receive replacements? If not, why was the decision taken to let students use condoms from a batch that the clinic believed had unacceptably high levels of defects?

A. The Arkansas Department of Health began distributing Ansell condoms years before December, 1990. The product typically was distributed with 3 packages to a unit, 48 units to a box, 10 boxes to a case. Each case, then, contained approximately 1044 condoms. The first reported complaint to the Arkansas Department of Health occurred in December, 1990. The Department of Health returned 50 condoms to Ansell due to a high school clinic's complaint to the Department about "breakage". That clinic's communication to the Department was based on one student's report of his experience. The number of condoms distributed at that clinic and the number of those which were not defective does not appear in the records of the Arkansas Department of Health. When notified of the student's experience, Ansell replied that the condoms had been manufactured to meet product specifications and had passed a quality control test prior to distribution. Ansell reported to the Department that no other complaints had been received on these condoms. Therefore, in December, 1990, there was insufficient basis on which to notify users that there had been a complaint about breakage and/or that all users should return condoms to the school-based clinic.

4. Similar problems continued to be reported in clinics throughout your state. Generally, your department handled these problems by exchanging one batch of condoms for another made by the same manufacturer. Did your agency also notify people who already had received the condoms about the potential hazards?

A. Between December, 1990 (when one clinic reported a breakage problem) and February, 1992 (when a county health unit reported another), to my knowledge, the Arkansas Department of Health received no reports of breakage in the condoms it distributed. From February, 1992 until Ansell instituted a nationwide recall of its product in September, 1992, there was only one occasion (in addition to the instance prompted by the December, 1990 communication) in which Ansell replaced the condoms previously supplied to the Department of Health. The replacement supply consisted of a different, stronger condom than the ones previously purchased by the Department of Health. In February, 1992, there was insufficient basis on which to notify users not to use the Ansell condom.

5. On June 24, 1992, the Baxter County Health Unit notified an official in your department that "three successive HIV antibody test clients who were issued Lifestyle condoms during their pre-test counseling stated that the condoms broke in every use." This occurred at least 18 months after your department had been informed of serious problems with condoms from this manufacturer. Did your agency alert other clients who had been tested for HIV infection that the condoms the clinic was distributing had high failure rates?

A. The December, 1990 report of "breakage" made no reference to or finding of "serious problems with condoms from this manufacturer." There were no reports to the Department about condom failure during 1991. During 1992, the Department of Health was seeking to collect the experience in the State with Ansell condoms. That process was ongoing during June, and thus no notification of "high failure rates" was indicated.

6. Throughout much of 1991, the state legislature engaged in a rather contentious debate over the question of whether school-based clinics should dispense condoms. During this same period, your clinics were experiencing serious problems of breakage and leakage with the condoms that it was distributing to the public. Had your agency made a conscientious effort to notify persons who had received condoms from your clinics to this fact, what effect would this have had on the legislature's deliberations?

A. During all of 1991, to my knowledge, the Department of Health received no reports of breakage or leakage in the use of Ansell condoms distributed by the State. I do not know what the effect on the legislative debate would have been had the Department experienced serious problems with the condoms and reported that fact to the Arkansas legislature.

7. Eventually, the FDA approved a seizure of every condom that your agency had purchased from Ansell, Inc. The FDA never went through with the seizure, nor did it order a recall. Instead, it suggested that you return condoms still in your inventory to the manufacturer. At this point, having returned all of your stock of Ansell condoms to the manufacturer, did you instruct your state public health clinics to notify people who already had received condoms of the possible defects?

A. On August 12, 1992, the Nashville office of the Food and Drug Administration recommended a seizure of Ansell products. That seizure would have affected only those products actually tested in Arkansas and found defective. Other Ansell products — those that had not specifically been tested in Arkansas or elsewhere in the nation — would not have been affected by a seizure. A recall, but not a seizure, can reach product beyond that actually tested and found deficient.

On August 28, 1992, the Center for Devices and Radiological Health within FDA concurred with the Nashville FDA office's recommendation for a seizure. On September 3, 1992, before the seizure decision was finally endorsed and implemented, Ansell wrote to FDA announcing that it would recall the product nationally. Customers in twenty-seven states plus Guam and the District of Columbia were contacted by the manufacturer and returned to Ansell their supplies of the product. The manufacturer destroyed the returned condoms on April 8, 1993.

To my knowledge, Arkansas was the only Department of Health that brought to FDA's attention its experience with Ansell condoms.

Meanwhile, on July 21, 1992, the Department of Health wrote to all Area Managers of the Department regarding the Ansell condoms. Among the instructions to the Managers was the following: "1. Review with the client the reasons for condom breakage — Most breakage problems can be solved with a review of proper handling and use. 2. If no explanation is evident, have the client return any unused condoms and send them to the Department of Health for testing."

8. Did your agency, at any time during the 19-month period of time during which you experienced repeated problems with condoms purchased from Ansell, make any effort to notify people who had obtained condoms from your clinics, including school-based clinics, of these problems? Did your agency undertake any program to ask people who had been given these condoms that they should return them to your clinics and exchange them for more reliable condoms?

- A. As noted earlier, there was not a period of 19 months in which the Department of Health "experienced repeated problems with condoms purchased from Ansell...". As also noted earlier, in July, 1992, the Department notified all Area Managers to "...have the client return any unused condoms".

9. Throughout much of 1991, the Arkansas legislature debated whether to continue the Health Department's program of dispensing contraceptives to high school students. Did you at any time notify lawmakers that your agency was distributing defective condoms to high school students under this program?

- A. I did not notify lawmakers in 1991 about the condoms the Department of Health was distributing. As noted earlier, to my knowledge, the Department had no reports of breakage or leakage involving Ansell condoms during all of 1991.

10. Did you at any time notify the Governor of the fact that your clinics were dispensing defective condoms? If so, when? What steps, if any, did he direct you to take to ensure the safety of people who had received condoms from your clinics? Did he direct you to notify people who had received condoms from your clinics to return them in exchange for more reliable condoms?

- A. I did not notify the Governor when I received reports about condoms from local or area health units. I did not notify the Governor that there were no reported problems with the Ansell condoms during 1991. The Governor did not, then, give me directions regarding the distribution of condoms.

FAMILY PLANNING

1. It was recently announced that Baltimore City Schools are expected to be the first in the nation to offer Norplant, a surgically implanted contraceptive, to teenage girls. The drug is expected to be offered to students at Laurence Paquin Middle and High School, and will eventually be expanded to the six high schools that have school-based health clinics on campus.

a. Do you support the distribution of Norplant to this population?

- A: Norplant, a new implantable hormonal, long-term contraceptive, has been approved by the Food and Drug Administration as safe for use as a contraceptive method in the United States. Local community groups have a right to provide voluntary contraceptive services to sexually active individuals in compliance with any relevant Federal, State or local requirements, including informed consent requirements.

b. Given the drug's short history, do you believe these minor girls should have to obtain parental consent before implanted with Norplant?

- A: Norplant has been approved by the FDA as a safe, reversible family planning method. These inserts can be removed through a simple, outpatient procedure. As with all other contraceptive services provided to adolescents through the Title X national family planning program, Norplant is available to adolescents who request such services on a confidential basis. I would however urge parents to become involved with their children's decisions whenever practicable.

c. If you do not support parental consent before Norplant is distributed to minor girls, do you at least support parental notification before this new drug is distributed?

A: There are no Federal laws that require parental consent or notification for the provision of contraceptive services to minors, nor would I recommend that Norplant be singled out for such a requirement.

d. Would you support using federal funds for this type of distribution?

A: Funding for the provision of Norplant is currently available through various Federal programs including Medicaid and the Title X national family planning program. Title X specifically requires that all family planning services to adolescents be provided in a confidential manner, and prohibits parental consent or notification requirements for the provision of such services.

e. What if any restrictions would you place before federal funds could be used to distribute Norplant to minors?

(see above response)

2. Section 1008 of the Public Health Service Act implementing the title X Family Planning Act provides that: "None of the funds appropriated under this Title shall be used in programs where abortion is a method family planning."

a. How do you interpret this section of the law, which has not been altered since 1970?

A: The Title X statute has always prohibited the use of funds for abortion. The Department of Health and Human Services is not seeking any change in that prohibition.

b. Do you support regulations known as the "Gag rule" which aim to separate abortion related activities from federally supported family planning activities. If not, do you support any limitation on the ability of clinics receiving federal funds to counsel or refer women for abortion in federally funded Title X clinics?

A: I support the President's position as expressed in his January 22 Memorandum in which he directed the Department to suspend the so-called "gag rule" and promulgate new regulations to implement Section 1008 in accordance with the notice and comment procedures of the Administrative Procedures Act.

Under suspension of the "gag rule", Title X family planning projects must provide information on all pregnancy options for managing an unintended pregnancy when asked by a client.

c. Do you view the federal family planning program as preventive in nature?

A: Yes, family planning is our best means of planning pregnancies and avoiding the need for abortion, and I support making family planning services more accessible.

d. Do you think it is important to separate abortion activities from legitimate family planning or preventive activities? How do you propose to separate abortion activities from legitimate family planning activities?

A: Under suspension of the "gag rule", grantees must comply with section 1008, with the Title X guidelines, and with the program policies developed since the inception of the program that were in effect prior to 1988 dealing with the interpretation of the abortion restrictions in Title X. A statement published by the Department in the Federal Register on June 23, 1993 announced the availability of a summary of pre-1988 policies. This summary outlines the standards to be applied to insure sufficient separation of abortion activities from Title X activities.

e. Should Title X clinics be permitted to perform abortion on the same site as the federally funded Title X clinics?

A: Under suspension of the "gag rule", the title X program is operating under program policies that were in effect prior to 1988 which require that projects maintain some degree of separation from abortion activities. A statement published by the Department in the Federal Register on June 23, 1993 announced the availability of a summary of pre-1988 policies. This policy summary states, "separation of Title X from abortion activities does not require separate grantees or even a separate health facility, but separate bookkeeping entries alone will not satisfy the spirit of the law." I believe this is a reasonable approach but I would like to reserve my final opinion until the comment period has closed and comments on this and other policy positions are analyzed.

f. Should personnel whose salaries are supported by federal funding be permitted to work in abortion related activities at the same site?

A: Under suspension of the "gag rule", the title X program is operating under program policies that were in effect prior to 1988 which require that projects maintain some degree of separation from abortion activities. A statement of those policies which was published by the Department in the Federal Register on June 23, 1993 announced the availability of a summary pre-1988 policies. This policy summary states, "Similarly, common staff is permissible, so long as salaries are properly allocated and all abortion-related activities of staff members are performed in a program which is entirely separate from the Title X project. I believe this is a reasonable policy but I would like to reserve my final opinion until the regulation comment period has closed and comments on this and other policy positions have been analyzed.

3. Since its involvement in funding contraceptives and family planning, the Federal government has invested over \$2 billion to curb teenage pregnancy. Yet the rate of teenage pregnancy and sexually transmitted diseases afflicting teens continues to grow.

Many experts feel it is time for us to admit that this approach has not yielded the returns we had hoped for, and to recognize that we have focused on the symptom of teen pregnancy rather than the root, which is teen sexual activity.

a. What, if anything, will you direct the Department of Health and Human Services to do to curb the rate of teen sexual activity?

b. What role should abstinence education play in this effort?

A: Abstinence education, including teaching resistance and decisionmaking skills, is obviously an important part of any sexuality education program, especially when targeting younger adolescents. I would expect such a component to be included in comprehensive school health education programs.

MARIJUANA

1. Do you, as the press has reported, support a physician's right to prescribe marijuana for their patients, if it would be "beneficial"?
(The Salisbury Post, December 20, 1992)

A. If the Department of Health and Human Services concludes that the use of marijuana for therapeutic purposes is beneficial. Research is currently being performed as to the therapeutic benefits of marijuana for such diseases as glaucoma, cancer, and AIDS. I believe the Secretary is planning to review the issue of marijuana's use for those purposes. I support such a review and would, therefore, defer a conclusive statement on the matter until the review has been completed.

2. Are you aware that Federal drug agencies prohibit marijuana's medical use because smoking it may cause lung cancer, may damage brain cells and compromise the immune and reproductive systems?

A. I am aware of the health risks associated with marijuana.

3. Would you use your office as Surgeon General to promote marijuana's "medicinal uses"?

A. Again, I would await the results of the Secretary's planned review before reaching any conclusions on the matter.

MERCY NURSING HOME

1. Did the Mercy Nursing Home provide home health services?

A: No.

2. Was Audrey Ruffin ever employed or connected with the Mercy Nursing Home? Is so, would her health care have been regulated in any way by the Arkansas Department of Health?

A: Ms. Ruffin at one time was employed by the Mercy Nursing Home. Her health care was not regulated in any way by the ADH.

3. Could you please explain the Arkansas Department of Health's involvement in the provision of home health services?

A: The ADH provides home health care services in all but six counties in Arkansas. These services include providing nurses, nurses aids and licensed practical nurses to assist in the patient's home as ordered by the attending physician.

4. Please explain how the ADH operates its home health agency.

A: ADH operates its home health agency under a certificate of need for each county in which it provides services. Payments must be approved by Medicare, as they must be for any other home health agency.

5. When did you first become employed by the Mercy Nursing Home?

A: I first became employed by the Mercy Nursing Home in or about 1959, while I was still a medical student.

6. What was your position at the Mercy Nursing Home? Please describe your responsibilities and activities at the nursing home.

A: When I was first employed at the Mercy Nursing Home, I worked under the supervision of a licensed doctor to provide any needed medical care to the residents. In or about the late 1960s, I became the Medical Director of the nursing home. In that capacity, I oversaw the medical procedures at the nursing home, referred patients as needed to outside physicians for medical care, and otherwise supervised the medical needs of the residents.

7. As Director of the Arkansas Department of Health (ADH), did you play any regulatory role with respect to nursing homes?

A: The ADH does not play any regulatory role with respect to nursing homes.

8. What financial responsibilities did you have in relation to nursing homes as Director the ADH?

A: As Director of ADH, I had no financial responsibilities in relation to nursing homes. See response to Question 7 above.

9. What state or federal assistance would the Mercy Nursing Home have received?

A: The Mercy Nursing Home would have received Medicare and Medicaid payments, as do most nursing homes in the state.

10. According to a letter from the ADH dated April 18, 1989, (Appendix A), the ADH's home health agency operates on "reimbursements from Medicare and Medicaid," among other public funds. Do you see any conflict of interest in receiving a salary from a nursing home, while simultaneously serving as the Director of the ADH?

- A: I saw no conflict of interest whatsoever in receiving a salary from a nursing home while simultaneously serving as the Director of ADH. As noted in response to question 7, ADH did not regulate nursing homes. The fact that ADH has a home-health agency that operates on "reimbursements from Medicare and Medicaid" did not in my judgment create a conflict of interest.

11. During testimony before the Committee, you indicated that you served simultaneously as Director of the ADH and as the medical director of the Mercy Nursing Home for "...nine months or so." You stated that the nursing home closed only "...months after (you) became health director". You became Director of the ADH in October 1987, yet your 1989 financial disclosure indicates you were still being paid by the Mercy Nursing home in 1989. Did you hold both of these positions simultaneously for only nine months? Please clarify.

- A: I do not have any record of precisely when I ceased working as the Medical Director of the Mercy Nursing Home. As best I now recall, I ceased working at the Mercy Nursing Home in or about November 1989 or until all patients requiring nursing home care were transferred to other facilities. The disclosure form filed in 1989 listed my salary for the 1988 calendar year. The form that would have been filed in 1990 would have reflected the Mercy Nursing Home income received in calendar year 1989.

At the time of the hearing, I was under the impression that the nursing home had closed in 1988. Upon reflection, I believed that the nursing home may have closed in 1989.

12. Were there any contractual agreements between the State of Arkansas and Mercy Nursing Home?

- A: I have no knowledge of any contractual agreements between the State of Arkansas and Mercy Nursing Home. The Mercy Nursing Home had a certificate of need issued by the state of Arkansas.

13. As Director of the ADH, did you ever file any recusals with respect to Mercy Nursing Home?

- A: I do not recall any issues that related in any fashion to the Mercy Nursing Home coming before me as Director of the ADH. As a result, I have no recollection of ever filing a recusal with respect to the Mercy Nursing Home.

14. Was Audrey Ruffin ever an employee of the Mercy Nursing Home? If so, was this at the time that she was employed to care for Leona Elders?

- A: As I stated in response to Question 2, Ms. Ruffin was at one time an employee of the Mercy Nursing Home. I do not recall whether she may have continued to work there on a part time basis after she was hired by my father-in-law to care for Mrs. Elders in the summer of 1988.

15. According to the Associated Press, Mercy Nursing Home's 85 beds were assigned to another facility. What facility was the Mercy Nursing Home assigned to? What role, if any, did the ADH have in this assignment?

- A: The Mercy Nursing Home sold its certificate of need to another facility. ADH had no role in this sale.

NATIONAL BANK OF ARKANSAS

1. You testified on Friday that you had been reprimanded by the Comptroller of the Currency as a director of the National Bank of Arkansas ("NBA"). You further testified that the Comptroller of the Currency found that you and your fellow directors did not, in the opinion of bank examiners, take adequate action to correct the activities of bank management that had previously been cited. What unsafe and unsound banking activities was the management cited for?

A: Management of the NBA was cited by the Comptroller of the Currency for loans in excess of lending limits, inaccurate call reports, improper investments, improper loans to an affiliate, and excessive investment in bank premises.

2. Did these involve loans to a Little Rock business man named James R. Hodges?

A: Yes.

3. Did you know Mr. Hodges? If so, what was your relationship to him?

A: I did not know Mr. Hodges.

4. At what point did you become aware that the National Bank of Arkansas had extended loans totaling \$2.82 million to Mr. Hodges over a period of five years?

A: I became aware through briefings on the examination report that the OCC was taking the position that the National Bank of Arkansas had extended loans exceeding the lending limit to Mr. Hodges and his affiliated companies. I was not aware at the time the National Bank of Arkansas extended the loans to the various entities that they were affiliated with Mr. Hodges. As a result, I was not aware that the NBA was exceeding the loan limit. According to Ronald Tullos, then President of NBA, the loan officer failed to disclose to bank management and the Board of Directors that the entities were affiliated.

5. Were you present at any board meetings during which the loans to Mr. Hodges were discussed?

A: After the OCC examination report, I was present at several board meetings where the board discussed methods of bringing the Hodges-related loans into compliance with the lending limit.

6. Did you vote with other directors to approve a loan to a Mr. Dan Walker of First American Savings Association of Benton, Illinois?

A: I have no specific recollection of voting with the other directors to approve a loan to a Mr. Dan Walker of First American Savings Association of Benton, Illinois. I may have done so.

7. Were you aware of a commitment from Mr. Walker to guarantee a loan to Mr. Hodges that would permit Mr. Hodges to repay the National Bank of Arkansas?

A: If there was such a commitment, I was unaware of it.

8. Did you agree with other directors to approve this illegal transfer of funds? If not, did you vote or otherwise express your opposition to this illegal activity?

A: I was not aware that the loan to Mr. Walker was improper in any fashion, and to my knowledge none of the other directors believed that the loan to Mr. Walker was improper or unlawful. Since I was unaware that the loan was improper, I did not express my opposition to the loan. Had I known that the loan was improper, I would have opposed approval of the loan.

9. What other safety and soundness violations was management cited for?

A: See response to Question 1 above.

10. What corrective actions were called for by Comptroller of the Currency?

A: As I recall from the briefings at board meetings around the time of the issuance of the CCC examination report, the OCC called for tighter procedures to ensure that the NBA did not engage in investments exceeding the loan limit, to prevent the filing of inaccurate call reports, to monitor closely all investments, to prevent improper loans to an affiliate, and to preclude excess investment in bank premises.

11. Which corrective actions were taken, in the judgment of the banking examiners?

A: I believe that the banking examiners acknowledged that the bank had taken some corrective measures including adoption of policies to minimize the likelihood of future violations of the lending limits.

12. Which were not taken?

A: I believe that the bank examiners took the position that the bank had not taken sufficient steps to obtain repayment of the Hodges-related loans. Bank examiners also believed that the bank had taken insufficient steps to collect on a loan involving an affiliate. As to a number of the other alleged issues, the bank examiners acknowledged that they were not brought to the attention of the bank until after I was no longer a director.

13. You also testified on Friday that you and other directors had voted yourselves an unsecured \$230,000 line of credit. You said that you abstained on the vote to extend you that same line of credit. Was this a "round robin" vote -- in other words, did you abstain from voting on your own line of credit while voting to establish such a line of credit for others, and did other directors do the same?

A: I did not testify that the directors of the bank voted themselves "an unsecured \$230,000 line of credit." To the contrary, I testified that I believed that the "line of credit" represented a lending limit and was not in and of itself an extension of credit on which I could draw. As I testified, all loans that I thereafter obtained from the NBA were individually approved as required and at rates and terms generally available to other borrowers. As I recall, the votes of the Board of Directors to establish these lending limits occurred during one meeting in 1981 and one meeting in 1982. On each occasion, I abstained from voting with regard to my "line of credit" limit.

14. At the hearing, you were asked whether you recused yourself "from discussion or approval by the board of any loan that you had requested." Your answer was that you had abstained from the vote giving you a \$230,000 unsecured line of credit. Did you also recuse yourself from discussion or approval by the board of other loans that you had requested from the NBA?

A: I do not recall whether the particular loans that I sought from the NBA were individually approved by the board and whether I attended the meetings if such approval occurred. At such a meeting, I would have recused myself from discussion or approval by the board of such loans to myself.

15. Are you able to serve as a director of a financial institution without obtaining clearance from federal banking regulators?

A: I believe that the federal banking regulators approve directors of a federally chartered financial institution. There was no other restrictions on my ability to serve as a director as a financial institution.

16. In your position as a director of the board of the Arkansas National Bank, did you violate federal law? Did you violate the National Banking Act?

A: As I testified at the hearing, I was briefed at board meetings on the content of examination reports by the OCC and the president of the board. I was advised that all directors were cited in the examination report as having violated national banking laws and safety and soundness laws relating to their failure to supervise bank management. I was advised that the examination report did not find their activities to be criminal.

NORPLANT FOR PROSTITUTES

1. During a phone in program called Talk Live, you were asked what you would do with crack addicted prostitutes who get pregnant. You responded, "I would hope that we would provide them Norplant so they could still use sex if they must to buy their drugs and not have unplanned babies." Would you recommend we use federal funds for this purpose?

A: I would, of course, strongly urge women not to use crack or engage in prostitution. Those women who do engage in prostitution should use barrier methods to protect themselves and their partners from disease. I also would encourage use of a highly effective contraceptive method like Norplant to prevent unwanted pregnancies. The FDA has approved of the use of Norplant as a contraceptive and Norplant is included as a covered device by Medicaid in all 50 States. As with any contraceptive, Norplant is only provided to women who give their informed consent for the procedure. Certainly, Norplant is only distributed with informed, written patient consent.

2. Are you at all concerned about linkages between drug abuse, prostitution and the spread of AIDS?

A: Yes. Drug abuse and prostitution are among the causes for a rising rate of HIV infection among women. We need primary prevention to help women avoid drug abuse and we need more intervention and access to comprehensive services for women who desire to stop their drug addiction or prostitution. Currently, we have many more women asking for these services than we have spaces available.

PAY ISSUE

1. A series of opinions prepared by the Office of the Attorney General for the State of Arkansas indicate that you had a special arrangement to receive a salary, in excess of the cap that applied to all other state employees, including the Governor. Under this arrangement, the Department of Health, which you headed, transferred the amount of your salary (and, at least in some years, additional funds as well) to the University of Arkansas Medical School. UAMS then added more money to the sum that had been transferred from the Health Department and paid you as a faculty member. When did this unique salary arrangement begin?

A: I believe that the salary arrangement began in fiscal year 1987-88. I do not believe that the arrangement is unique. Several other states, including Florida, Texas, and Washington, D.C. have similar arrangements to encourage medical professionals to accept supervisory positions in their respective departments of health.

2. Did the Attorney General approve this arrangement? If so, for which years was approval given? For which years was approval not obtained?

A: It is my understanding that the Attorney General was not asked to approve the method by which I was compensated. My understanding is that the Arkansas Department of Finance and Administration approved the contract each year.

3. Did the Chief Fiscal Officer of the state approve this arrangement? If so, for which years was approval given? For which years was approval not obtained?

A: Yes. The Department of Finance and Administration, which is headed by the Chief Financial Officer, approved this arrangement in each year.

4. With whom did you negotiate this arrangement? Was the Governor involved in these discussions?

A: I did not negotiate the contract, which was between the University of Arkansas Medical School ("UAMS") and the Arkansas Department of Health. The Governor initially offered me the position, but I informed the Governor that I could not accept the position if it required me to resign from my tenured faculty position with UAMS and to take a reduction in salary. I do not know whether or to what extent the Governor was involved in the discussions between UAMS and the ADH.

5. An April 7, 1988 Attorney General opinion stated: "An employee of a state agency who is drawing the maximum salary with that agency would presumably be drawing in excess of that maximum upon receipt of any salary or stipend received by virtue of a contract or employment with another state agency." Prior to the issuance of this opinion, did you receive any salary or stipend from UAMS in excess of the maximum salary set by the state legislature for the Director of the State's Department of Health?

A: My salary was approved by the appropriate state authorities and it is my understanding it did not violate applicable state law.

6. Did you receive any salary or stipend from UAMS in excess of the maximum salary set by the state legislature for the Director of the state's Department of Health subsequent to the issuance of the April 7, 1988 Attorney General's opinion?

A: See answer to Question 5 above.

7. An Attorney General opinion dated July 11, 1990 described your pay arrangement as follows:

"The Department of Health takes the \$72,907 appropriation for the director's [i.e., the Director of Health] salary and pursuant to A.C.A. 19-4-526, has it transferred to a budget classification for professional services contracts, and then pays the salary, plus an additional \$14,717 from unidentified sources, to UAMS, which uses it to help pay Dr. Elders's UAMS salary. Thus, this sum is paid by the Department of Health to UAMS, and then paid by UAMS to Dr. Elders as a part of the total compensation she receives from UAMS."

Since you were Director of the Department of Health, can you please describe how this transfer of funds from the agency you directed to UAMS was accomplished?

A: It is my understanding that the Department of Health forwarded each month one-twelfth of my annual salary as the Director of Health to UAMS. There, it is my understanding that the payment was commingled with funds UAMS receives from all other sources.

8. Can you also explain where the \$14,717 of additional Health Department funds came from? Were they taken from a state health program? Were they taken from state personnel funds? If not, where did this money come from?

A: It is my understanding that the additional funds came from the Department's general operations budget, derived from its state appropriation.

9. Did the Chief Financial Officer and relevant agency heads certify that the performance of your work as Director of the Department of Health would not interfere with your duties as a faculty member at UAMS?

A: No. The Department of Health and UAMS jointly made that determination.

10. What were your duties as a faculty member of UAMS during your tenure as Director of the State Department of Health?

A: I performed occasional services such as publishing scholarly articles, taking medical students on rounds, and lecturing at UAMS seminars. I also served on the Human Research Advisory Committee and was a member of the faculty in the division of Pediatric Endocrinology and performed duties such as clinics rounds and consultations with faculty, students and housestaff.

11. Did your "personal services contract" for years after 1991 provide for you to receive additional compensation beyond the amount that you were entitled to receive in your capacity as Director of the Department of Health?

A: I did not have a "personal services contract." The contract was between UAMS and the Department of Health.

12. Were you also paid by the Arkansas Children's Hospital at any point in your tenure as Health Director? If so, how much were you paid, and during what time period did you draw this pay? What conflicts of interest did this create since, as Health Director, you had certain administrative responsibilities for the hospital?

A: I was a member of the University of Arkansas School of Medicine faculty which provided professional services to Arkansas Children's Hospital. I had an appointment at Arkansas Children's Hospital as a Professor of Pediatric Endocrinology. I did not receive a separate salary from the Arkansas Children's Hospital. As a result, I saw no conflicts of interest in my role there.

13. What discussions have you engaged in with officials of the U.S. Department of Health and Human Services or any officials of the United States government to allow you to draw a salary in addition to the salary appropriated by Congress for the Surgeon General of the United States?

A: I have had no discussions with officials of the U.S. Department of Health and Human Services or any officials of the United States government concerning allowing me to draw a salary in addition to the salary appropriated by Congress for the Surgeon General of the United States.

SEX EDUCATION

1. Is it true that you believe sex education should begin in kindergarten? (Arkansas Gazette, July 3, 1988). You are quoted as saying "We taught them what to do in the front seat. Now it's time to teach them what to do in the back seat." (Evening Times, West Memphis, Ark.)

A: I have never said "sex education" should begin in kindergarten. I believe in age-appropriate, comprehensive health education in grades K - 12. I have made the statement concerning the front seat/back seat. All schools in America teach driver's education because we recognize the importance of providing our children with the skills necessary to negotiate on our freeways. We teach them not to drink and drive, to wear seat belts and to obey traffic regulations. I was just reflecting on my belief that we need to also recognize the need to provide our children with adequate tools to negotiate life's highways. Hopefully, that means the ability to say "no" to sex, until they are married. We would all want this for our children. However, if they do not adopt that value, then I would hope that we could at least teach them to be responsible so they do not bring another life into this world until they are ready to accept the overwhelming responsibility that childrearing brings to parents today.

2. What do you mean by sex ed in kindergarten? Are you familiar with any of the literature developed for students by Marcia Quackenbush? One of the books "A Kid's First Book About Sex" is described by the author as an introduction to sexuality for young readers. The table of contents reveals chapters on "Your Body, Nudity, Touching, What is Sexy, Sex Parts, Feeling Sexy (Orgasm), Masturbation, Sexual Intercourse, etc...") Are these the types of subjects you think should be discussed with pre-schoolers?

A: I have never used the term "sex ed" for kindergarten students. I believe in comprehensive age-appropriate health education. That means teaching children the "need to know" information concerning their health, their bodies and themselves. For very young children, that means teaching them that there are places on their bodies that nobody should touch and if someone does, they should go tell somebody about it. It means teaching them about nutrition, personal hygiene, the health consequences of tobacco use, alcohol abuse and drug abuse. We need to teach health education like we teach math, every day in our classrooms. Instead, too many of our programs only offer a thirty minute lecture once a month or so. This strategy will not effectuate behavioral change in our young people. Good health must become a way of life. To do this, yes, we must start early.

I am not familiar with Ms. Quackenbush's work.

SOCIAL SECURITY AND FICA

1. Could you or your husband have told Audrey Ruffin what her responsibilities were?

A: Audrey Ruffin's responsibilities were established by Oliver B. Elders, Sr. when he hired her in the summer of 1988. At that time, she was given the duties of caring for my mother-in-law, Mrs. Elders. Ms. Ruffin did not perform services for my husband and myself, and I believe that, had we directed her to perform services for my husband and myself, she would not have done so.

2. Could you or your husband have told Audrey Ruffin when to come to work?

A: As I testified at the hearing, when Ms. Ruffin was not at our home, my husband and I had responsibility for caring for Mrs. Elders. As a result, we would attempt to coordinate our schedules with Ms. Ruffin to ensure that Mrs. Elders received needed care.

3. Please provide a break down of the \$15,300 in back taxes and penalties you paid. Was this all in connection with the taxes due on the wages of Audrey Ruffin? Are any additional amounts due?

A:	Form 942	Form 940	Total
Taxes Owed	\$ 7,792.72	\$ 1,996.40	\$ 9,789.12
Penalties	1,843.73	499.10	2,342.83
Interest	2,511.97	666.39	3,178.37
Total	\$12,153.42	\$ 3,161.89	\$15,315.32

Forms 942 and 940 relate to the payment of Social Security taxes on wages paid and federal unemployment taxes for a portion of the total wages paid by Mrs. Elders. I am advised by the accountant who assisted in this matter that no additional amounts are due, and that Mrs. Elders may receive a refund because certain of his estimates of penalties and interest may be overstated. Moreover, the \$15,315.32 includes both the employer and the employee social security tax payments.

4. If you had not been nominated for this position, when would you and your husband have paid these taxes?

A: As I testified at the hearing, I regarded Mrs. Elders as the employer of Ms. Ruffin, and she was paid out of Mrs. Elders's income. Mrs. Elders received income from retirement benefits and rental property that she owns. That income was deposited into the joint checking account of myself and my husband. My husband and I then paid Ms. Ruffin from our joint account. Mrs. Elder's income was sufficient to cover the payments to Mrs. Ruffin.

I did not regard the payment of social security taxes on the salary of the nurse employed by my mother-in-law as my responsibility. As a result, I did not focus on the nature of Ms. Ruffin's services for Mrs. Elders, and any attendant tax liability that Mrs. Elders may be incurring. Following the increased attention in this area since January 1993, and as I began to prepare for my confirmation hearing, I decided it was necessary to address this issue. Although I do not believe that my husband's failure, under his power of attorney from his mother, to pay the social security taxes for Ms. Ruffin is my responsibility, I decided to insist that the taxes be paid prior to the hearing to avoid any possible issue.

5. During testimony before the Committee, in response to a question regarding your familiarity with the procedures for hiring and paying private health care providers, you stated that it was your understanding that "... private-duty nurses really are independent consultants or independent contractors and they handled their own finances."

A letter received on July 26, 1993, by this Committee (see Appendix A), dated April 18, 1989, from the Arkansas Department of Health in response to an IRS inquiry, indicates that your Department was informed by the IRS that the ADH was in violation of the law for treating personal care aides as "independent contractors."

(a) Please explain how, in light of this letter, you were still not aware of the proper withholding practices for personal care aides?

A: As Director of ADH, I was generally aware that the issue of the proper tax treatment of personal care aides was being raised by the Internal Revenue Service. In our agency, the matter was being handled by Finance Department at ADH. I was not aware at the time of the criteria for determining when a home health aide was an employee as opposed to an independent contractor.

(b) If you were unaware of this letter, please state how, as Director of ADH, you administered inquiries by a federal agency regarding violations of federal law by your Department.

A: I recall that ADH immediately responded to the IRS letter, determined whether our practices were consistent with the requirements of the law, and adjusted our practices to ensure compliance.

(c) If you are confirmed by the Senate, please fully state how you would implement review procedures to ensure that the Public Health Service is administered in complete compliance with the law and managed with proper responsibility.

A: If confirmed as Surgeon General, I am committed to maintaining the highest standards of ethical behavior and compliance with the law both by myself and the Public Health Service over which I have authority. Also as Surgeon General, I will impose rigorous controls and oversight as necessary to ensure proper compliance with all legal, regulatory, and ethical requirements.

6. Could you please supply the Committee with copies of the correspondence from the IRS to the ADH regarding the issues?

A: I am no longer the director of the ADH, and do not possess copies of the correspondence from the IRS to the ADH regarding these issues.

SPROLES HOME HEALTH AGENCY

1. Was there any relationship between Tommy Sproles' Home Health Agency and the Mercy Nursing Home?

A: No, to my knowledge, there was no relationship between Tommy Sproles Home Health Agency and the Mercy Nursing Home.

2. Were you ever a shareholder in either the Mercy Nursing Home or the Home Health Agency?

A: No, I was never a shareholder in the Sproles Home Health Agency or the Mercy Nursing Home.

3. Were Audrey and/or Rose Ruffin ever employed by or connected in any way with Tommy Sproles and/or the Home Health Agency?

A: No, to my knowledge, neither Audrey nor Rose Ruffin was ever employed by or connected in any way with Tommy Sproles or the Home Health Agency.

TEEN PREGNANCY

1. You stated as State Health Director....

2. We haven't given abstinence a chance—so how can you say that abstinence won't work? Further, given these facts, how can you say that the current approach does work?

- A: I support abstinence as the best choice for young women. I do not feel that we can rely only on abstinence messages because this does not provide any help to those young persons who do decide to become sexually active. For this reason I believe that information on sexuality and contraception must be provided along with abstinence information. Programs which have provided both abstinence and contraception information within a comprehensive framework—such as the Reducing the Risk program and the Postponing Sexual Involvement program have shown both increased postponement of initiation of sexual activity as well as improvements in contraceptive practice among those teens who do become sexually active.

Provision of family planning programs does not cause sexual activity. Most teens are sexually active for almost a year before they seek contraception from a family planning clinic. Increases in the funding for family planning and sexuality education programs followed, not preceded, the increase in teen sexuality activity and sexually transmitted diseases. The failure of these programs to stem the problems can be more accurately attributed to the inadequate funding they have received over the past decade; indeed, the Title X program currently has only about half the purchasing power it had in 1980.

- b. If you had no success in Arkansas in reducing the rate of teen pregnancy, why should we believe you will have any success in implementing the same plan on a national level?

- A: To the contrary, we did have success, although not as much as I would have liked, on reducing the rate of teen pregnancy. This is a task which requires the involvement of teens, their parents, schools, communities and community leaders and the media which glorify sex as safe and costless and glamorous. A state health director or Surgeon General can work to coalesce these forces, but it will not be until they adopt the message that real progress will begin to be made.

- c. You have blamed the failure of your plan to reduce Arkansas' teen pregnancy rate on "Poverty and ignorance and the Bible-belt mentality." Would you please comment on that?

- A: The statement is not in response to the failure of my plan to reduce Arkansas' teen pregnancy rate but rather is a statement concerning the continuing increase in the teen pregnancy rate on the national level.

2. On the issue of the minority children born to teenagers, you have been quoted as asking, "Why should we want a race of black people who are retarded, ignorant and poor?" (The New York Times, October 15, 1989) Do you really believe that children born to teenagers are "retarded, ignorant, and poor"? Jesse Jackson appeared before this committee yesterday to testify on adoption of African American children and he told the committee how he was born to (SIC) teenager, and was later adopted. Surely you don't mean to imply that all or even most of the children born to teenagers are necessarily ignorant or retarded?--

- A: Children born to teenagers are 80% more likely to be poor, are 12% more likely to be a low birth weight baby, and more likely to be in a special education class. No, I do not mean to imply that all or even most of the children born to teenagers are necessarily ignorant or retarded, but we would like for all children to have two nurturing parents and to be planned and wanted.

3. In February of this year the Washington Post reported you told the American Medical News that teenage mothers and their babies make up America's newest slave class. "If Medicaid does not pay for abortions, does not pay for family planning, but pays for prenatal care and delivery, that's saying, 'I'll pay for you to have another good, healthy slave, but I won't pay for you to use your brain and make choices for yourself...If you are poor and ignorant, you are a slave.' (Washington Post, 2/16/93).

One month later you were quoted as saying, "The public assistance tab for teen mothers and their children came to \$26 billion in 1991, up from \$19.3 billion four years earlier. Single, unemployed with no job skills and on welfare, children who have children constitute America's newest slave class." (Los Angeles Times, March 8, 1993)

Could you please elaborate?

A: I am a proponent of access to family planning services for poor women to enable them to avoid pregnancy if that is their wish. Although we as a Nation focus our time and resources on health care for pregnant women and their children, we do not focus enough on preventive health measures such as family planning that can assist women in planning or delaying their pregnancies until they are best able to care for their children.

This is evidenced by the fact that in FY 1992, the estimated Federal share of Medicaid funding for all maternal and infant care was \$5.0 billion, while the Federal share of Medicaid funding for family planning services was just \$405 million. In addition, over the last decade, after adjusting for inflation, there has actually been a decrease in Title X funding for family planning services, the Federal government's major source of grant funding for family planning services to poor women.

With regard to Medicaid, although Medicaid expenditures for family planning services have been increasing, because States use different sets of income guidelines to determine Medicaid eligibility, coverage for family planning services for poor women varies greatly by State.

In addition, while Medicaid regulations require States to provide obstetrical coverage for pregnant women whose incomes are up to 133 percent of poverty for a period of 60 days post partum, most poor women who are not pregnant can only receive Medicaid coverage (and therefore reimbursement for family planning services) if they qualify for AFDC. And, income eligibility criteria varies greatly from state to state — for example in Arkansas, individuals are eligible for AFDC payments only if their income falls below 21 percent of the Federal Poverty Guidelines.¹

^{1/} Medicaid Source Book: Background Data and Analysis (A 1993 Update) A report prepared by the Congressional Research Services for use by the Subcommittee on Health and the Environment of the Committee on Energy and Commerce. January, 1993 P. 746

4. Upon what sources did you base the statistic that 60% of American children are "unplanned and unwanted?"

A: My information source was a publication from the National Center for Health Statistics using data from the National Survey of Family Growth. In 1988 among never-married women aged 15-44 65% of the children born to them were unplanned and unwanted. [39.8% mistimed and 25.4% unwanted] In this report a pregnancy was classified as "unwanted" at conception if the woman had stopped, or had not used, contraception for reasons other than seeking pregnancy, or if she had become pregnant while using contraception and had not wanted a baby. Births that were wanted but occurred sooner than desired were classified as "mistimed." "Unintended" births are those that were either unwanted or mistimed.

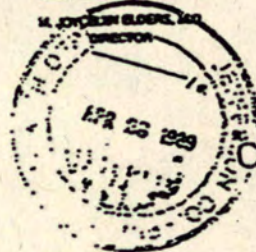


BILL CLINTON
GOVERNOR

Arkansas DEPARTMENT OF HEALTH

4015 WEST MARSHMAN STREET - LITTLE ROCK, ARKANSAS 72205
TELEPHONE AC 304 681-3000

H. JOYCE BLODER, M.D.
DIRECTOR



*Copy for Lu A
+ Cole Team
Mike Gough
Baker*

April 18, 1989

Mr. Paul Southard
Internal Revenue Service
First Federal Building, Room 430
401 W. Capitol
Little Rock, AR 72201

Dear Mr. Southard:

This letter is in response to your inquiry regarding our treatment of Personal Care Aides, Registered Nurses, Physical Therapist, Speech Therapists, Licensed Practical Nurses, and Occupational Therapists as "Independent Contractors."

Our home health agency operates on public funds: a mix of state funds, reimbursements from Medicare and Medicaid, and some Veteran's Administration. As such, we are expected to provide care for people regardless of whether or not they have a third-party payment source for the care. Our patients are typically suffering from a major illness (cancer, stroke, heart disease, new diabetes, etc.), or are so frail that they are about to enter a nursing home. These services are generally the critical factor in the patient's being able to remain at home, using family support in a loving environment.

We have been under the belief that a selected group of our "personnel" were appropriately classified as independent contractors, since we do not directly supervise them, but rather provide them with a Care Plan for their professional services. They do have the latitude to refuse assignments, and to select their own working hours.

However, in reviewing the documentation which you sent to us, we understand that we should be treating these workers as "employees."

We have met with the Arkansas Department of Finance and Administration, with our Accounting and Financial Management sections, and with our data systems managers, and have made the following plans for complying with recent IRS rulings. As you review these plans, please keep in mind that we are a statewide organization which must collect information from personnel in 75 counties of Arkansas.

LETTER TO MR. SOUTHWARD
April 17, 1989
Page 2

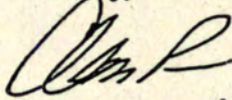
1. He will pay both our portion and the employees' portion of FICA for the period January 1, 1989 through June 30, 1989. He will do this because we do not feel that we can guarantee to you that we will have the necessary withholding systems in place prior to that date.

On July 1, 1989, we will begin standard withholding for those employees which we had previously considered "independent contractors." (This will necessarily include meetings with the employees, collection of necessary tax information, as well as computer changeovers; restructuring of data systems, etc.)

2. He will process the first batch (both employees' and employers share) of FICA payments for one group of personnel which comprises the majority within two weeks. He will phase in FICA payment for the remaining individual employee groups by the end of May. He will spend June accumulating tax information statewide necessary for the withholding process.
3. He will provide you with a status report on June 15, 1989, and on July 30, 1989.

We hope that this plan is acceptable to you; we appreciate your calling the matter to our attention—we honestly thought we were operating in accordance with applicable rules. If we can provide any further information, please don't hesitate to call us.

Sincerely,



Clay Parton, Director
Division of In-Home Services

cc: Nancy Kirsch
Rob Robinette
Tom S. Butler
Jim Mills

RESPONSES OF M. JOYCELYN ELDERS, M.D.
TO
QUESTIONS SUBMITTED BY
SENATOR NANCY LONDON KASSEBAUM

ROLE OF THE SURGEON GENERAL

You were preceded in your role by two surgeon generals who successfully advocated different public health causes. Dr. C. Everett Koop led a national crusade against tobacco use and called for preventative measures to curb the spread of HIV. Dr. Antonia Novella focused the nation's attention on the adverse effects of alcohol usage and abuse, especially among teenagers.

Q: What are your goals in your role as health advisor to the Nation?

A: The role of the Surgeon General as I see the office and understand it at the present time is articulated in a document I am attaching to these responses. (See Appendix A). Some of these views were given in my opening statement to the Committee. As Surgeon General, my goal will be to improve the quality of life by:

- preventing chronic and infectious diseases, including cancer, heart disease, hypertension, tuberculosis and AIDS;
- reducing teen pregnancy, infant mortality and morbidity;
- eliminating the serious disparities in health problems which minority groups experience;
- preventing and reducing the toll of injuries and disabilities in our society;
- improving women's health; and
- providing care and services for our elderly so they can live in dignity and comfort during their final years.

Q: What public health causes do you plan to advocate?

A: I will be a strong advocate for programs outlined in this brief, in addition to other major public health issues seen as needs by the Congress, President and the American people.

Traditionally, the Surgeon General has been the nation's health policy advisor. Under a proposed reorganization of the Office of the Assistant Secretary for Health, I understand you could be assigned roles different than previous surgeon generals. If the reorganization occurs, you would be the direct supervisor of the Office of Women's Health, Minority Health, Disease Prevention and Health Promotion and Population Affairs.

Q: Is this true? How will your role be different than previous surgeon generals? Why is there a change in the role of Surgeon General? To whom will you report, Dr. Lee or Dr. Shalala?

- A: Under the intended reorganization within the Department's Office of the Assistant Secretary for Health, the role of the Surgeon General will be expanded. The Assistant Secretary for Health will remain the head of the United States Public Health Service, while the Surgeon General manages the PHS Commissioned Corps personnel system and serves as the health advisor to the nation.

The expansion of the Surgeon General's role entails placing four programs within the Public Health Service under the Surgeon General's supervision. These programs include the Office of Women's Health, Office of Minority Health, Office of Health Promotion and Disease Prevention, and Office of Population Affairs. Since these programs are located in the Office of the Assistant Secretary for Health, a major reorganization and relocation is not required.

Although I look forward to working closely with the Secretary, I will report if confirmed to the Assistant Secretary for Health, Dr. Philip Lee, just as my predecessors have.

Q: What is your top priority for each of the offices you will direct? A large role of each of these offices is to coordinate activities across the entire Public Health Service. In your role, will you also try to prevent unnecessary duplication of efforts across the Public Health Service?

- A: I want the opportunity to study the current activities of these Offices in more detail before I decide the priorities for these programs. I do intend to work toward preventing the duplication of effort across the Public Health Services. However, eliminating duplication is not enough. Based on my experience in Arkansas, I know that we must improve the coordination of effort in our programs and increase flexibility.

TEEN HEALTH

In Arkansas, you initiated different programs to improve the health of teenagers. You are credited with expanding the number of school based health clinics. In addition, during your tenure, the Arkansas teenage pregnancy rate climbed, but at a lower rate than the nation's.

Q: What are the most pressing health problems facing teenagers today?

- A: As I have stated in my testimony, all too often I have seen bright young people all over this country surrounded by social problems which negatively impact their health such as drugs, alcohol, violence, homicide, suicide, AIDS and teenage pregnancy.

The overall health profile of teenagers is distressing especially when reviewing the morbidity and mortality associated with adolescent's poor or high-risk health behaviors:

(1) According to data from the CDC, in 1987 and 1988, about three-fourths of all deaths among U.S. young people aged 10-24 years were related to only four major causes: motor vehicle accidents (36.8%), homicide (13.7%), suicide (12.1 %), and other injury (11.9%).

(2) In addition, over the last decade, drug abuse, alcohol and cigarette use and unprotected sexual intercourse among adolescents have become a significant health problem contributing to high rates of adolescent morbidity.

(3) All too frequently, these health and social problems are interrelated. As many as one in four adolescents are considered to be "at risk" for school failure, delinquency, early unprotected sexual intercourse and substance abuse.

Q: What were the most successful initiatives you undertook in Arkansas to improve the health of teenagers, and why do you think they were effective?

A: A combination of various initiatives have contributed to efforts to improve adolescent health in Arkansas. The key is focusing public attention the health concerns of young people, educating both public health personnel and the general public, and making health services accessible through approaches such as school-based or school-linked health initiatives.

I think efforts such as the Arkansas "time bomb" initiative and the community health promotion project are examples of successful initiatives. The "time bomb" initiative was a joint venture between the Arkansas Department of Public Health and the local NBC affiliate to target PSA's at youth. This particular initiative won a Peabody Award. Another example is the Community Health Promotion Projects which through funding from the Kaiser Foundation provided support for five community based projects to work with adolescents in areas that had high rates of teenage pregnancy.

Q: In your role, do you plan to advocate for a Federal program of school based clinics? If so, what role should the parent play in these settings?

A: Yes, I do plan to advocate for the establishment of school based clinics with full participation by local communities.

The role of parent in a school based setting is one of partnership with the health care provider and the school. In Arkansas, no service is provided to the student without the consent of the parent. The parent chooses and consents to the services provided to their child and works together with the school and health care provider to keep the child healthy and ready to learn.

TEEN PREGNANCY

Q: I understand that two of the Arkansas School Based Clinics distribute birth control on site. Should all school based clinics do this? If not, who should decide which programs do?

A: The school based clinics in Arkansas that dispense condoms or birth control on-site do so at the request of the local school board. This is, and should be, a local decision of the school board and the school to choose the services to be offered. No service should be provided to a student without the consent of the parent.

Q: What are the best methods to reduce the rise in teen pregnancy across the country? Which of these do you advocate?

A: I believe that the best methods include:

(1) Education: Children who are doing well in school are three times less likely to be teen parents. If children are to do well in school, we must start with early childhood education for all children, especially for those at greatest risk. Children that live in poor socioeconomic environments are also more likely to be teen parents. The combination of doing poorly in school and low socioeconomic status increases risk nine fold. We must also educate parents on how to be good parents and how to educate their children. We need multiple strategies for most adolescents, nurturing parents, supportive community, education, early and continuous availability of health and contraceptive services, in addition to hope for the future;

(2) Development and dissemination of health education curricula: These curricula would be part of a comprehensive health education program which begins in the early grades at age-appropriate levels. I would include education on reasons to delay sexual activity, especially targeted to younger adolescents, but also including complete information on contraceptives;

(3) Support for school based and school linked services: Funding support would ensure the provision of comprehensive health education and services. This support would be provided for those communities that request it;

(4) Increase outreach efforts: Outreach efforts would include disseminating information to demystify clinic procedure as well as to dispel myths and incorrect information about sexuality and contraceptives. Information would be delivered to adolescents through group education and familiarization sessions at clinics, presentations in schools and in other community centers;

(5) Enhanced counseling services; and

(6) Making contraceptives available and accessible to every person who is at risk of having an unintended pregnancy.

I advocate any and all of these methods in order to help reduce the incidence of adolescent pregnancy.

Q: During your tenure, the number of abortions for 15 to 19-year-old women decreased from 2,028 in 1987 to 1,736 in 1991. Why do you think this happened?

A: The absolute number of abortions for 15 to 19-year-old women is dropping partly because the number of teen women is declining. Since all states do not collect information on abortions, accurate national data are hard to come by, but it appears that this decline is a national phenomenon.

MATERNAL AND CHILD HEALTH

While in Arkansas, you implemented policies which appear to have improved the health of mothers and their infants.

Q: I understand the percentage of women who did not receive prenatal care in the first trimester decreased for 33.5 percent to 28.6 percent from 1987 to 1991. What programs did you implement to increase prenatal care? What special initiatives do you plan to address this issues in your role as surgeon general?

A: I'm very proud that the number of women seeking early pre-natal care increased during my tenure. The major programs implemented in Arkansas to increase this number were related to increasing Medicaid coverage from 29% to 185% of poverty and having presumptive eligibility so pregnant women could be Medicaid covered from their initial visit to the health department. Secondly, we had excellent Healthy Babies campaign where mothers were rewarded with coupon books for coming in for early prenatal care. We increased awareness of the entire community of the need for early prenatal care by involving our businesses, schools, churches, civic groups and others. We extended our clinic hours to make services more convenient for mothers. We improved our education of mothers so they would know to come in early and to tell their friends about coming in early. We also improved our public health facilities to make them more user friendly so women would want to come to our clinics to receive early prenatal care.

If confirmed as Surgeon General, I plan to address infant mortality with some of the same strategies developed in Arkansas and other states. We need to evaluate the best of these programs and make them available for all states so they can tailor the programs to fit the needs of their community.

Q: The number of children screened for development and adequate growth increased dramatically in Arkansas during your tenure. You promoted screening in a variety of non-clinic settings, including WIC application centers. Do you plan to address children's health issues in your new role? If so, what are your plans?

A: Early periodic screening diagnosis and treatment (EPSDT) was markedly increased during my tenure at Arkansas. This was again related to making sure that children in the health department received whatever services they needed, whether it was for WIC, immunizations or their EPSDT screen. We took advantage of every opportunity to serve our children.

Secondly, we changed the periodicity schedule for immunizations and well baby check-ups in the State of Arkansas to make it conform more to what pediatricians were doing in their offices.

Thirdly, we made EPSDT forms available in physicians' offices and in health departments so they did not have to be scheduled by DHS, the administrator of Medicaid in Arkansas. This put more responsibility on parents, it allowed them to make their own appointments rather than just be mailed an appointment time by DHS without regard to when parents could best keep their appointment. The "no show" rate for EPSDT decreased.

Fourthly, we increased the awareness and training of our nurses and nurse practitioners, many of whom could do the screening themselves.

I definitely plan to address children's health issues in my new role. I have been a strong advocate for children's health for many years now both as a pediatrician, a pediatric endocrinologist and a health director. I plan to continue these activities. I feel that we cannot educate children if they are not healthy and we can't keep them healthy if they are not educated. I will strongly push for continued early prenatal care for all mothers. I would like for every child born in America to be a planned and wanted child. I would like for that child to be able to be healthy, educated, motivated and to have hope. I would push for early childhood education for all children, especially those at the highest risk. I want to make health services available to all children as a right and not related to their ability to pay.

I will strongly support those concerns which help to strengthen families such as early childhood education, parenting education, male responsibility programs, college scholarships and work for a healthy environment which will allow children to grow up healthy, motivated and with hope.

PUBLIC HEALTH AND HEALTH CARE REFORM

Recently, you called for an expanded role for public health in a reformed health care system. One result of health care reform might be universal insurance for all Americans and a reduction in the financial burden placed on State and local public health departments.

Q: Freed from paying for the costs of health care for many persons, what will be the role of State and the Federal public health in the future? Will there be a need for new Federal public health resources?

A: It would be premature for me to comment on the roles of the State and Federal public health care agencies since the specifics of the President's health care reform plan are still being finalized. However, I believe that the State and local public health departments will continue to play a vital role in meeting the health care needs of their communities.

With regard to additional Federal public health resources, I would not want to preempt the President on this issue. I am sure this will be addressed when the health care reform plan is announced in the coming weeks.

Q: In your position as surgeon general, what type of reorganization do you plan for the Public Health Service's Commissioned Corps?

A: My concern is to make sure that the Commissioned Corps uses its resources to the greatest benefit of the public health. I have several ideas in this regard.

(1) We may decide to provide incentives for medical officers to move out of some administrative positions and into jobs involving the delivery of patient care. I feel that we should use trained physicians to provide needed care in

Indian Health Clinics, and at community and migrant health centers wherever possible;

(2) Also, we should consider options for revising the Corps policies to attract even more health care professionals into public service;

(3) Finally, we should look at how the corps could be used more effectively in case of natural disasters like the catastrophic flood in the midwest.

Q: What role, if any, will you play in the health care reform discussions?

A: I don't know the exact role that I will play in health care reform discussions.

1990 ARKANSAS FINANCIAL DISCLOSURE FORM:

Your 1990 Arkansas Financial Disclosure form is missing from the Secretary of State's office.

Q: Could you provide information regarding the amounts and sources of income you listed on the 1990 form in addition to your salary as director of ADH?

A: For my spouse, the Little Rock School District would have been listed in Section 3. The block "more than \$12,500" would have been checked.

For myself, Mercy Nursing Home would have been listed. The box marked "more than \$1,000" would have been checked.

GIVING ENDORSEMENTS TO GROUPS SEEKING GRANTS FROM THE ADH:

On at least three occasions you gave written endorsements to groups seeking grants from the Arkansas Dept. of Health during your tenure as director of the agency.

Q: Do you feel endorsements for groups applying for funds from the agency over which you presided represented a conflict of interest?

A: On the three occasions that are referenced in this question, I do not believe that my endorsements represented a conflict of interest. It is my recollection that on each of those three occasions, I was unaware at the time that the endorsement was solicited that ADH would be the disbursing of funds.

With respect to the Planned Parenthood letters, my recollection is reinforced by Nancy Liebke, Executive Director of Planned Parenthood of Greater Arkansas. She has written the Committee stating that for the two letters that she solicited from me, she did not inform me that the grant applications would be made to the ADH; indeed, she believed on each occasion that the Centers for Disease Control and Prevention would be funding the grants directly.

Q: If confirmed as U.S. Surgeon General, would you give written endorsements to groups applying to the National Institutes of Health for research grants?

A: No.

ACCRUED VACATION DAYS AS
CONSULTANT TO U.S. DEPT. OF HHS:

During your testimony before the Senate Labor and Human Resources Committee on July 23, 1993 you stated that you had accrued 60 days of vacation from your job as director of the state Dept. of Health which you used as a consultant with the U.S. Dept of Health & Human Services beginning April 18, 1993.

Q: It is my understanding the maximum number of vacation days allowed to be accrued and carried over annually by Arkansas state employees is 30. Could you reconcile this apparent discrepancy?

A: It is also my understanding that the maximum number of vacation days that can be carried over annually by Arkansas State employees is thirty. As of January 1, 1993, I carried over the full thirty days of leave. Thereafter, I earned leave at a rate of 15 hours per month.

Q: How many vacation days (8 hours per day) did you eventually use as a consultant with the U.S. Dept. of Health & Human Services?

A: 28 days.

SALARY ARRANGEMENTS AS
ARKANSAS DEPT. OF HEALTH DIRECTOR

The Arkansas Attorney General has issued at least three opinions appearing to conclude the arrangement under which you were paid a salary by UAMS as director of the ADH, was legally questionable.

Q: Were you notified that you were possibly violating state law by being paid a salary exceeding the legal cap for authorized salaries to state agency directors?

A: See the answers on "Pay Issue" to Senator Coats' questions.

Q: Since you were being paid by both UAMS and the state health dept, could you explain how many hours you continued to work as a professor on the staff of UAMS while holding down the full-time job of state health director?

A: I received a single paycheck from UAMS, where I was a tenured professor of pediatrics. My understanding was that the ADH contracted with UAMS for my services. I performed occasional services for UAMS such as publishing scholarly articles, taking medical students on rounds, and lecturing at UAMS seminars. I also served on the Human Research Advisory Committee and was a member of the faculty in the division of Pediatric Endocrinology and performed duties such as clinics rounds and consultations with faculty, students and housestaff. I estimate that I averaged in the vicinity of 8-10 hours per week on such activities.

AUTHORIZATION OF TOM SPROLES
CONSULTING CONTRACT WITH ADH:

In early 1990, as director of the ADH, you reportedly authorized a consulting fee of \$18,000 with Tom Sproles who had donated his private Central Arkansas Home Health Agency, to the state health department. You also approved a contract by which the ADH would lease Sproles' building housing his agency for five years at \$21,063 annually.

Q: Could you explain the reason for approving this consulting fee for Sproles as well as the arrangement by which the ADH acquired Sproles' home health agency?

A: In early 1990 two home health agencies in Pulaski County offered their agencies to the Arkansas Department of Health as both of these agencies were failing in terms of cash flow. Prior to being able to negotiate a deal, one of these agencies failed leaving no one in Pulaski County that provided many in-home health services to the poor, minorities and the underinsured. Mr. Sproles's agency fell into this category. Since he had provided services in this community for a long period of time, he wanted to be assured that the personnel and the patients were cared for and that the transition occurred in an orderly manner. The ADH did not have a Home Health Agency in Pulaski County. We wanted to serve this county and needed a consultant with experience to help with patient and physician recruitment. Therefore, we hired Mr. Sproles.

As to the building lease, the State Building Service evaluated and approved the building and equipment lease for the \$21,063 annually.

ARKANSAS DEPT. OF HEALTH FAILURE
TO PAY SOCIAL SECURITY TAXES FOR EMPLOYEES:

Q: Was the Arkansas Department of Health (ADH) cited by the IRS in 1989 for failure to withhold Social Security taxes for personal home care aides who were employed and paid by the ADH?

A: See the answer to Senator Coats' question number 5 under "Social Security."

Q: To the best of your knowledge, how much in back taxes and penalties did the state pay?

A: As I recall, ADH paid back social security taxes in the approximate amount of \$200,000 to \$300,000. The IRS did not assess penalties.

Q: Were you, in your position as director of ADH, held accountable for this omission?

A: I was not held accountable for this omission. I believe that the ADH practice of not withholding Social Security taxes predated my appointment as Director of ADH. When I learned that the IRS had questioned ADH's failure to withhold Social Security taxes, I directed my staff to respond immediately and appropriately to the IRS inquiry. I believe our response satisfied the Internal Revenue Service.

PULSE HOME CARE

In 1992, during your tenure as ADH director, the ADH entered into an exclusive contract with Pulse Home Care, a Little Rock home care staffing agency.

Q: Did this arrangement violate Arkansas government contracting laws and ethics when there were at least 6-7 firms in the state which could have provided this type of personnel staffing?

A: No. Information was sent to all staffing agencies in the state. Two of the three firms made offers. Only one agreed to enter into a contractual relationship with the department.

Q: What criteria did you and your senior ADH staff use in deciding to contract with Pulse to provide home care staffing?

A: There were two criteria: 1) the agency had to be in the staffing business; and 2) the agency could not be a home health agency.

Q: Did you personally authorize this contract between Pulse and the ADH?

A: No. Contracts are usually handled by the local program person and presented to the Deputy Director. All contracts of this nature have to be presented to a legislative committee for their advice. Only if there was a question or if problems arose were they discussed with me. I would then present the contract before the legislative committee rather than the local program director.

In this case, the initial contract was approved by the legislative committee. Only upon an amendment of the contract did I have to appear before the legislative committee. There were several home health agencies in the state objecting to the contract at that time.

Q: How much did Pulse Home Care bill the ADH per hour for home care patient staffing?

A: The billing varied depending on the area of the state. The range is between \$9 - \$24 per hour. The usual rate was \$18 per hour.

Q: How many patients has the ADH referred to Pulse Home Care since the contractual arrangement began?

A: Since November 1992, the total number of patients served for continuous care is forty-four. There are currently twelve patients being provided continuous care. In addition, Pulse may provide nursing staff for occasional intermittent visit services for patients on weekends or in areas where recruitment of nurses is particularly difficult. Pulse provided staff which made approximately 2,000 visits during FY '93.

Q: What percentage of the private home care industry business does this represent?

A: For continuous nursing care, it represents eight to ten percent since there are less than 150 continuous care patients in the state. Of the total home health care, the Pulse contract represents 0.1%.

NARCOTICS FOR MEDICAL USE

You have been quoted as advocating the use of marijuana for patients suffering from glaucoma, cancer, and AIDS.

Q: If confirmed as Surgeon General, would you advocate the use of narcotics for medical use that are currently prohibited by the Federal Government?

A: Research is currently being performed as to the therapeutic benefits of marijuana for such diseases as glaucoma, cancer, and AIDS. I believe the Secretary is planning to review the issue of marijuana's use for those purposes. I support such a review and would, therefore, defer a conclusive statement on the matter until the review has been completed.

I would not, however, advocate any action that was contrary to law or, even if lawful, contrary to the policy of the Department of Health and Human Services.

TEEN PREGNANCY INCREASE

It's been reported that during your tenure as State Health Director, Arkansas' teen pregnancy rate and the incidence of sexually transmitted diseases rose dramatically.

Q: Could you state the actual pregnancy rate and the rate of sexually transmitted diseases during your term and its relation to the national average?

A: Statistics concerning "teen pregnancy" include live births, induced abortions, fetal deaths, and spontaneous abortions of 15-19 year-old women. "Teen fertility" represents the number of live births to women ages 15-19 divided by the total number of women ages 15-19. "Teen pregnancy" represents the number of live births, abortions, and an estimate of fetal deaths to women aged 15-19 divided by the total number of women aged 15-19.

Arkansas	1987	1988	1989	1990	1991
teen pregnancy.	105.5	108.6	113.0	118.9	118.4
teen fertility	68.3	70.8	77.2	79.9	77.8
**U.S.A.					
teen pregnancy.	105.8	110.8	n/a	n/a	n/a
teen fertility	50.6	53.0	57.3	59.9	n/a

With regard to sexually transmitted diseases (STDs), only cases of syphilis and gonorrhea are recorded age-specifically at the CDC. (Rate is the number of cases (males and females) ages 15-19 per 100,000.)

U.S.A.	1987	1988	1989	1990	1991
syphilis	19.2	21.8	24.9	29.9	29.8
gonorrhea	1025.9	1032.5	1052.5	1060.6	1098.6
Arkansas	1987	1988	1989	1990	1991
syphilis	19	17	22	20	41
gonorrhea	1500	1400	1300	1400	1222

*Arkansas Department of Health

**National Center for Health Statistics, CDC, DHHS

Q: How do you explain this in terms of your emphasis on birth control counseling and free distribution of condoms?

A: Decreases in teen fertility do not happen overnight. But from 1987-1990, teen fertility in Arkansas increased at a slower rate than that in the U.S. The changes may have happened faster if more of the programs and approaches I sought had been implemented. Throughout the state there are 24 comprehensive school health service centers, and 22 schools are on the waiting list for funding to implement already approved student health centers. Only 4 centers currently offer contraceptives as part of comprehensive health services, hardly enough to have an effect on statewide statistics.

INCOMPLETE REAL ESTATE HOLDINGS

It appears that the real estate holdings you listed on the Senate financial disclosure form are incomplete and in some cases, carry an incorrect address for individual properties.

Q: Could you please provide an updated list of real estate properties owned by you and your husband that include correct addresses for each property?

A: Attachment B to these responses is a chart, previously provided to Senator Coats, which updates information on the real estate properties owned by myself and my husband.

RESPONSES OF M. JOYCELYN ELDERS, M.D.
TO
QUESTIONS SUBMITTED BY
SENATOR JUDD GREGG

SCHOOL-BASED CLINICS IN ARKANSAS

1. What proportion of the school districts in Arkansas had school-based clinics in 1990, 1991, 1992 and 1993?

A: See Chart Below

School-Based Clinics in Arkansas				
	1990	1991	1992	1993
# of schools with SBCs	8	23	24	24
# of school districts with SBCs	5	14	15	15
# of school districts in Arkansas	328	323	320	316
Proportion of School District with SBCs	1.5%	4.4%	4.4%	4.4%

Q: How many individual schools and individual school districts, in those year in Arkansas had school-based clinics?

A: See Chart in response to above question.

3. I am aware that the teenage pregnancy rate in Arkansas during the years 1987-1991 went up at about the same rate as the national rate. Has anyone ever studied the teen pregnancy rate within the school districts in Arkansas that had school-based clinics and compared that to the rate for the remainder of Arkansas? If so, what were the results?

A: These studies are presently being done.

4. In Arkansas, some school-based clinics dispense contraceptives and others do not. What proportion do? Is there any evidence that the rate of teenage pregnancy in those that do distribute condoms is lower than in those that do not? If so, please describe it.

A: Only 4 schools in Arkansas dispense contraceptives. Studies are incomplete and are presently being done.

5. Do you have any non-anecdotal evidence that school-based clinics are an effective way to bring down the rate of teenage pregnancy? If so, could you please describe it?

- A: Yes. A school-linked program, designed and administered by The Johns Hopkins School of Medicine and carried out with the cooperation of the administrators of four Baltimore Public Schools, provided sexuality and contraceptive education, individual and group counseling and medical and contraceptive services. An evaluation of the program found that, in addition to increases in contraceptive use and decreases in pregnancy, initiation of sexual activity was delayed an average of seven months. Another evaluation of six diverse school-based clinics found that education on pregnancy and AIDS prevention, in combination with contraceptive services, increased contraceptive use among sexually active students. There were no significant differences between clinic and nonclinic sites with respect to sexual activity rates.

Zabin, L.S., et al., "Evaluation of a Pregnancy Prevention Program for Urban Teenagers", Family Planning Perspectives, May/June 1986.

Kirby, D., et al., "Six School-Based Clinics: Their Reproductive Health Services and Impact on Sexual Behavior", Family Planning Perspectives, January/February 1991.

BANKING RELATED QUESTIONS

6. You were reprimanded by the Comptroller of the Currency for unsafe and unsound banking practices as part of votes you made as a member of the Board of Directors for an Arkansas bank. Were you ever sued in relation to your work on any bank board? If so, could you please describe the complaint against you, your explanations for the conduct, the facts of the matter, and the disposition of the suit?

- A: In the spring of 1989, outside investors achieved a "hostile" takeover of the NBA. As a result, in or about March 1989, a majority of the directors of the NBA, including myself, were removed as directors by vote of the shareholders.

Following that removal, the new directors caused the NBA to sue the former executives and board members, alleging various breaches of duties to the NBA.

The complaint was filed in or about 1992.

Thereafter, defendants filed a "Joint Answer and Counterclaims," denying that the former officers and directors had engaged in any improper conduct or breach of duties to the NBA. To the extent that applicable bank laws and regulations may have been violated, such violations occurred without the knowledge or intent of the outside directors.

I believe that all of the former executives and board members have now agreed on settlement terms with the National Bank of Arkansas. Pursuant to that agreement, the settlement terms are confidential.

I note that on July 21, 1993, in response to newspaper articles relating to this lawsuit, the Davidson Law Firm, Ltd., which represented the plaintiffs in this matter, issued a statement. In that statement, plaintiffs' counsel state:

With respect to Dr. Joycelyn Elders, she was joined as a party defendant in her representative capacity as a former outside

director of National Bank of Arkansas and National Banking Corporation from 1981 through March 29, 1989 at which time an entirely new Board of directors was elected by the shareholders. Dr. Elders was sued only in her representative capacity as a former director of the bank and holding company. There were no allegations of personal wrongdoing against her individually and no allegations of bank fraud or common law fraud against her or any of the other defendants. The lawsuit sought civil money damages from all the former board members. Fraud was not alleged in the lawsuit.

Both the bank officers and its attorneys have a high regard for Dr. Elders personally, professionally, as a physician and a public servant.

TEEN PREGNANCY

7. During your confirmation hearing, you listed the following as the causes of the rising teenage pregnancy: (1) in earlier times, more teenagers were married than currently, (2) children are now going into puberty earlier than previously, (3) 70 percent of our teenage pregnancies occur between three and five o'clock in the afternoon, when the children are home, and (4) children are now poorer than they were before. Is this an accurate representation of your views?

A: Yes, but I would like to expand on my answer.

Each year in America more than one million girls between the ages of 10 - 19 years become pregnant. Many of these young women are unmarried. In addition to the causes of rising teenage pregnancy listed in my testimony are (1) increasing sexual activity among teens, (2) earlier age of starting sexual activity, (3) younger teens are less likely to use contraceptives, (4) lack of knowledge of contraceptives and (5) increasing social problems impacting the behavior of adolescents. I believe we must educate our children so that they will make responsible decisions.

8. In addition to those causes in Question 7, are there any other causes of the high rate of teenage pregnancy in the United States, in your opinion? Please explain.

A: Yes. Adding to the increased pregnancy rates in the U.S. is a lower level of educational attainment, increased drug and alcohol abuse, lower socioeconomic status, the lack of health education in our homes and in our schools, and less community involvement and family support for adolescents.

9. I was interested in your statement that 70 percent of teenage pregnancies occur between three o'clock and five o'clock in the afternoon. I am interested in looking into that further. Could you please supply me with the source for that statistic.

- A. The well known Kantner and Zelnik surveys of adolescent women found that more than 75 percent reported their first sexual encounter occurred in either their own home, their partner's home or a friend's home. A comparable proportion reported their most recent sexual encounter also occurring in one of those three places. The most important point, however, is the absence of parental supervision. For example, a classic study (Hogan and Kitagawa) found that adolescent girls were 75 percent more likely to be sexually active if parental supervision of dating was lax rather than strict.

NURSING HOME RELATED QUESTIONS

10. In your confirmation hearing, you said that the Arkansas Health Department had no relationship to the nursing home in which you worked. Did the Health Department pay Medicaid claims by the home or its residents? Did the Health Department conduct any licensing, quality assurance, or sanitation activities in regard to the home? If so, please give details.

- A: The Arkansas Department of Health does not have any involvement with the payment of Medicaid claims. The Arkansas Department of Health does not conduct any licensing, quality assurance, or sanitation activities in regard to nursing homes.

11. Did you ever visit the home in your capacity as Director of the Arkansas Health Department? If so, please explain.

- A: I did not visit the Mercy Nursing Home in my capacity as Director of the ADH.

12. Did you ever supply consultation to the home by telephone, or to its residents, while on the job at the Arkansas Health Department? If so, please explain.

- A: I do not recall ever supplying consultation to the home by telephone, or to its residents, while on the job at the ADH.

QUESTIONS RELATED TO TAXES

13. In the hearing, you seemed to say that money was transferred from Mrs. Elders' accounts, of which your husband was guardian, into the joint checking account of you and your husband. The money was then paid by you or your husband to the nurse. Is that accurate? If not, please explain.

- A: Mrs. Elders received income from retirement benefits and rental properties that she owned. That income was deposited into the joint checking account of myself and my husband. My husband or I then paid Ms. Ruffin from our joint account. Mrs. Elders income was sufficient to cover the payments to Ms. Ruffin.

14. Why didn't your husband issue the money to the nurse directly from his mother's accounts, instead of first transferring the money to your joint account and then issuing it?

A: See response to Question 13.

15. In paying the nurse, was the money used to pay her your money, your husband's money, or Mrs. Elders' money?

A: The money used to pay Ms. Ruffin was Mrs. Elders' money.

16. In your confirmation hearing, you seemed to say that you were not aware of the fact that the law requires the payment of Social Security taxes until the past few weeks. Is that accurate? To ask the question another way, during the time when you were issuing checks to the nurse for nursing care, did you ever know that failure to pay Social Security taxes was a violation of the law? During that time, did anyone ever tell you that Social Security taxes were due on the salary paid to the nurse?

A: As I testified at the hearing, I did not regard the payment of social security taxes on the salary of the nurse employed by my mother-in-law as my responsibility. As a result, I did not focus on the nature of Ms. Ruffin's services for Mrs. Elders, and any attendant tax liability that Mrs. Elders may be incurring. Following the increased attention in this area since January 1993, and as I began to prepare for my confirmation hearing, I decided it was necessary to address this issue. Although I do not believe that my husband's failure, under his power of attorney from his mother, to pay the social security taxes for Ms. Ruffin is my responsibility, I decided to insist that the taxes be paid prior to the hearing to avoid any possible issue.

17. In your own words, why weren't the taxes paid?

A: Ms. Ruffin was hired by my father-in-law, not by my husband. When my father-in-law died, my husband simply continued the arrangements that had been established by my father-in-law, without attention to whether any additional requirements were necessary. After the attention given to this area earlier this year, we focused on the problem and paid the back taxes, penalties and interest.

18. Who paid the back taxes to the IRS? Whose funds were used to pay those back taxes?

A: The back taxes were owed to the IRS by Mrs. Elders, who is the employer. Mrs. Elders is 97 years old, has Alzheimer's disease, and is not currently competent to handle her own financial affairs. My husband acted on her behalf under the power of attorney that she granted to him when she was competent.

In light of the desire to resolve this matter rapidly, taxes were paid out of available funds. Appropriate accounting adjustments will be made to reflect the payment of these taxes from Mrs. Elders's funds.

19. Did you or your husband ever take a tax deduction or claim an exemption for Mrs. Elders? Did you ever claim Mrs. Elders as a dependent? If yes to either question, please supply details.

A: My husband and I filed joint tax returns. We did not take a tax deduction or claim an exemption for Mrs. Elders on our return. We did not claim Mrs. Elders as a dependent.

DR. MALAK

20. Would you please describe in detail your relationship and dealings with Dr. Fahmy Malak.

A: I have known Dr. Fahmy Malak in his capacity as a medical examiner and as an employee in the ADH's AIDS program.

As Director of the ADH, I was Chairman of the State Medical Examiner's Commission. Following some questions concerning Dr. Malak's role as the Arkansas State Medical Examiner, the State Medical Examiner Commission retained outside experts to review Dr. Malak's office and his conclusions in several cases. In November 1988, we received a report from the outside experts, generally supportive of Dr. Malak. The principal area that the experts questioned was the adequacy of the staffing level at the Office of the Arkansas State Medical Examiner. In or about March 1991, supervision of the Arkansas State Medical Examiner was transferred to the Arkansas State Crime Laboratory Board. I am not a member of that Board.

In or about September 1991, Dr. Malak was hired as an employee in the ADH's AIDS program. I believe that he was hired through the ordinary hiring processes, including submission of an application, interviews, and recommendation by a hiring panel.

I have no personal relationship with Dr. Malak.

21. Did you ever help exonerate Dr. Malak of charges of negligence, and recommend him for a raise? Did you ever hire Dr. Malak to head the Health Department's AIDS Program?

A: I have never helped exonerate Dr. Malak of charges of negligence. As noted in response to Question 20, Dr. Malak is not the head of the Arkansas Health Department's AIDS Program. He was an employee within that program. After the death of the laboratory director, Dr. Malak became a clinical consultant for the laboratory.

On July 16, 1993, I received a memorandum from Robert L. Horn, Director of the State of Arkansas Public Health Laboratories. That memorandum states in part as follows:

Dr. Malak is functioning as a clinical consultant to the laboratory's clients, i.e., local health units, hospitals, clinics and other private providers. In this capacity, he advises clients to assure that the appropriate tests are ordered and assist them in interpreting clinically significant results.

He is a knowledgeable clinician and relates well to laboratory clients. He screens selected laboratory results to assure that values are consistent with expectations. His consultations with users have satisfactorily resolved clients questions when rare or unusual results were reported.

...

Dr. Malak is the first clinical consultant available to the laboratory and his function in this capacity has been most beneficial.

PAY ARRANGEMENTS IN ARKANSAS

22. An allegation has been made in the press that you were paid at the Arkansas Health Department under an arrangement that was questionable. According to the allegation, you avoided a statutory cap on state salaries by receiving salary from more than one state source simultaneously, the Health Department and the University of Arkansas. Would you please give your side of those allegations.

A: See answers to Senator Coats' questions on "Pay Issue."

CONDOMS

23. With regard to the defective condoms referred to in your confirmation hearing, where in the United States were the defective lots distributed?

A. According to Ansell, condoms like those distributed by the Arkansas Department of Health, were distributed in the District of Columbia and Guam, and in twenty-seven states [Alabama, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New Jersey, New Mexico, New York, North Carolina, Oregon, Pennsylvania, Texas, Vermont, Virginia and Washington.] A number of the customers in those locations were federal entities (e.g., military bases and hospitals) and, as well, a number of college/university health clinics, county health departments and state health departments.

24. Please explain your reasoning in deciding not to issue a notice to the public warning them of the defective condoms.

A. Senior level staff at the Arkansas Department of Health were involved in the decision not to publicly announce the recall of the condoms. The Deputy Director for Administration, the Deputy Director for Services, Department General Counsel, the Director and the Medical Director of Maternal and Child Health, and Division Directors of the Divisions of Pharmacy Services, Reproductive Health Services, and AIDS and STD Services all participated in discussions which came to that conclusion. Three meetings were held, two in July, and the third, in August, 1992, following notification to the Department of Health by FDA of the results of its testing of Ansell's condoms. At all three meetings, public notification was discussed. At each of the first two meetings it was determined not to do public notification because, to my

knowledge, the FDA had not completed testing on the condoms. At the third meeting, after lengthy deliberation, a unanimous decision was made not to make a public notification because of the overriding public health risks. The Department senior staff recommended that the risks associated with the failure generally to use condoms far outweighed the risks associated with the use of condoms with a higher than acceptable potential failure rate. I agreed with my senior staff on the basis of their unanimous recommendation.

VARIOUS QUOTATIONS

25. During your confirmation hearing, Senator Coats read a quote attributed to you in the L.A. Times. The quote referred to a belief that pregnancy was God's justification for fornication. You said, essentially, that you had been misquoted. If possible, please supply the correct quote and what you meant to say.

A: See answer 8 under Abortion, Senator Coats.

26. Did you ever say that "most of our society believes that a baby is God's just punishment for fornication"?

A: See answer 8 under Abortion, Senator Coats.

27. Did you ever say, "We would like for the right-to-life, anti-choice groups to really get over their love affair with the fetus and start supporting the children"?

A: See answer 10 under Abortion, Senator Coats.

28. Did you ever comment to Arkansas legislators when they rejected a tax increase on cigarettes, "You sold our children out to the tobacco industry."

A: During the 1993 Session of the Arkansas General Assembly, I attempted to increase taxes on cigarettes and smokeless tobacco products to fund some children's programs as well as increasing funding for elderly programs and a cancer registry in the state. The statement was made following a committee hearing in which I was unsuccessful in getting committee approval for the proposed tax increase. The entire Arkansas legislature was never given the opportunity to vote on the proposal. The statement was directed to those members of the committee that blocked the proposal.

29. Did you ever characterize abortion foes as part of a "celibate, male-dominated church, a male-dominated legislature and a male-dominated medical profession"?

A: See answer 11 under Abortion, Senator Coats. This entire statement was made during that speech.

30. Have you ever publicly referred to your opponents as "non-Christian" or "un-Christian"?

A: See answer 7 under Abortion, Senator Coats.

31. Have you ever publicly referred to your opponents as having "slave-master mentalities"?

A: See answer to Senator Coats' Question 9 under "Abortion."

32. Please feel free to comment upon, justify, or place in context any of the above quotations.

RESPONSES OF M. JOYCELYN ELDERS, M.D.
TO
QUESTIONS SUBMITTED BY
SENATOR JAMES M. JEFFORDS

Q: The State of Vermont has the fourth highest incidence of breast cancer in the United States. Therefore, we in Vermont are understandably looking for any steps that can be taken to help reduce the incidence of breast cancer, improve educational efforts and access to health care in this regard. As Surgeon General, what type of strategy would you pursue to achieve these goals?

A: I am aware that breast cancer is a particularly serious problem in Vermont. I know that women's health, including the problem of breast cancer prevention and control, are a major priority for Secretary Shalala and within the Public Health Service.

This spring, the Centers for Disease Control and Prevention (CDC) in collaboration with the Food and Drug Administration and the National Cancer Institute developed the National Strategic Plan for Early Detection and Control of Breast and Cervical Cancers. This plan addresses such areas as public education, professional education and practices, and quality assurance. The Public Health Service, in particular CDC, is working with the States as well as professional and voluntary organizations to assure that an organized system of services are made available to all women.

RESPONSES OF M. JOYCELYN ELDERS, M.D.
TO
QUESTIONS SUBMITTED BY
SENATOR EDWARD M. KENNEDY

1. You referred to some of your Arkansas opponents as having "a love affair with the fetus" and being the "very religious non-Christian" right. You also characterized abortion foes as being "a celibate, male-dominated church, a male-dominated legislature, and a male-dominated medical profession" and as being people who "love little children as long as they are in someone else's uterus." In making these statements did you mean to denigrate the views of millions of Americans who are sincerely anti-abortion?

A: I am sorry for any offense that I may have given to the many Americans who sincerely oppose abortion and who also care deeply about the well-being of mothers and children. In Arkansas, I have worked closely to develop constructive programs to prevent teen pregnancy and to promote maternal and child health with many individuals of good will who also oppose abortion on religious grounds. While I do not share their religious attitudes on this issue, I view every abortion as a failure, and I look forward to working closely with abortion opponents and pro-choice advocates on a common agenda of good health for mothers and children and prevention of unwanted pregnancies.

2. In your decision not to publicly announce the recall of the condoms that were thought to be potentially defective, you were following the unanimous recommendation of the staff of the Arkansas Department of Health, were you not?

A: Yes. The bureau directors and the division of reproductive health made that recommendation to me and I carefully evaluated and accepted it.

3. And at that time you didn't actually know the condoms were defective, did you? The FDA had not tested them, and you had conducted your own recall based on five complaints over a period of approximately 2 years. Is this correct?

A: To the best of my knowledge, the FDA had not completed testing on the condoms.

RESPONSES OF M. JOYCELYN ELDERS, M.D.
TO
QUESTIONS SUBMITTED BY
SENATOR PAUL WELLSTONE

1. Dr. Elders, I applaud your decision to spend part of your training at the University of Minnesota. Right away I know we have no reason to question your judgment. Can you discuss with us your motivation for focusing on pediatrics in your medical training?

A: I was the oldest of eight children. I have always wanted children to be able to grow up healthy, educated, motivated, and to have hope for the future. I had excellent mentors in pediatrics during my training as a medical student as well as during my internship at the University of Minnesota. I have always felt that as a physician, the things that you would do for children would last a lifetime.

2. Dr. Elders, I have received many letters of support for you. I'd like to submit an alphabetical listing of those groups for the record. Of particular interest to me was a letter from Erima J. Vaughan in Hempstead, N.Y., which I shared with you. She urges me to vote for your confirmation, saying that she is the single mother of two boys, and like you, is a woman of color who had to learn to speak plainly. She's proud of the fact that, as she says, her two sons "date, but no girls got pregnant. We must help young people understand the dangers of AIDS or an unwanted pregnancy," she concludes.

Can you discuss your interest, as Director of the Arkansas Department of Health, in educating young people about the importance of knowing how to protect themselves from diseases and unwanted pregnancy?

A: As the Director of the Arkansas Department of Health I found that Arkansas had the second highest rate of birth to teenagers in the United States. The United States has a pregnancy rate which is twice that of Canada, and ten times higher than Japan. As I evaluated the literature and talked to people who had been working in this field for many years, I found that there were several themes that were common to all successful education and pregnancy prevention programs.

First, you must start early if you want to make a difference with children through early childhood education. Second, you must educate them about health by having comprehensive health education from kindergarten through twelfth grade. Third, you must educate parents. Fourth, you must involve the young men and teach them to be responsible. Fifth, services need to be available for the children where they are -- in school. And last, they need to have hope for the future. I feel that the only place for all children to have an equal opportunity for access to health and education is at school. I therefore began to work with the education community to try and make services available for all children at school, the place where they spent most of their day. The services are available, they are easily accessible, they are affordable, and they should be age appropriate.

3. Minnesota as you know is home of the nation's oldest school-based clinics. In fact, they are celebrating their 20th anniversary this fall, and we hope you may be able to join us in Minnesota to mark the occasion. Would you tell us what role you will advocate for school-based clinics if you are confirmed as Surgeon General?

A: The role that I would advocate for school-based clinics if I am confirmed as Surgeon General would be to serve a very important role in providing primary, preventive health services on site. These services should include primary preventive health care, education, nutritional educational services, reproductive health services, treatment of minor injuries, sports physicals, and any other services that would be desired by the community and the school based on the needs of the children. I strongly support involving the community, and I feel that school boards should decide if they want a school-based health service. School boards should decide the services they would like to have available in their clinics, and parents should make a decision whether their children should use the school-based health services. To be successful, school-based clinics need to involve the entire community. Churches, businesses, parents and all other available resources in the community must help children be able to lead successful productive lives. I do not feel that you can educate children if they are not healthy. And you can't keep them healthy if they are not educated. We have copied many of the wonderful attributes of the first school based clinic started in this country in Minnesota, and we are very pleased with the things they've done to make a difference in children's lives over the past 20 years.

4. Dr. Elders, I admire your hard-fought accomplishments. It is rare that we have a nominee who is so well-suited to face the challenges of the job ahead. You know about poor access to health care, about rural poverty and the need for expanding primary care services. I envision you, with eloquence to match your knowledge and experience, as a Surgeon General in the grand tradition of C. Everett Koop, stirring the nation's conscience to do what we need to do. Can you describe how you hope to move the nation's health agenda forward during your tenure, and which issues you find the most compelling?

A: This question has been addressed in question No. 1 of Senator Kassebaum. I hope that I will have the eloquence and the high profile of Dr. C. Everett Koop and be able to address the multiple issues which will be on our nation's health agenda during my tenure. I feel the most compelling issue before us at this time relates to the issues surrounding AIDS, having unplanned, unwanted children, and certainly making health care accessible for all Americans.

ATTACHMENT A

The Role of the Surgeon General

The overall mission of the Public Health Service, the principal health agency of the Federal government, is the protection, improvement, and advancement of the health of all the American people. The Surgeon General serves as the principal Federal health advisor to the Nation on public health matters. As a public health advocate, the Surgeon General has a pivotal role in shaping and articulating the public health priorities that serve to protect and improve the health status of Americans.

DETERMINANTS OF HEALTH

What determines our health status? There are four principal determinants of health:

1. Genetics - One's genetic makeup contributes to a susceptibility for certain morbidities and is the principal agent for others, such as Tay-Sachs disease and sickle cell anemia.
2. Behavior - Behavior and health are strongly linked. A growing body of evidence links a handful of personal health behaviors to the leading causes of death in the United States: heart disease, cancer, cerebrovascular disease, injuries, and chronic obstructive pulmonary disease. Smoking alone contributes to one out of every six deaths in the United States. Failure to use safety belts and driving while intoxicated are major contributors to motor vehicle fatalities. Physical inactivity and poor nutrition contribute to coronary atherosclerosis, cancer, diabetes, osteoporosis, and other common diseases. Certain sexual practices

increase the risk of unintended pregnancy, sexually transmitted diseases, and acquired immunodeficiency syndrome. (1)

3. Health care - Access to health care certainly affects one's health, particularly access to clinical preventive services. Preventive measures which have made a tremendous difference in our overall health status include prenatal care, mammography and clinical breast examination, the Pap test for early detection of uterine cancer, and immunizations. (2)
4. Environment - Our health is greatly affected by what we drink, eat, breathe, and are exposed to through the environment. Additionally, our health is affected by our social environment - our family, socioeconomic status, and the availability of social support services within the community.

GOVERNMENT'S ROLE IN HEALTH

Many of the major improvements in the health of the American people have been accomplished through public health measures. Control of infectious diseases, safe food and water, and maternal and child health services are only a few of the public health achievements that have prevented countless premature deaths and improved the quality of American life.

The mission of public health is defined as fulfilling society's interest in assuring conditions in which people can be healthy. The core functions of public health agencies at all levels of government are assessment, policy development, and assurance. (3)

Assessment

An understanding of the nature and extent of community health needs is a fundamental prerequisite to sound decision-making

about health. Public health assessment involves systematic collection, assembly, analysis, and dissemination of available information on the health of the community, including statistics on health status, community health needs, and epidemiologic and other studies of health problems. (3)

Policy Development

Policy development is the process by which society makes decisions about problems, chooses goals and the proper means to reach them, handles conflicting views about what should be done, and allocates resources. Public health agencies bear the responsibility of ensuring that the public health interest is served. Public health leaders must raise crucial questions that no one else raises; initiate communication with all affected parties; consider long-range issues in addition to crises; speak on behalf of persons and groups who have difficulty being heard in the process; and build bridges between the various constituencies. (3)

Assurance

Assurance is making sure that necessary public health services are provided to reach agreed upon goals, either by encouraging private sector action, by requiring it, or by providing services directly. Assurance involves seeing to the implementation of legislative mandates as well as maintaining statutory responsibilities. It includes developing adequate responses to crises, sustaining basic services, regulating services and products, and maintaining accountability by setting objectives and reporting on progress. (3)

PREScriptions FOR IMPROVEMENT

As Surgeon General, I have six prescriptions for continued protection and improvement of the health of Americans.

Prescription #1: A pound of prevention

If an ounce of prevention is worth a pound of cure, let's aim for a pound of prevention! It is time that every American knows that:

- 1) Our leading health problems are preventable, and
- 2) It is easier and cheaper to prevent health problems.

Indeed, it is estimated that one out of three premature deaths and two out of three hospitalizations are related to no more than six risk factors: tobacco use, alcohol and other drug use, physical inactivity, inadequate nutrition, high blood pressure, unintentional injury, and gaps in basic health care. (4)

Prescription #2: Health education in the clinic, classroom,
and community

Prevention of health problems largely depends on awareness and knowledge of risk reducing and health promoting behaviors. Primary care clinicians should give greater emphasis to counseling on personal health practices. Schools should provide comprehensive, sequential, and age appropriate health education in grades kindergarten through twelfth grades. A comprehensive health education curriculum provides teaching on personal health/growth & development; nutrition; safety, first aid, and injury prevention; environmental health; tobacco and other substance use and abuse; consumer and community health; disease prevention and control; mental and emotional health; and family life and health. Community-based organizations can be important resources for health education, particularly for working adults and elderly citizens. A growing number of workplaces are offering health education and health promotion activities for their employees. Chapters of the American Association for Retired Persons and agencies serving senior citizens have been

instrumental in getting the elderly involved in health education initiatives.

PRESCRIPTION #3: Universal access to primary health care

We must aim at assuring for every American the clinical preventive services that can prevent and provide early detection and treatment of health problems. We need to expand nontraditional approaches to health care delivery that increase access for the hardest to reach and most vulnerable of our citizens. There are many promising strategies underway in America for reducing the gaps in primary health care. One example in school-based clinics. Over 300 school-based clinics, operating in 33 states, are now providing accessible, age-appropriate, preventive and primary health care to children and adolescents.(5)

To achieve universal access, health care reform will need to successfully address many areas of concerns, such as the inadequate supply and maldistribution of primary health care providers and disproportionate rises in health care costs.

#4: Advancement of knowledge about the relationships between environmental exposures and health

Tremendous gains in health status have been accomplished during this century through public health efforts to assure safe supplies of food and water, management of sewage and municipal wastes, and elimination or control of illnesses borne by insects and other organisms. It is essential that these efforts be sustained.

The greatest challenge for environmental health today is advancing our knowledge about the relationships between environmental exposures and health problems. Population

growth, urbanization, new energy sources, advanced technology, industrialized and modern agricultural methods have created dramatically different environmental health challenges. (2)

#5. Support for our most important social environment, the family.

It is the job of families to provide the environment in which their children and loved ones can be their healthiest and it is the job of government to support those efforts. There's a continuum of family concerns which need governmental support: family planning; early childhood education; parenting education; male mentoring; college education; in-home and community based systems of care for persons with long term health needs and disabilities; and hospice care. These concerns must be adequately addressed for our children to be able to grow up healthy, motivated, and hopeful.

PRESCRIPTION #6: Continued support for the Public Commissioned Corps

The Surgeon General is responsible for the administration and management of the Commissioned Corps, a uniformed service of the Public Health Service, consisting of health professionals in 11 different categories. The largest contingent, approximately 40 percent of the 6,500 officers, are assigned to the Indian Health Service where they provide health care to native Alaskans and Americans, often in very remote and isolated areas of the country. In addition, approximately 1,000 officers are detailed to other Agencies such as the United States Coast Guard, Bureau of Prisons, Environmental Protection Agency, Health Care Financing Administration, and the District of Columbia Mental Health Commission to provide health expertise.

All the officers play a critical role in protecting and improving the public's health. As a nation providing world leadership in the area of public health it is important to have a unique, respected corps of health professionals who have the credentials which make them effective in relationships with the public, other governmental agencies and representatives of foreign nations. Continued support for the Commissioned Corps is vital to the Federal government's ability to respond to present and emerging public health needs.

CONCLUSION

To protect and improve the health of every American, we must learn about the conditions affecting our health status, educate ourselves to the opportunities for improving our health, and find the political will to obtain the resources and implement the strategies that will make a difference in all of our lives.

REFERENCES

1. United States Preventive Services Task Force. Guide to Clinical Preventive Services: An Assessment of the Effectiveness of 169 Interventions. Report of the U.S. Preventive Services Task Force. Williams & Wilkins. 1989.
2. United States Department of Health and Human Services. Public Health Service. Healthy People 2000: National Health Promotion and Disease Prevention Objectives. 1990.
3. Institute of Medicine Committee for the Study of the Future of Public Health. The Future of Public Health. National Academy of Sciences Publication IOM: 88-02. 1988.
4. Partnership for Prevention. Today's Solution for Tomorrow's Health. 426 C Street, N.E., Washington, D.C. 20002.
5. Waszak, C. and Meidell, S. School-Based and School-Linked Clinics: Update 1991. Center for Population Operation. Washington, D.C.. 1991.

ATTACHMENT B
RENTAL PROPERTY

HELD BY

M. JOYCELYN ELDERS, M.D.

as of 7/21/93

Property Location	Date of Purchase	Current Mortgage Company
405 S. Pine, Little Rock, AR	07/01/74	Ms. E.N. Shivers, El Dorado
Rt. 4, Box 365G Elders Ct., Little Rock ("Rt. 4, House A" on Schedule A)	07/01/74	none
5417 Elders Ct., Little Rock, AR ("Rt. 4, House B" on Schedule A)	07/01/74	none
3717 W. Capital, Little Rock, AR	12/01/74	none
301 S. Oak, Little Rock, AR	01/01/76	1st Commercial Bank, L.R.
309 S. Oak, Little Rock, AR	10/01/77	1st Commercial Bank, L.R.
5424 Elders Ct., Little Rock, AR ("Rt. 4, Trailer E" on Schedule A)	10/01/77	none
9325 Roundtop Dr., Little Rock, AR ("Rt. 4, Trailer A" on Schedule A)	07/01/74	none
5407 Elders Ct., Little Rock, AR ("Rt. 4, Trailer B" on Schedule A)	04/01/75	none
5412 Elders Ct., Little Rock, AR ("Rt. 4, Trailer C" on Schedule A)	04/01/76	none
5420 Elders Ct., Little Rock, AR ("Rt. 4, Trailer F" on Schedule A)	01/01/74	none
4308 W. 11th, Little Rock, AR	05/01/82	none
4321 W. 11th, Little Rock, AR	08/01/82	none
4323 W. 11th, Little Rock, AR	03/01/91	none
2621 Abigail, Little Rock, AR	07/01/82	none
2301 Cumberland, Little Rock, AR	06/01/82	none
3405 Lamar, Little Rock, AR	03/16/84	1st Commercial Bank, L.R.
3417 Lamar, Little Rock, AR	03/16/84	Charter Mortgage, N.L.R.
3806 W. Capital, Little Rock, AR	03/16/84	Charter Mortgage, N.L.R.
306 S. Schiller, Little Rock, AR	03/01/84	none
8906 & 8920 Morris Manor, Little Rock	03/01/86	1st Commercial Bank, L.R. Ms. Kathryn North, Havana
315 S. Maple, Little Rock, AR	07/01/79	none
516 - 518 S. Pine, Little Rock, AR	07/01/75	Superior Federal Savings, L.R.

The CHAIRMAN. The committee stands in recess.
[Whereupon, at 4:54 p.m., the committee was adjourned.]