THIS PACKET WAS PUT INTO BINDERS & GIVEN TO COMMITTEE DEMS THE WEEK BEFORE THE HEARING

Henry W. Foster, Jr.

Nomination Hearing for Surgeon General
May 2, 1995

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A LIFE-LONG RECORD OF SERVICE:
The Accomplishments Of Dr. Henry Foster

HIGHLY TRAINED PHYSICIAN – *DELIVERED THOUSANDS OF BABIES:*

Dr. Foster is a highly trained obstetrician/gynecologist, who has delivered thousands of babies in his 38 years of medical practice.

- After receiving an undergraduate degree from Morehouse College in Georgia, he was accepted to medical school at age 20. He was the only African American in his medical school class at the University of Arkansas.
- After earning his Medical Degree in 1958, Dr. Foster did his internship at Detroit Receiving Hospital in Michigan and conducted residency training in Massachusetts and Tennessee.
- Dr. Foster served the United States as a Captain in the U.S. Air Force, stationed as a Medical Officer in Washington state from 1959 to 1961. He then served in the active Air Force Reserves in Boston, Massachusetts from 1961 to 1962.

RESPECTED EDUCATOR – *TAUGHT HUNDREDS OF MEDICAL STUDENTS:*

In 1973, Dr. Foster was asked to chair the Department of Ob/Gyn at Meharry Medical College in Nashville, Tennessee -- in large part because of his proven record in encouraging the doctors he trained to work hand-in-hand with the communities they served. For the past 21 years, Dr. Foster has helped train hundreds of America's finest medical practitioners at Meharry, which produces many of the nation's black doctors and dentists.

- Acting President of Meharry Medical College -- from October 1993 until left for sabbatical in June 1994.
- Dean of School of Medicine and Vice President for Health Services, Meharry Medical College, 1990-1993
- Professor and Chairman, Department of Obstetrics and Gynecology, Meharry Medical College, 1973-1990

MATERNAL AND INFANT CARE PROGRAM [Tuskegee, Alabama] --
NEW IDEAS TO FIGHT INFANT MORTALITY IN THE RURAL SOUTH

- Dr. Foster is one of the nation's leading experts on, and advocates for, maternal and child health. Immediately after completing his medical training, Dr. Foster returned to the rural south and began his lifelong crusade against infant mortality. At that time, rural areas suffered from a shortage of doctors; many poor women had no access to health care until it was time to deliver their babies with lay midwives at home. To address Alabama's high level of infant mortality, Dr. Foster applied for a grant from the Department of Health to expand the *Maternity and Infant Care Program* at Tuskegee Institute, and directed the development of this program from 1970 - 1973.
- Dr. Foster developed a comprehensive approach to maternal and child health -- involving teams of doctors, nurses, social workers and nutritionists -- with the ambitious goal of preventing health problems in mothers and newborn children. The teams worked in the rural communities to reach women early in their pregnancies, identify those women with a high potential for complication, and ensure they received specialized attention throughout their pregnancy and following the birth. *[continued]*

- Dr. Foster's approach was well ahead of its time, becoming a national model for "regionalized perinatal care" -- a program involving extensive community outreach, specialized services for high risk women, and comprehensive care of mothers and infants both before and following birth. Primarily because of this pathbreaking work, Dr. Foster was elected to the prestigious Institute of Medicine.

"HIGH RISK" YOUNG PEOPLE'S PROGRAM [Robert Wood Johnson Grant]--
IMPROVING THE HEALTH OF TEENAGERS THROUGHOUT THE U.S.

- After working with the Robert Wood Johnson Foundation to replicate his perinatal model, Dr. Foster was chosen by the Foundation to direct a multi-million dollar grant initiative to increase health care services for teenagers throughout the United States.
- This initiative targeted young people, aged 15 to 24, who lived in areas characterized by high rates of teen pregnancy, violence, drug and alcohol abuse, and mental illness. Under Dr. Foster's guidance, 20 teaching hospitals developed comprehensive health programs to expand services for young people in their own communities, improve their health, and train doctors and nurses in the specialized care of high risk youth.
- Between 1982 and 1986, these programs provided health services to approximately 306,000 young people. In addition, formal training in adolescent care was given to 115 adolescent medicine fellows, 974 medical residents, and 753 graduate trainees in nursing, medicine, psychology, and social work.

"I HAVE A FUTURE" [Nashville, Tennessee] --
CURBING TEEN PREGNANCY THROUGH ABSTINENCE AND HOPE:

- In February 1987, Dr. Foster began a pioneering effort to reduce the number of teen pregnancies by stressing abstinence and improving self-esteem. Dr. Foster established *"I Have A Future"* because he found that most teen pregnancy programs were limited to advocating contraception, rather than empowering teenagers to take charge of their lives and consciously make other choices. "I Have A Future" stresses job skills, education, and personal responsibility. Based in the housing developments it serves, the program involves parents and communities in advocating a strong anti-drug message, and teaching alternatives to violence and early sexual activity.
- The results speak for themselves. In 1994, twenty-four participants graduated from high school and sixteen -- including eight African American males -- went on to college. Four other participants entered the armed forces.
- And based on internal evaluations, preliminary results show significant differences -- in self-esteem, sense of responsibility, life options, number of pregnancies -- between teens in IHAF and those who did not participate. One 30-month interim review reported only one known pregnancy among active participants in the two IHAF sites.
- This nationally recognized program has received numerous awards -- from groups such as the American Medical Association and the State of Tennessee House of Representatives. *"I Have A Future's"* approach to preventing teen pregnancy was recognized by President Bush in 1991 when he chose the program to be one of America's "Thousand Points of Light."

MEHARRY HOSPITAL MERGER WITH METROPOLITAN GENERAL:
A STUDY IN MANAGEMENT SKILLS, LEADERSHIP, AND VISION:

- In 1992, Dr. Foster directed a process that helped save one of the nation's foremost black hospitals and medical training programs. Like many historically black hospitals, Meharry's Hubbard Hospital had been denied adequate public funding, which led it to lose patients. This threatened the viability of some of its residency training programs -- which play a vital role in attracting minorities to medicine and providing doctors to rural and inner-city communities.
- In 1992, Dr. Foster played a key role in the merger of Meharry with Metropolitan General Hospital, an overcrowded city hospital which was looking for additional space and a newer facility. The merger was conditional upon the recruitment of a top-flight medical faculty, a successful process led by Dr. Foster. Through an extensive notification and screening process, Dr. Foster recruited 74 full-time physicians six weeks ahead of the deadline -- in the face of skepticism by the political and medical communities that Meharry could achieve that goal.
- *"Dr. Foster led that recruitment and brought some outstanding physicians from around this country who were dedicated to the mission of Meharry to serve the underserved. . . Many people didn't believe we would be able to recruit people like that."* Dr. John Maupin, President of Meharry [NPR, *"All Things Considered,"* 2/17/95]

AWARDS: ***A LIFETIME OF ACHIEVEMENT:***

- Elected to Institute of Medicine, 1972 [then one of youngest people ever elected]
- *Man Of The Year*, March of Dimes Birth Defects Foundation, Nashville Chapter, 1982
- *Faculty Award for Excellence in Science and Technology*, first White House Initiative on Historically Black Colleges and Universities, 9/25/88
- *Meritorious Service Award*, Mayor's Office of Drug Policy, 3/14/93
- *Honorary Degree*, Doctor of Science, University of Arkansas, 5/15/93
- *"Physician, Teacher and Scholar Award"*, National Medical Association, 8/10/93

THE TUSKEGEE SYPHILIS STUDY

April 25, 1995

In 1932, the Public Health Service (PHS) began a study of over 600 black men in Macon County, Alabama, including over 400 with latent syphilis. PHS followed the men over a period of 40 years, but never provided treatment; nor did they ever inform them that they were not being treated. The men, poor and ill-educated, trusted the study leaders as medical men and government officials. Their life expectancy was reduced by 17 percent.

The study became public in July 1972, with a New York Times story by Jean Heller. A firestorm of criticism erupted at the spectacle of a government health agency deceiving poor, ill-educated men into thinking that their government was providing them with medical treatment, when in fact it was watching with clinical dispassion as they died. The fact that all of the men were black prompted charges of racism in the medical establishment. The study became the subject of hearings chaired by Sen. Kennedy, and helped prompt a national reassessment of the use of human subjects in medical experimentation.

Among those expressing shock in 1972 was the president of the local medical society, Dr. Henry W. Foster. Critics have charged that the expression of shock was a sham: that Dr. Foster knew of the study well before 1972 and did nothing to stop it.

The argument that Dr. Foster knew of the Tuskegee Study depends upon three premises:

1. The study regularly was reported in medical journals which Dr. Foster likely read or should have read;
2. The study was well known locally, and local doctors were told not to treat the men in the study; and
3. Dr. Foster had learned of the study three years earlier when he attended a May 19, 1969 briefing on the study, and even if he did not attend, he would have known the subject of the meeting as vice-president of the local medical society;

Each of these premises is false. The medical articles on the study appeared primarily in specialty journals unlikely to be read by Dr. Foster, and in any event were written well before his time. They are arid and at times misleading, and in themselves did not spark the interest of anyone, including national newspapers provided with copies. To condemn Dr. Foster on the strength of these articles is to condemn literally every member of the medical profession who practiced prior to 1972.

Official state medical records provide strong evidence that Dr. Foster did not attend the May 19, 1969 meeting. State medical records show that he was delivering a baby at the time.

These records are far more reliable than the memory of the lone individual who places Dr. Foster at the meeting, Dr. Luther McRae; indeed, there are reasons to question the reliability of Dr. McRae. Nor is there any evidence at all that any local participant at the meeting ever discussed it afterwards with Dr. Foster or any other person.

The second premise treats the Tuskegee Study as a uniform project throughout its 40 year life. It was not. By the time Dr. Foster came to Tuskegee in 1965, the study was far different than at its inception or during its heyday, a period of roughly 10 years from 1935 to 1945 when PHS actively interfered with treatment of the men. By 1965, the barriers to treatment had crumbled from disuse; indeed, almost all of the men by then had received treatment from some source outside the study. The study was not widely known in Tuskegee, and existed only vestigially. When PHS finally met with the local doctors in 1969, they did not tell the black physicians that they were withholding treatment from black men without the mens' knowledge or consent. Indeed, as noted below, PHS appears to have reported that all of the men had received effective treatment, and to have given a report of procedures for their "continued" care.

I. MEDICAL JOURNALS

Most articles on the Tuskegee Study appeared in specialized journals not normally read by obstetrician-gynecologists. The study involved only men, none of whom ever would have been an OB/GYN patient. By Dr. Foster's graduation from medical school in 1958, moreover, penicillin largely had rendered the question of the long term effects of non-treatment moot, or of historical interest. Only one article, a 1964 article in the Archives of Internal Medicine, was published between Dr. Foster's 1958 graduation and 1973. There is no indication that he would or should have read any of the articles.

Indeed, the articles tended to obscure the factors that made the study shocking when disclosed in 1972. The 1964 article reported that 96 percent of the men actually had received treatment by that time. The issue of the men's consent often was overlooked or misrepresented. A 1955 article states that the study began with "a group of Negro men over 25 years of age who **volunteered** for the examination." Schuman et al., "Untreated Syphilis in the Negro: Background and current status of Patients in the Tuskegee Study," Journal of Chronic Diseases 2 (1955) 544 (emphasis added). The same article also confused the issue of treatment. Although minimal scientific control standards would appear to require that the men in the untreated study group not be treated, the article indicates that they were.

> It was expected that medical histories of the men in the study would reveal that they had received large amounts of antibiotic therapy for nonsyphlitic as well as syphilitic

> conditions. ...27.5 percent of the syphilitic patients examined in 1952 had received penicillin in varying amounts as compared with 32.6 percent of the nonsyphlitic patients examined. ... It is the practice of the Public Health Service officers to refer men who develop syphilitic or nonsyphlitic conditions requiring therapy to the proper sources of treatment.

The reader would assume that the study involved informed volunteers and that appropriate treatment was being provided.

In 1969, Dr. William Jenkins, an epidemiologist at PHS, attempted to expose the study, but he was inspired not by the articles but by a colleague at PHS who had survived a Nazi concentration camp. Dr. Jenkins himself did not understand the import of the study until it was explained to him from the survivor's special perspective. Dr. Jenkins sent copies of each published article on the study along with a cover note to 20 or more newspapers, including the Washington Post and New York Times. None of the newspapers printed a story on the study.

II. GENERAL KNOWLEDGE OF THE STUDY

The Tuskegee Study began in 1933 as a temporary expedient when funds for treatment of the men were not available, possibly with the expectation that treatment would be given when funding was found. When treatment became available in 1935, however, PHS withheld it and, through the end of World War II, actively prevented the men from receiving treatment. After the war the barriers to treatment relaxed, and by Dr. Foster's arrival in Tuskegee had disappeared. All but one of the men received penicillin. By the May 19, 1969 meeting, PHS was sensitive to the issues which it had so callously overlooked a generation earlier, and was trying to extricate itself from the problem it had created.

Background

As described in Bad Blood by James Jones, the Tuskegee Study grew out of a project to treat syphilis among rural blacks following the 1926 cut-off of federal funding for venereal disease treatment. In 1929 the Rosenwald Foundation set up a $50,000 demonstration project to treat syphilis in Macon County and five other southern counties. The Foundation could not maintain such a funding level, and when Congress denied funding for continuing treatment in 1932, PHS determined to study the untreated men for six months. This temporary expedient lasted for 40 years.

The study evolved in a haphazard manner with no written protocol. The 1972 post-disclosure HEW advisory panel identified six different rationales for the study at various times. Men were shifted between the syphilitic and control groups, and the study focus shifted from one field to another with little

scientific, let alone moral integrity. Indeed, the most recent medical commentator writes that its purpose was not to study the men at all, but merely to obtain syphilis-positive blood samples for serological studies. Roy, "The Tuskegee Syphilis Experiment: Biotechnology and the Administrative State," Journal of the National Medical Association, Vol. 87, No. 1. (January 1995).

Local Involvement

The local medical community never was accurately informed of the study. When the study began as a six-month effort in 1933, the State of Alabama gave its blessing on the condition that "[e]veryone examined and found to be syphilitic would have to be treated." (Jones at 98-99). Jones notes a PHS "desire to conceal the true purpose of the study." (Jones at 99-100). State law mandated treatment of syphilitics (but provided no funds for such treatment at the time). It may well be that all parties initially hoped and expected that funds would become available as prosperity, then "just around the corner," returned.

PHS also met with the Macon County Medical Society in 1933. "Treatment was not discussed." In 1933, PHS "did not intend that anyone be denied treatment on a long-term basis; the experiment was supposed to last only six months to a year," (Jones at 95) or until the lack of funding for treatment was resolved. As Jones notes, "there was no reason to ask these physicians to withhold treatment; there was no real danger they would provide it. The subjects were medically indigent. They had not received medical care in the past and there was no reason to think they would in the future." (Jones 144-145) The local doctors were not given any reason to believe that treatment would be withheld when it became available and efficacious. The lack of treatment at this point was a "natural" product of the limited access to health care. The men, like other poor blacks, were neglected by the medical community.

They also were deceived. The men were not told of the nature of their disease or the study in which they were to be participants. While there was mention of "bad blood," a lay catch-all for everything from syphilis to anemia, the men were never told of the dangers of their disease. Indeed, they were told that they were being treated, and given aspirin and "spring tonic." PHS also arranged for their burial.

The Tuskegee Study continued beyond six months with little apparent explanation to anyone in Macon County beyond a handful of persons -- Nurse Rivers, local medical board physician Dr. Murray Smith, and a few others. In 1935-1936, the study underwent a change from neglect to active prevention of available treatment. The men were kept out of the regular VD treatment program initiated under the New Deal in 1935, and Dr. Smith arranged with the local draft board during World War II to exempt the men from military service, and thus from the physical

examinations which would have led them into the nation's VD treatment program. These steps were taken even though the early results of the study clearly showed the deadly results of untreated syphilis. From roughly 1935 to 1945 the Tuskegee Study was thus transformed from a study of the effects of the inadequate delivery of health care in the rural deep South into an exercise in watching black men die.

As the study took on this sinister character, local knowledge narrowed to a small circle. With no treatment, there was little local activity. "By the 1938 checkup inertia was working to keep the experiment stable. The tasks were so well delineated that they could be carried on by new personnel with or without full knowledge of the ramifications of the study." In 1941, Jones quotes Dr. Smith: "The officials at Tuskegee Institute ... know nothing about the study." Jones at 176-77). In 1946, as penicillin was becoming widely available, the study disappeared from the annual reports of the Surgeon General.

The circle was kept small by PHS as a matter of policy. When Dr. John Kenney returned as Medical Director of Tuskegee, The PHS moved its autopsies from Tuskegee to funeral homes, and curtailed burial payments directly to Tuskegee to escape detection by Kenney. These extraordinary maneuvers must have been political subterfuge to keep the study covert. This suggests fear that Kenney (who was at odds with the American Medical Association by his espousal of national health care and criticism of its exclusion of blacks) would oppose the Tuskegee Syphilis experiment.
Roy, pp. 59-60. The move to funeral homes was at considerable sacrifice. A 1955 article in the Journal of Chronic Diseases noted that "none of the undertaking establishments has refrigeration, and the postmortem examinations often are made under inconceivably adverse conditions."

Treatment

Following the war, however, the barriers to treatment relaxed just as penicillin was becoming widely available. By 1955 the rate of antibiotic treatment of the study members was substantial, and rate for the syphilitic men (27.5%) in the study differed far less from that of the control group (32.6%) than would be expected if the local physicians had known of and participated in the study. After the final, 1970 survey of the men, "only one of the Tuskegee syphilitics has apparently received no treatment." Caldwell, et al., "Aortic Regurgitation in the Tuskegee Study of Untreated Syphilis," Journal of Chronic Diseases 26 (1973). Such treatment was as haphazard as the study itself, however, and the policy of PHS had returned to one of neglect. PHS never provided or encouraged treatment nor did they inform the men of their condition.

By the 1960s there is very little evidence that local

doctors ever brushed against the study. Peter Buxton, a former PHS worker who was instrumental in breaking the story in 1972, became interested in 1966 when he heard from a co-worker that a Macon County doctor was "sanctioned" by the local medical board and perhaps the local medical society for treating a study subject in 1965. The specific story appears unreliable both from the lack of direct or circumstantial corroboration and specific inaccuracies (there was no local medical society in 1965). One incident that did occur shows the vestigial nature of the study. Dr. Robert Story was urged by a nurse not to give a patient penicillin because he was "one of Nurse Rivers' patients." Dr. Story could extract no further details from the nurse, and was unable to reach Nurse Rivers. After satisfying himself that there was no medical reason to withhold penicillin, Dr. Story administered the medicine and moved on to his next patient. He was never contacted by Nurse Rivers or any other person about the treatment and never pursued the issue himself. Dr. Story remained unaware of the study until it became public in 1972.

Such lack of awareness was the rule. Dr. David Sencer, later Assistant Surgeon General, was completely unaware of the study even while working for PHS in an adjacent county for five years in the late 1950s. Jones notes that "[f]ollowing the retirement of Dr. Dibble, none of the staff [at Tuskegee-John Andrew] had been involved directly with the study." Dr. Dibble retired in 1964, as did Dr. Murray Smith and Nurse Rivers. By 1965, when Dr. Foster came to Tuskegee, the men in the study were elderly. They would, as men, have no direct contact with OB/GYN or Dr. Foster, and indirect contact as parents or partners was unlikely because the men's syphilis was latent rather than infectious. It could not be transmitted to women, and the now elderly men were unlikely to father new children.

PHS Reassessment in 1969

At PHS, the study was coming under increasing scrutiny. Peter Buxton had written a series of letters to the PHS leadership and an internal group of black employees had raised the issue. Dr. Jenkins had confronted Dr. Sencer at an EEO retreat. PHS called an ad hoc committee to reassess the study.

The group met on February 6, 1969, and realized immediately that it faced a sensitive situation. The members saw "that a Study of this type would never be repeated. Public conscience would not condone carrying a group of people through lifetime with untreated syphilis." (Kiser memorandum.) The notes of the meeting are spotty and confused, but it appears that the committee opposed automatic treatment of all members of the group, with Dr. Eugene Stollerman dissenting, because of potentially "catastrophic" reactions. They were willing, however, to provide treatment where appropriate. Dr. Stollerman pressed for criteria for determining whether to treat, and the discussion shifted to local involvement and the local medical

society. It was suggested that the men themselves be informed of the study. They were not.

Arrangements to meet with the Macon County Medical Society were made with its president, Dr. Luther McRae. McRae received a call from Alabama State Health Officer Dr. Ira Myers, and a letter from assistant Surgeon General David Sencer, and the meeting was set for May 19, 1969. As they set up the meeting, the PHS officials were especially sensitive to the racial aspect of the Study. They faced not the all-white medical society of 1933, but a predominantly black group. The ad hoc group anxiously consulted with Dr. Myers on the attitude of the black physicians, and approached them one step at a time, beginning with Dr. McRae. Dr. Brown noted "white" next to McRae's name in the margin of a letter on the meeting with the Medical Society.

Their concerns were not idle. Macon County at that time was a hotbed of civil rights activity. There was contest for Mayor of Tuskegee between black and white candidates in 1968, and the county was achieving a number of electoral "firsts": the state's first black sheriff in 1966, and the first black state legislators in 1970. The movement even swept up the men in the study. One, Charlie Pollard, was a precinct captain for the black voters league.

The May 19, 1969 Meeting

Into this atmosphere PHS sent Dr. William Brown, Chief of the VD branch of PHS, Dr. Leslie Norins, and Dr. Alfonso Holguin. Based on extensive interviews, it appears that the meeting was held at 7:00 p.m. at a restaurant four miles outside of Tuskegee. The entire group of perhaps 10 persons sat at a single table. There was no formal presentation, no one rose to speak, and there was no prepared text. The dinner lasted one to 1 1/2 hours, with estimates of the time for any presentation and discussion ranging from five to 45 minutes. There is no known record of the meeting, and Dr. Settler, then Society secretary, states that it is unlikely that he took any notes. Those who were present remember little. Dr. Norins remembers it as a purely social affair, with no substantive presentation at all. Dr. Settler does remember being told that the subjects already had received broad-spectrum antibiotics by local physicians for treatment of other ailments.

The most detailed substantive recollection is that of Dr. Holguin, whose responsibilities at PHS only recently had been expanded to include the VD branch. Dr. Holguin states that he had been told in an initial briefing that PHS had decided to continue the study primarily because by then any harm to the men already had been done, and they now received significant benefits in terms of medical care (medical visits and treatment normally not open to the rural black poor), and without the study, PHS had no authority to provide such care. Dr. Holguin understood that

PHS had established a relationship of sorts with the men and did not see how to terminate it.

According to Dr. Holguin, he was told (as was the Medical Society) that PHS also wished to avoid duplicative and thus potentially lethal treatment of the men. They were told specifically that all of the men had received penicillin adequate for the treatment of late latent syphilis. Holguin agrees that additional doses of penicillin might, without adequate precautions, have resulted in fatal reactions in the elderly men, and that for the at-risk men, further penicillin should be given only by those with special training, i.e., doctors in the local VD clinics. In the case of such high-risk patients (those with heart problems) doctors would make such referrals regardless of any study, and that in any comparable area of black, low-income rural population, there would be numbers of men whose syphilis had not been treated promptly or intentionally: there was nothing unusual in their advice to the Society.

Dr. McRae states categorically that there was no statement that any of the men had been denied treatment, and no instruction not to treat the men or to direct them to PHS for treatment. There was no mention of informed consent, which Dr. McRae assumed had been obtained. Dr. McRae remembers receiving a list of 25 participants in the study (of whom he personally had treated several); however, PHS knew of at least 86 surviving men at the time. By all accounts, the presentation was sufficiently unremarkable that none of the doctors present thought it merited comment. The doctors agree that it was never discussed at any subsequent Society meeting. Indeed, none ever mentioned it to another person afterwards. As Dr. Sencer later testified, Brown and Holguin reported back a "total lack of interest." Such a total lack of interest is a compelling indication that the study was not presented in the full detail that made it so shocking in 1972.

Post-Meeting Actions

The records following the meeting are consistent with the Holguin version of the meeting. PHS records contain, for the first time, letters to the mens' doctors alerting them to conditions found in the PHS examinations. The conditions include syphilis indicators, but there are no instruction not to treat the conditions. A letter to Dr. H. S. Blanton (actually Banton) of neighboring Union Springs, Alabama, includes a diagnosis of paresis. The letter includes no caution against treatment and Dr. Banton states that he never received any. (Banton, too, had never heard of the study although he had practiced general medicine in the neighboring county since 1948.) When Nurse Kennebrew was hired to replace Nurse Rivers, her job briefings did not involve any mention of consent or treatment. She was not told that the men should not be given penicillin.

The record also shows a pattern of suppression of information by PHS. Dr. Brown embargoed publication of the results of the study, noting that publication should await "a more favorable national climate." (Brown to Robertson, 11-16-69). A 1971 paper based on study data omitted any mention of the study (and recommended treatment of the subjects.) Dr. Brown wrote to an associate dean of the University of Michigan School of Public Health who had inquired about the results of the study, "The climate in recent years -- disfavor of research involving human volunteers as well as racial tension -- has not been conducive to wide publicity of the Tuskegee findings." (Brown to Magnuson, 2-16-70).[1]

Disclosure of the Study

Depite Dr. Brown's efforts, the study was exposed in 1972. Dr. Foster publicly expressed his shock and expectation that the study would be discontinued. Dr. Foster called a meeting of the Macon County Medical Society, which voted to try to find as many of the participants as possible and give them treatment if it was needed. Dr. Settler expressed concern that because of the stigma associated with syphilis, some men may have withheld information of the disease in giving their medical histories to him and others. The advisory panel established by HEW to assess treatment options which hurried to Tuskegee in the wake of disclosure found the Society and John Andrew Hospital eager to cooperate with HEW treatment efforts.

The initial reaction of PHS was to deny the charges. Their July 27, 1972, post-disclosure "Administrative Details Concerning Tuskegee Study" states:

> Participation in the study by both syphilitic and non-syphilitic persons was voluntary. The syphilitic group was informed that they had syphilis, and informed that they would be treated for the disease if they so requested.

The same document claims that the Macon County Medical Society was "fully informed of the study," but this clearly was no more true than the other claims.

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[1] Jones suggests (at 200) that a "revitalized relationship" arose between the study and the Tuskegee Institute, based on an April 1970 PHS contract through hospital administrator Luis Rabb for PHS to have the men's X-rays done at John Andrew Hospital. Mr. Rabb, however, states that he was told nothing of the nature of the study. He received an offer from PHS to pay for X-ray support and he was happy to obtain the revenue. Mr. Rabb says that he had no reason to question officials from the nation's leading health organization as to their motives.

III. DR. FOSTER AND THE MAY 19, 1969 MEETING

State medical records give strong evidence that Dr. Foster was not at the May 19, 1969 meeting of PHS officials and the Macon County Medical Society. While he was Vice-President of the Society, Dr. Foster's schedule did not permit his attendance at all meetings, and he did not attend this one. Indeed, among all of those present, the only person who places him at the meeting is Dr. Luther McRae.

Dr. McRae's memory of the meeting is highly precise as to small details (the seating arrangements, the color of a shirt), but not entirely consistent or as detailed as to the substance of the meeting. (He does not recall the telephone call or calls from state and national medical leaders to set up the meeting and preliminarily explain the study to him.) While Dr. McRae places Dr. Foster at the entire meeting (sitting precisely two seats to his left, leaning back with a troubled look on his face), State of Alabama birth records place him at John Andrew Hospital in Tuskegee, delivering the baby of Ms. Minnie Jamison.

The delivery was far from routine. It involved a Caesarean section after a long and high-risk pregnancy. Ms. Jamison had suffered two miscarriages, and problems developed early on. Ms. Jamison was bedridden for seven of the nine months prior to delivery, and it was necessary to perform a surgical procedure in the fourth month to prevent a spontaneous abortion. Ms. Jamison went into labor and was hospitalized on the evening of May 18, and, after being given medicine to slow labor, stayed there through her delivery and recuperation.

The birth certificate shows that the delivery occurred at 9:17 p.m. Ms. Jamison and her husband recall the delivery occurring at 7:00 p.m., and that it was nighttime. (The sun sets at 7:43 p.m. CDT on May 19.) She recalls that the surgery took approximately two hours, and does not contest the medical record of a 9:17 p.m. birth. At any event, the complex delivery of a high risk pregnancy occupied Dr. Foster at the very minimum for the great bulk of the period of the meeting with PHS. Dr. Foster had another delivery later that evening, at 1:32 a.m., and the mother likely was at or on the way to the hospital.

There are additional reasons for concern as to Dr. McRae's recollections. Dr. McRae was the chief of staff at Macon County Hospital, where black doctors were not allowed to practice. (Black physicians ultimately were given staff privileges at the hospital during McRae's tenure but only under the pressure of federal law and under intense economic pressure: the white population of the county was declining, and the absence of black staff effectively shut the hospital off from the large pool of well-insured black Veterans Administration employees.) Dr. McRae's hospital finally closed, the last straw being a lawsuit

(filed after McRae's departure) blocking federal funds for upgrading-expansion of the white facility on grounds that the plans, drafted during McRae's tenure, would perpetuate racially segregated medical care in the community.

Dr. McRae left Tuskegee suddenly in 1970, according to other doctors, closely followed by reports of substantial unpaid debts, including an airplane which was repossessed. Later, in 1985, Dr. McRae's license was suspended for illegal prescription of schedule II controlled substances. The suspension in Georgia, where Dr. McRae had moved, was for 30 days, with a one year ban on prescribing or possessing controlled substances, and a requirement for 50 hours of education. Dr. McRae's license was revoked entirely in Alabama after he failed to attend a scheduled hearing and failed to present exculpatory evidence. He applied for reinstatement in 1990, but again failed to attend the evidentiary hearing, and the revocation continues.

The facts give no assurance that Dr. McRae's reports of the meeting, initially broadcast through extreme anti-abortion groups rather than mainstream media, are entirely disinterested or at all reliable. They clearly are less reliable than state medical records, which place Dr. Foster at John Andrew Hospital successfully performing a high-risk birth.

No other doctor places Dr. Foster at the meeting, nor is there any evidence that any participant spoke to him of the meeting afterwards. Even Dr. McRae raises no such claim; indeed, whatever was presented at the meeting (which certainly omitted the issues of consent and treatment) was sufficiently unremarkable that not one of the doctors mentioned it to a single living soul afterwards, or connected Dr. Foster with the meeting until his nomination to be Surgeon General.

CONCLUSION

The facts show the complete absence of any connection between Dr. Foster and the Tuskegee Study. The evidence indicates strongly that study was not a matter of public knowledge in Tuskegee by the time Dr. Foster arrived, that he did not attend the May 19, 1969 meeting, and that no report was given to him afterwards. Given the heightened racial and political sensitivities in Tuskegee at the time, it is inconceivable that the PHS officials who were directly misleading about the study afterwards told the full story of the study to a group of black physicians, or that if they had, that no one would have batted an eyelash.

That the study was discussed in medical journals raises different questions. There is no indication that Dr. Foster ever would have or should have read any of the articles. To indict Dr. Foster on the strength of these articles is to indict the

entire medical profession.

The more troubling question lies outside the issue of Dr. Foster's knowledge. Many people did read the articles, but no one seems to have noticed the moral issues. The articles themselves seem never to have shocked anyone, not even the New York Times or Washington Post. Only when the study was put into context -- the report to Buxton of a doctor sanctioned for treating a patient, or the concentration camp survivor's explanation to Jenkins -- did anyone see through the murk of clinical language to the larger social and moral context. The key is the sad fact that our medical system did not assume or assure that all sickness would be treated. Not only these 400 men, but thousands of other Americans went untreated for a host of afflictions during the course of the study.

Far from ignoring the untreated, Dr. Foster has spent his career bringing treatment to them. One bright spot appears in the Tuskegee Study documents. When the HEW advisory panel came to Tuskegee in the wake of disclosure, panel member Dr. Vernal Cave pointed, amid the evidence of inadequate services and facilities, one "delightful experience," a presentation on, the Maternal and Infant Care project at John Andrew,

> a comprehensive medical and health care program made possible by a five year grant ... with Tuskegee Institute providing matching funds. ... On the basis of the performance described, citing this one example, the John A. Andrew Memorial Hospital has an admirable record for the utilization of grant funds.

Dr. Foster directed the project. Dr. Foster, indeed, has spent his career delivering excellent health care to high-risk patients in underserved areas, and training other doctors for such service. Three out of four Meharry graduates have gone on to practice in underserved communities.

The Tuskegee Study recalls that even the Public Health Service has been a part of the culture of non-treatment. The confirmation of Dr. Foster would be a step away from the Tuskegee Study, and an affirmation of the national commitment to health care for all Americans.

MEHARRY MEDICAL COLLEGE-HUBBARD HOSPITAL

April 25, 1995

Meharry Medical College was founded in 1876, and moved to establish Hubbard Hospital in 1893 as its teaching hospital. From the beginning, the school and its hospital have faced a host of financial problems. Opponents of the nomination of Dr. Foster have asserted that these problems are Dr. Foster's fault. Their charges are specious, involving matters entirely outside Dr. Foster's control, and illustrates a lack of understanding of the special role which Meharry Medical College continues to play.

The charges involve an administrative/accounting dispute with HEW in 1979-1981 with which Dr. Foster had no involvement, a pair of highly unreliable surveys that ranked Meharry as the worst medical college in the nation, and long-standing financial problems of the college and the loss of accreditation of three programs at the medical school.

I. Financial Problems and Accreditation

It is beyond dispute that Meharry Medical College and Hubbard Hospital have suffered under severe financial pressures during Dr. Foster's tenure at the school, and that the OB/GYN residency program lost its accreditation in 1991 due to low patient volume, a year after he left its chair to become Dean. Two other specialties also lost accreditation in 1989 and 1991. An examination of the school's problems reveals clearly that they were not the fault of Dr. Foster but the result of structural problems over which he had no direct control. Rather than indicating any unfitness for the position of Surgeon General, Dr. Foster's role in addressing the difficult issues facing the school and hospital shows the vision and leadership which well qualifies him for the position of Surgeon General.

Background

The roots of the financial problems of Meharry lie in the past history of segregation. Hubbard Hospital was established shortly after Nashville had built a new city hospital ten minute's walk from the Meharry campus. City officials denied Meharry staff and teaching privileges at the new hospital in 1893, however, on account of their race. Meharry accordingly was forced to take on its own shoulders the expense of building and operating a hospital.

That burden included unreimbursed treatment of indigent black citizens. Many of the black poor from Nashville and surrounding areas turned to the hospital as their only source of medical care. They could not pay and the hospital could not,

consistent with its mission of service, turn them away. The burden became such that in 1948, Meharry announced that the hospital would be closed, and that teaching opportunities would be arranged with other hospitals.

The city responded with a promise to reimburse Hubbard for indigent care, and the hospital continued in operation. The city's payments never covered the full cost of treatment, however, and the school continued to sag under a burden of debt. By 1973, the city only certified for reimbursement 20 percent of those eligible, and one fourth of the entire hospital capacity was continuously occupied by indigent patients for whom the city provided no reimbursement. The deficit for indigent care alone was $2 million per year. Summerville, Educating Black Doctors, University, Alabama, 1983, p. 208. By contrast, the city assumed full responsibility for indigent care at Nashville General Hospital, the city-run facility used as the Vanderbilt teaching hospital. The city provided $15-20 million in subsidies to Nashville General. Nashville Banner, May 11, 1992.

Meharry-Hubbard thus faced a severe structural problem. The need to build and maintain a separate facility, and to provide care for indigent blacks without the city financial support provided to others is the principal source of Meharry-Hubbard's long-standing financial difficulties. Other more recent problems of national scope have further undermined its financial position. These include the general shift to outpatient care to save costs, and the movement of population and doctors to the suburbs:

> [P]hysicians follow their patients to the suburbs and establish ... offices. Once in the suburbs, physicians admit their patients to suburban hospitals. Fewer new physicians replace those lost physicians in the inner-city hospital have fewer admitting patients.

Rice, "Inner-City Hospital Closures/Relocations: Race, Income Status ad Legal Issues," Soc. Sci. Med. Vol 24, No. 11, p. 890. The loss of patients for inner city hospitals is accelerated by news of financial setbacks:

> The physicians on the staff move quickly to seek appointments at other hospitals and then to justify their membership on the staff, admit some patients to the new facility, thereby depriving the original hospital of patients. Whenever a newspaper reports on the financial difficulty of a hospital, this self-fulfilling prophecy occurs; it is often the final blow to the hospital's viability.

Id., citing Primrose, "Comments on Hospital Closings in New York, Health Serv. Res., 18, 576 (1983).

Historically black facilities such as Hubbard have had to face yet another burden: one-way integration.

> Integration is not a two way street. Blacks will go to white people for services, but white people in general will not go to black people for services. When the barrier [of] segregation fell, (that was) probably the most significant event leading to the problems of black hospitals.

Taravella, "Black Hospitals Struggle to Survive," Modern Healthcare, p. 21 (1990). The result of each of these factors has been to pull patients away from hospitals like Hubbard, and to leave them to serve a disproportionately indigent population with incomplete compensation.

Accreditation

The loss of patients also can lead to a loss of academic accreditation, and such was the case with Meharry for three programs in 1989 and 1991. It is clear from all accounts that the 1991 loss of accreditation in OB/GYN was a function of low patient volume. The Accreditation Council for Graduate Medical Education has established detailed requirements for achieving or maintaining accreditation, and numerous institutions fail to meet one or more of these standards each year. In 1991, a total of 86 programs lost their accreditation. One accreditation standard requires a minimum number of patient and procedures to ensure that the educational process is complete and well-rounded, including extensive work with patients. Meharry did not meet this standard because it lacked the necessary volume.

The low patient volume at Hubbard reflected a number of national trends as described above. These trends fell particularly heavily on Hubbard because of the extraordinarily high ratio of hospital beds to population in Nashville. The Nashville area has 4.7 hospital beds per 1,000 population, the fourth highest ratio among the 48 metropolitan areas with over 1 million people. (Memphis has a ratio of 5.0 per 1,000 and St. Louis and New Orleans 4.8 per 1,000.) Other cities face far less competition for patients: the ratios for other cities such as Indianapolis (4.2), Boston (3.9), Cincinnati (3.8), Columbus (3.3), Detroit (3.2), Washington (2.5) and Seattle (2.3) are significantly lower. The higher ratio in Nashville means empty beds for all hospitals, and particularly for an inner city hospital such as Hubbard.

The accreditation loss had nothing to do with the quality of teaching. David Denton of the Southern Regional Education Board, made clear, "People shouldn't confuse the residency problems with the quality of teaching at Meharry. It has been very successful in getting its graduates licensed." USA Today, June 26, 1991. The same article notes the strong results Meharry has produced: nearly 40 percent of the black doctors in the United States, and

four of ten black faculty members in the nation's medical schools.

Solution: Merger

The usual result of these national trends for hospitals in Hubbard's position has been closure. Dr. Vanessa Gamble has identified over 200 historically black hospitals dating to the 1800s. Today there are eight. Twenty-five closed between 1980 and 1988. As the 1980s drew to a close, Meharry was facing continuing financial reverses because of the financial drain from maintaining an inner city hospital in competition with a city-financed institution, Nashville General Hospital.

Meharry President David Satcher, now head of the Center for Disease Control, recognized that Meharry must face its structural problems with a structural solution, the merger of Hubbard and Nashville General. In light of his "sixteen years of outstanding service at this institution and the outstanding reputation you have developed in this community and throughout the country in academic medicine circles," in 1989 President Satcher named Dr. Foster to be Special Assistant for Merger Planning and Development. In 1990, Dr. Foster joined the school administration as Dean of the School of Medicine and Vice President for Health Services.

A plan was worked out under which the hospitals would merge. The city would lease the Hubbard facility as the merged physical plant for the municipal hospital and Meharry, rather than Vanderbilt, would staff the merged hospital. The merger allowed the city to avoid the costs of replacing Nashville General's inadequate physical plant, and addressed the structural problems of Meharry by reducing the total number of hospital beds, increasing Meharry's patient volume, and equalizing the financial burden of caring for indigent patients. The merger also squarely addressed the issue of "one-way integration" by the merger of the formerly white and black institutions under the aegis of Meharry.

Such a merger was not without opposition. Here, opposition focused on staffing. Traditionally the city had relied on Vanderbilt's School of Medicine for staff. Under the merger plan, Vanderbilt's role would recede and Meharry would become the principal staff provider for the merged hospital. With Vanderbilt's withdrawal, Meharry would have to recruit a large number of additional doctors, always a difficult task.

There was more to the concern, however. Vanderbilt would be replaced by an historically black institution, and many had reservations about the quality of care which Meharry could provide. The Nashville Academy of Medicine issued a paper opposing the merger on the grounds that the group lacked confidence that Meharry would be able to succeed at what it saw as a most difficult task: staffing the merged hospital. While the Academy had praise for the faculty of Meharry, "a well

qualified, extremely dedicated group of physicians," the group saw the difficulties of expanding that faculty as insurmountable in light of the usual problems in recruiting and the special problems for Meharry as a result of the loss of accreditation of certain programs. They also saw the provision for use of National Health Service Corps personnel as an interim measure unacceptable.

The proponents of merger responded by setting specific deadlines for the recruitment of 56 additional faculty in less than one year. Meharry was required to recruit one third of the total in less than two months, and to get commitments from two thirds of the necessary staff within seven months. If Meharry failed in recruiting, there would be no merger. Essentially the black institution asked for an opportunity to prove itself, to quiet the usually unstated concerns over quality by selecting a high-quality staff. The Academy again expressed its doubts, refusing approval until they could judge "the experience and expertise of the individual physicians who will be staffing the merged institution."

The task of recruitment fell to Dr. Foster. It was an unenviable assignment given the difficulty in locating and attracting specialists in a broad range of fields willing to uproot and move to a new city and a hospital facing an uncertain future. Meharry also was recruiting from a declining pool of teachers, as the number fo part-time medical professors had declined precipitously nationwide, with a nearly 20 percent drop from 1988 to 1989 alone. Nashville Business Journal, September 7, 1992. Dr. Foster succeeded.[1] He proved able to meet each interim deadline and to attract such leading physicians as Dr. Elwyn Grimes (OB/GYN), a nationally recognized expert in reproductive endocrinology; Dr. James Potts, Distinguished Professor and holder of the Harkness Chair of Cardiology established by the Centers for Excellence in Medicine; transplant surgeon Dr. Rodrick Stevenson, who performed a successful heart transplant for Gov. William Casey of Pennsylvania; and leading pediatrician Dr. Vernessa Wood. The group of physicians he attracted settled all doubts sufficiently that the vote of the medical board finally was unanimous.

The merger has not been a panacea. Nor does all of the credit by any means belong to Dr. Foster. He did, however, succeed at the linchpin task of recruitment under very difficult conditions, and was part of a successful effort to address a potentially divisive racial situation successfully, and in a measured and constructive way.

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[1] There were, of course, difficulties, especially in finding an orthopedist; and an ER recruit backed out at the last minute and had to be replaced. The goal, however, was fully met in the eyes of the city and medical board.

The structural problems which have faced Meharry-Hubbard over the years and which Dr. Foster provided leadership in addressing have been accompanied by peripheral issues which have been raised by opponents of Dr. Foster's nomination.

II. Surveys

Two surveys -- one in 1978 by two sociologists and a second in 1980 by now defunct Private Practice magazine -- ranked Meharry last among United States medical schools. Supporting articles submitted to the Committee by Mr. Bauer show how "shallow and subjective" the surveys were. Nashville Banner, January 19, 1978. The authors of the 1978 survey acknowledged that "[t]he quality of graduates produced by the schools was not considered as a factor." Id. The focus was on research and credentials rather than on the creation of health professionals, which Meharry sees as its mission. The 1980 survey also was shoddy. The magazine simply asked medical school deans and assistant deans to rank the top and bottom 10 schools without reference to any standard. It attracted responses from only 44 of the 200 deans and assistant deans surveyed; indeed, the Association of American Medical Colleges "vigorously criticized the survey and urged its members not to participate." Nashville Tennessean, March 10, 1980. The AMA said that the survey "definitely has no validity. The report has no foundation. It was not based on a visit to the school." A Vanderbilt spokesman also criticized the study: "The survey doesn't mean a thing. Meharry clearly is a school that has made a tremendous contribution in producing fine doctors." Id. Indeed, Meharry has produced nearly 40 percent of the black physicians and dentists in the United States, and 40 percent of the black medical school faculty.

The surveys also had a bias in favor of a credentialed student body, and in doing so ignored one of Meharry's signal accomplishments. Meharry takes students from distinctly uncredentialed backgrounds and gives them an opportunity and a future. This reflects its special role. As Dr. Foster has said, "We take kids knowing they bring academic baggage. We know they can catch up. It's not how they enter that counts, it's how they exit." The graduates return what they receive. Three out of four provide medical care to underserved areas.

The surveys were not scientific evaluations of the various schools' programs, but merely reflected the biases of the small minority who chose to participate. They say nothing at all of the quality of Dr. Foster's teaching or work, and are abundantly refuted by the many metropolitan, state and national panels and boards which have sought out Dr. Foster for leadership and guidance, and by his large body of scholarly work.

II. Administration and Accounting

Critics focus on 1979-1981 federal audits of expenditure of federal funds by Meharry. The issues involved accounting procedures and controls on expenditures. All of these problems related to the central administration of the school and hospital. Meharry for its part was critical of the federal accounting procedures. Regardless of the merits of the school's accounting procedures or their place in regard to the larger perspective, they cannot fairly be laid at Dr. Foster's door. At the time, he was simply chairing the OB/GYN department and had nothing at all to do with the school's accounting procedures. He did not establish the procedures and controls, review them or administer them any more than any other department chair in any other medical school; nor is there any claim that he did. Dr. Foster simply is damned by association. The charge is irrational and unfair.

President Reagan put the matter of the Meharry finance and accounting issues in perspective in 1983 by "burning the mortgage" for Hubbard Hospital. President Reagan observed that "[t]he contributions of Meharry Medical College to the health and welfare of this country over the past one hundred years are immeasurable. You have surmounted obstacles that would have defeated lesser institutions and leaders."

Meharry has indeed played an important role, as saluted by President Reagan and a host of others. Dr. Foster and Meharry-Hubbard have brought expert medical care to inner city Nashville. They have trained students who would not otherwise have been able to attend medical school, and has turned them in to fine doctors providing service to underserved areas. The school has given people a future, just as Dr. Foster has given a vision, a road map and a future for those in our most troubled areas.

STERILIZATION
April 26, 1995

- In the 1960's and early 1970's, Dr. Foster performed a small number of therapeutic sterilizations on severely mentally retarded women. Some people have sought to distort this information by failing to place Dr. Foster's practice in the context of the time and prevailing medical practice.

    - In August 1974, Dr. Foster delivered a paper before a meeting of the National Medical Association that included a discussion of the hysterectomies he had performed between May 1963 and May 1973. The paper, which was published in 1976, includes a bar chart showing that, among other reasons for performing hysterectomies to remove normal uteruses, he had performed four such procedures on severely mentally retarded women. Dr. Foster noted that hysterectomies could be performed on women with severe mental retardation "either for sterilization or to eliminate the menses, which is of significant hygienic benefit . . . ." *See* Henry W. Foster, Jr., *Removal of the Normal Uterus*, 69 Southern Medical Journal 13, 15 (1976).

    - Dr. James Todd, Vice President of the American Medical Association has confirmed that performing hysterectomies on severely retarded women for pregnancy prevention or to eliminate the menses for hygienic purposes "was thought to be the state of medicine back then." So has Dr. Joseph Gambone, Acting Director of Reproductive Endocrinology at UCLA, who indicates that the practice was common at the time. Dr. Luigi Mastroianni, a professor of obstetrics and gynecology who heads the division of human reproduction at the University of Pennsylvania, has said such procedures "were the most humane method we had to allow people with severe mental deficiency to have any comfort at all."

    - In that same 1976 article, Dr. Foster stressed that "obstetricians and gynecologists must guard vigilantly against the injudicious and indiscriminate removal of the normal uterus." Dr. Arthur Caplan, Director of the Center for Bioethics at the University of Pennsylvania, has said that Dr. Foster's 1974 paper on this subject "represents an enlightened and cutting-edge opinion about the need for caution and care with respect to that form of surgical sterilization."

- By the late 1970's, medical practice and legal standards had shifted, as had Dr. Foster's views. In 1980, Dr. Foster wrote: "It is understood if the patient is judged to be incapable of comprehending and thus not able to provide an informed consent, she must not be sterilized." *See* Henry W. Foster, Jr., *Ambulatory Gynecologic Surgery*, *in* Ambulatory Obstetrics & Gynecology 399, 416 (George Ryan ed. 1980).

- At all times, Dr. Foster's practice has been consistent with prevailing medical norms. In many ways, as Dr. Caplan's comments reveal, Dr. Foster has been ahead of his time on these issues.

The Washington Post

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HEADLINE: Medical Morality: When Consent Is Not Informed

BODY:

Every week seems to bring a new undocumented assault on the character of Dr. Henry Foster, the U.S. surgeon general nominee.

In response to the disclosure that in 1974 Foster performed a "small number" of sterilizations on severely retarded women (four seems to be the number), Charles Krauthammer asked whether it was "ethical to perform surgery and permanently sterilize women in no position to give consent" [op-ed, Feb. 17]. Krauthammer, who is not only a respected journalist but also a physician with a well-known interest in and sensitivity to moral problems in medicine, raised precisely the right question. Unfortunately he came to an uncharacteristically simplistic judgment.

Medical ethics in this most individualistic of all modern cultures has been "autonomy"-driven. Informed consent is at the heart of it. But with the seriously mentally impaired, consent itself can be immoral -- if not impossible -- to obtain. For example, one would not allow a significantly impaired person to sign away her fortune and her security. Nor, by the same token, should she be allowed to make major decisions that infringe on her health and survival. Whether she is to be subjected to an amputation, a coronary bypass or a sterilization procedure will all be decided by others.

In the case of the mentally impaired, we are forced to violate a cardinal principle of medical ethics: We abrogate her authority to decide for herself, assigning this right to others -- the family or institutions of society and the state.

Sterilization procedures have traditionally aroused anxiety and distrust, particularly since the World War II horrors of Nazi "eugenics" and the complicity of German doctors in racial experiments. So strong was the fear of eugenics that even authentic research in genetic influences on behavior was viewed with distrust. As distinguished a biologist as E. O. Wilson was assaulted by some of his colleagues as a fascist for daring to present the data (suggesting that human beings, like insects, have genetic directives) that has

since built his reputation as one of the great and humane scientists of our day.

But in the 1970s a counter-trend emerged. The civil rights movement had become a model for many disenfranchised populations other than African Americans, among them the handicapped. Consumer advocacy groups were being formed. The rights of the mentally retarded were freshly reasserted by organizations formed to defend them, which questioned even the definition of retardation. Mainstreaming became the order of the day.

Oddly enough, this new attitude created an atmosphere in which such extreme measures as permanent sterilization for the retarded were discussed in terms of their beneficence and as promoting the rights of the individual. The argument was that they would offer retarded persons an opportunity to participate in the new sexual freedom, unfettered by fears of pregnancies and child-rearing, which they might not be able to manage.

All this is by way of pointing out that what was morally correct and incorrect had hardly been settled by 1974, when Dr. Foster performed his operations. The law was confused, the philosophical community was divided, and the medical community was uncertain. Even the advocacy groups for the mentally retarded were deeply divided.

So great was the confusion that in 1976 a grant was given by the National Science Foundation to the Hastings Center (a nonpartisan, nondoctrinaire research institute concerned with society, ethics and the life sciences) to convene a group of scholars and advocates to help sort out the moral contradictions in this complex area.

The nature of that ethical discourse is too extended to be encompassed in this article, but a number of variables obviously would determine moral justification for sterilization procedures: Who initiated it, the government or the individual's family? If the government, what section: the punitive branch of the Justice Department in a criminal case or some paternalistic (although not necessarily more to be trusted) institution of mental care?

Also to be considered: Things done to a person to serve her interest are judged by different standards from those done her in the interest of her family, of other like individuals, the institution or the state. Moral dilemmas exist under all these conditions, and the proper resolutions in each case may be entirely different.

In that debate a distinguished liberal philosopher argued that sterilization of mentally retarded persons would be morally mandated if it would "enhance their position in the moral community" by facilitating their living together at home or in small communities outside traditional institutions. We do

not have to accept that particular argument, but what is clear to those of us who were privy to these discussions is that the moral question was not settled then, as it is probably not settled now. It is particularly unjust to equate a doctor who performs sterilization procedures for therapeutic reasons -- even if you feel he is misguided -- with doctors who participated in radiation experiments on unconsenting, unsuspecting subjects during the Cold War years, let alone the obscene Nazi camp experiments.

Krauthammer argues that "sterilization of the mentally infirm is a morally problematic procedure"; with that we heartily concur. But it is clearly immoral (nothing problematic here) to impugn the ethical character of Henry Foster on the basis of sterilization procedures he has performed or, for that matter, on abortions he has performed.

People of goodwill and good heart are entitled to hold differing views on emotionally charged social issues (in-vitro fertilization, assisted suicide, organ transplants, genetic engineering or, for that matter, divorce, capital punishment and gun control) without being demonized. For the Senate to form a judgment on Dr. Foster's character on the basis of his having performed suchprocedures would be indefensible and indecent.

Willard Gaylin is professor of psychiatry at Columbia University and co-founder of the Hastings Center. Allan Rosenfield is dean of the Columbia School of Public Health.

Foster's sterilizations for normal for that time, analysts say By Rachel L. Jones Knight-Ridder Newspapers

WASHINGTON Despite criticism about the sterilizations that Dr. Henry W. Foster Jr., the surgeon general nominee, performed in the mid-'70s, some doctors, ethicists and medical historians insisted this week that Foster was well within the medical mainstream at the time and that the rebukes are merely revisionist history.

''It's inappropriate to go back and judge procedures done 20 years ago by the standards of today," said Dr. Joel Howell, an associate professor in the internal medicine and history departments at the University of Michigan in Ann Arbor. ''Ethical norms and standards are structured by the society and times we live in, and that changes throughout history."

Foster, 61, an obstetrician and gynecologist nominated by President Clinton, initially came under attack from conservatives because of abortions he'd performed. Later, it was revealed that he had performed hysterectomies on four severely retarded patients in 1974. Foster had written about the operations in an article in Southern Medical Journal in 1976.

Opponents view the hysterectomies as even more proof that Foster is unfit for the job as the nation's top doctor.

But that's an ''unfair criticism," said Dr. Joseph Gambone, a gynecologist and acting director of the division of reproductive endocrinology at the University of California at Los Angeles.

''Procedures we perform today will probably look bizarre 10 years from now, at the rate we're making medical advances," Gambone said. ''But in the early '70s, it was common to remove a uterus for sterilization, and for a range of other reasons."

The number of hysterectomies performed in the United States reached a peak in the early 1970s, when anywhere between 800,000 and 1 million were performed annually. While many were performed due to disease, some women had the operation to prevent nuisance bleeding, or to avoid using birth control when they didn't want more children.

In the past two decades, medical advances and increased awareness of alternatives have helped reduce the number of hysterectomies performed on American women to about 650,000 in 1993.

But Foster's case is being scrutinized because the procedures were done on severely retarded women who weren't choosing to have the operation. Gambone said parents of such women frequently made that request for several reasons: because the women were incapable of performing the hygienic procedures connected with menstruation or because they feared their daughters might become victims of sexual abuse and wanted to prevent pregnancy.

The practice raised questions, however, and in 1974, the federal government banned the use of federal funds for the sterilization of the mentally incompetent without an independent review or judicial ruling.

In the medical article, Foster does not mention any judicial review of the operations.

But one medical ethicist says trying to find the moral high ground in this issue is extremely difficult.

''It's simplistic for me to imagine that this kind of decision was made without extensive ethical and medical considerations, or without anguish on the part of families," said Dr. Mary Mahowald, a philosopher who's a professor of obstetrics and gynecology at the University of Chicago.

Mahowald concedes there are concerns about sterilizing the retarded. ''There was clearly a time when these kinds of procedures were done for purely eugenic purposes," she said, referring to the term for the science of improving the hereditary qualities of a race or breed by weeding out undesirable members. ''You have to be sensitive to these kinds of overtones. But removing the uterus of a profoundly retarded woman is far too complex an issue to apply that extreme label."

(EDITORS: STORY CAN TRIM HERE)

Howell, the medical historian, noted that in the 1920s, the Supreme Court granted permission to sterilize a mentally impaired woman whose mother was mentally impaired and who had already given birth to one mentally impaired child. ''You don't get a much higher arbiter of what's societally acceptable than that," he said.

Howell points to other procedures to underscore the fluid nature of ethical standards in medicine. For example, at the turn of the century, women were heavily drugged into a unconscious state, called ''twilight sleep," during childbirth, and handed their newborns once they regained consciousness.

''Women were demanding it," Howell said. ''It was considered an enormously empowering, feminist thing to do. Today, many women insist on being awake and alert and don't want drugs during labor. Were those women 100 years ago wrong? Was the medical establishment wrong? Perhaps the answer is yes, but we certainly can't make that determination based on what we do today."

THE NEW YORK TIMES
MONDAY, FEBRUARY 13, 1995

White House Releases Papers That Defend Foster

By LAWRENCE K. ALTMAN
Special to The New York Times

WASHINGTON, Feb. 12 — In the face of mounting furor over Dr. Henry W. Foster Jr.'s performing abortions, as well as hysterectomies on severely retarded women, the White House issued documents over the weekend portraying Dr. Foster, President Clinton's nominee for Surgeon General, as a devoted medical educator dedicated to improving the health and welfare of the poor.

In one document, a scientific report published in 1976, Dr. Foster said he performed an unspecified number of hysterectomies on severely retarded women for sterilization and "hygienic" reasons at a hospital in Tuskegee, Ala.

The selected documents the White House made public on Saturday night included articles from scientific journals, speeches, Congressional testimony and book reviews. But they were not a complete set of his writings.

Among the documents made public by the Administration were some showing that Dr. Foster had spoken out about the need to expand the national health service to provide more care to poor people and to those in rural areas. In May 1994, he asked Congress for $24 million to help Meharry Medical College in Nashville, of which he was acting president.

Another document showed that as he completed a year as president of the Association of Professors of Gynecology and Obstetrics in March 1994, Dr. Foster gave a speech that was sharply critical of medical education's main organization, the Association of American Medical Colleges. He criticized what he called the group's flawed logic in recommending that obstetrics and gynecology be abolished as a required course for American medical students.

The surgical sterilizations were the latest disclosures about Dr. Foster's 38-year career to fuel criticism. But the White House maintains that Dr. Foster was very much in the mainstream of medical practice when he performed them, in the 1960's and 1970's.

A nominee's writings in the 70's are called 'enlightened.'

Some experts in obstetrics and gynecology as well as medical ethicists interviewed today agreed with the White House. They said those were times when doctors had little medication to protect severely retarded women against pregnancy and to help them avoid monthly periods. But some conceded that while the practice was in the medical mainstream, it was still disputed.

"Clearly it was very controversial, but well within the scope of standard practice around the country at the time," said Dr. Kenneth Ryan, chairman of the department of obstetrics at Harvard Medical School, who headed a national commission for the protection of research patients.

But Dr. Ryan noted that the practice was certainly less disputed then than now.

Dr. Luigi Mastroianni Jr., a professor of obstetrics and gynecology who heads the division of human reproduction at the University of Pennsylvania, said such procedures "were the most humane method we had to allow people with severe mental deficiency to have any comfort at all."

"It was not just a matter to provide pregnancy protection, but also hygiene," he added. "In the course of menstruation, they would not be able to care for themselves and you would have to restrain in order to put a tampon in, if you could get one in."

Today, he added, drugs can help.

But Dr. Mastroianni said he did not recall any dispute over the procedure at the time beyond the standard sensitivity to unnecessary surgery and undue risk. Indeed, he said he had performed such procedures after going through the difficult process of obtaining informed consent.

"Even now, the issue of sterilization is hotly debated, and among people who are retarded and who cannot make decisions for themselves, it is very hard to get a consensus on what to do," Dr. Mastroianni said.

Dr. Foster discussed his use of hysterectomies for severely retarded patients in an article in The Southern Medical Journal in 1976 where he reviewed 485 hysterectomies at the John A. Andrew Memorial Hospital in Tuskegee from 1963 to 1973.

Recognizing that hysterectomy for sterilization "is not a universally accepted practice," Dr. Foster said that he had "begun to use hysterectomy in patients with severe mental retardation." Dr. Foster did not specify the number of these hysterectomies he performed or for how long.

Dr. Arthur Caplan, who heads the Center for Bioethics at the University of Pennsylvania, said that in the Southern Medical Journal article Dr. Foster seemed keenly aware of the long history of abuse of surgical sterilization dating at least to the 1920's.

Dr. Caplan said that for its time, Dr. Foster's paper "represents an enlightened and cutting-edge opinion about the need for caution and care with respect to that form of surgical sterilization."

By the 1970's, Dr. Caplan said, there was "a shift in thinking in the profession that you ought not do this without proxy consent and probably court review."

"I HAVE A FUTURE": *SUMMARY AND ANALYSIS*

Table of Contents

I. Overview

In 1987, Dr. Henry W. Foster -- then Chairman of the Ob/Gyn Department at Meharry Medical College -- asked community leaders and parents in Nashville, Tennessee what services their teens needed to do well in school, stay out of trouble, and avoid pregnancy. Using their suggestions, Dr. Foster formed I Have A Future to serve teens in two housing developments. It is a pioneering effort to reduce the number of teen pregnancies while also addressing other serious problems of inner-city youth -- drugs, violence, alcohol abuse, homicide, unemployment. The goal is to raise the youths' self-esteem, promote abstinence, offer positive options for the future, and give these teens a reason to delay early sex and childbearing.

The prevention of teen pregnancy is a critical focus because early childbearing is so often linked -- either as a cause or a consequence -- to violence, drug abuse, tobacco and alcohol use, sexually-transmitted diseases, AIDS, poverty, and welfare. The goal of the I Have A Future program is to address these inter-related problems by enhancing the young people's self-image, stressing personal responsibility, and presenting positive alternatives for the future.

II. History

After moving to Nashville in 1973, Dr. Foster was asked to head a grant project with the Robert Woods Johnson Foundation to provide health services to high risk youth [young people aged 15-24 living in areas characterized by high rates of teen pregnancy, violence, drug and alcohol abuse, and mental illness.] Some of the nation's first school-based clinics developed from this initiative. But Dr. Foster realized that these clinics could never have a real influence in these teens' lives because they were not accessible. They were closed after school, on weekends, and during the summer -- times when teenagers have free time, need something to do, and often get into trouble. In fact, one statistic says that almost 70% of teen pregnancies occur between 3 and 5 in the afternoon. So, Dr. Foster decided to establish a program for high-risk teens that was located where they lived -- in the public housing developments themselves -- and which would be open, with interesting things for the teenagers to do, when they needed it most

III. Family/Community Involvement:

Dr. Foster wanted the community to play a key role in designing the program from the start. He met with community leaders and the heads of the resident's associations who agreed there was a profound need for such a program and decided where the two sites would be located. Dr. Foster then commissioned a *Community Needs Assessment* -- asking parents and community leaders what the main problems were that their teenagers faced and what programs might help solve them. The three biggest problems they identified were: drug and alcohol abuse, teen pregnancy, and crime. To solve these, they recommended: tutoring and job training, drug prevention programs, computer classes, and sexual education. And, most importantly, the parents indicated a willingness to participate as volunteers in the program.

It is notable that the parents asked for strong sexuality education and contraception programs to prevent teen pregnancy. Perhaps this was because 73% of the mothers who responded had themselves been teen mothers and wanted different futures for their children. This would also explain why 91% of parents responded that it should be easier for sexually active teenagers to get birth control.

The survey also helped Dr. Foster determine the socio-economic status of this community. It consists of predominately black [98%], single [83%], female [87%] heads of households, with low education and employment status. Over three quarters [79%] of them reported household earnings of less than 5,000; 93% with less than 10,000.

IHAF is now part of the fabric of the community itself, with a role for everyone -- from parents and grandparents, to clergy and business leaders, to volunteers and teachers. Because they were involved in designing the program from the start and because it responded to needs they identified, the parents in the community are very involved in the program and have ownership of it. It's right across the square from their apartments. And it has services for them as well, including a program called *"Parents of Worth"* -- run by the parents themselves, with the help of IHAF staff -- that teaches parenting skills and tries to prevent drug and alcohol abuse.

IV. Membership / Eligibility

Any teenager, aged 10 - 17, who lives in or near the *John Henry Hale* or the *Preston Taylor* housing developments may participate in IHAF -- which attracts an average of 150 youths each week. More than half of the participants are African American males, a significant feat as it is usually hard to keep the interest of this group. Over 850 youths have participated since the program was founded. All of the participants are African-American, as are 98% of the residents in these developments.

V. Approach to Preventing Teen Pregnancy

Traditional Teen Pregnancy Programs Weren't Working:

As early as 1984, Dr. Foster wrote an article saying that *"early childbearing is a significant problem for our nation"* and recognizing the need for a new way to approach the problem of teen pregnancy. Traditional teen pregnancy programs either 1) distributed contraceptives, or 2) taught sex education, or 3) both -- each addressing the *capacity* to get pregnant and how teens could control that. Dr. Foster, among others, saw that these programs did not have a significant impact on teen pregnancy because they did not address the *desire* to have a child.

Research has shown that many impoverished teenagers in inner-city neighborhoods think their futures hold little hope other than having babies. In 1986, Washington Post reporter Leon Dash wrote an eye-opening series on teen pregnancy that had an enormous effect on many leaders in this field, including Dr. Foster: ". . . *many teen-agers have sex, often reject birth control, get pregnant and have children*

-- not because of ignorance, but because they see those actions as ways to keep a relationship alive, or escape their families, or achieve something in a life filled with failure, violence, uncertainty."

Thus, it is ironic that IHAF is criticized for being a contraceptive-only program when in fact Dr. Foster founded it to provide a real-world alternative to such programs.

Why Not Just Teach An Abstinence Curriculum?

Dr. Foster also knew that teens in these neighborhoods needed more than just a traditional *"Just Say No"* abstinence campaign. By itself, such an approach was bound to fail. Why? Abstinence is not valued in these communities -- which is clearly one of the program's biggest challenges. There is a pattern of teen pregnancy going back generations. Many of the mothers of these teens were themselves teen mothers. And, as the Dash series clearly showed: *'It's not cool to be a virgin. It's not cool to say you're a virgin. You shouldn't be on birth control.'* For this reason, a pledge-signing program or a parent-child abstinence ceremony -- popular in many middle-American communities and churches -- was not, by itself, a realistic option.

The IHAF "Life Options" Approach

Dr. Foster was convinced that a much broader approach was needed, one that taught different values and empowered inner-city teens to take control of their own futures -- giving them incentives to delay childbearing until a more appropriate time. Dr. Foster wrote: *"The IHAF Program is built on the premise that changes in sexual behavior should be pursued within a framework that enhances self-image and presents positive alternative futures."*

In this way, IHAF is much more than a conventional pledge-signing abstinence program. It is a life-options program. It helps teenagers understand what they should say "no" to -- stressing abstinence throughout the curriculum and teaching teens how to stand up for what they believe in. But, more importantly, it also gives them something to say "yes" to -- education, jobs, and successful futures within their reach.

The Role of Contraceptives in the Program

IHAF's goal is to reduce teen pregnancy and they do this in several ways. The first, again, is by stressing abstinence, and showing teens that early sex and early pregnancy can limit their lives. And, they take pains to describe the responsibilities of parenting and the limiting effect having a baby can have on the future. But this is a real-world program addressing real problems. They do not stop there.

"The need to be sexually responsible" is defined in the program as choosing abstinence or regularly using birth control. They first encourage abstinence -- and give teenagers the skills and confidence to enforce this -- but they also provide extensive education about contraceptive use. In addition, they have health clinics which dispense condoms or birth control pills to those teens who don't heed their advice and choose to be sexually active. It is interesting to note that IHAF's doors opened in February 1988 but there was not a medical clinic -- and therefore no contraceptive distribution -- until May 1990. While contraception is a *part* of the program it is, by no means, the *purpose* of the program.

VI. Curriculum

A fair analysis of IHAF's teaching modules reveals that it is a thoughtful, moderate, and realistic approach to addressing the many problems teenagers face. The program seeks to teach values -- in open acknowledgment of the "real world" of the housing projects in which these teenagers live. It tries to help the teenagers develop a value system of their own and then give them the tools they need to uphold that value system. One of the primary lessons stressed throughout is -- *"the need to make your own decisions and to take responsibility for the outcome."*

"Nguzo Saba": A Culturally-Sensitive System of Values

Dr. Foster realized that the first step was to raise the self-image of these teens. Many African American youths have feelings of low self-worth -- and hatred of their communities and families -- because they have internalized the stereotypes typically applied to people of their race and social situation. This limits their outlook -- and, within this negative image, they see few positive choices for their futures.

Dr. Foster also realized that the young people in these housing projects needed a good value base, which many had grown up without. He chose the *Nguzo Saba* principles to accomplish both of these objectives: giving the teens a sense of cultural pride and a system of values. *Nguzo Saba* is -- at its core -- a philosophy rooted in values. It was developed in the 1960's as part of the cultural *Kwanzaa* celebration which aimed to give African Americans a sense of their common identity and history in order to strengthen their communities. As part of IHAF, *Nguzo Saba* is a culturally-sensitive approach to communicating with African American teenagers by giving them a sense of the value of their history and the positive attributes of their communities and families. When they are proud of who they are and where they came from, they can then look upon their life choices in a much more positive -- and much less limited -- way.

The *Nguzo Saba* principles, also called the "Seven Principles of Blackness," are: *Nia* [Purpose], *Umoja* [Unity], *Kujichagulia* [Self-Determination], *Ujima* [Collective Work And Responsibility], *Ujamma* [Cooperative Economics], *Kuumba* [Creativity], *Imani* [Faith]. IHAF uses these to promote self-esteem, encourage responsibility and impart a sense of community -- within the context of the youth's socio-economic situation and the historical struggles of the black people. These values are recited by the group at the start of every class and discussed in relation to the day's subject.

Since this feature of the program could be deliberately misinterpreted, the IHAF staff takes pains to define the terms themselves -- clearly describing the ways the philosophy can be used to discourage violence, drugs and early sex. The modules repeatedly explain why they chose this particular value system: to help create positive images of themselves and their communities in impoverished African American youth. When Dr. Foster speaks publicly about the goals of the IHAF program and his desire to replicate it in other communities, he takes pains to stress that any such program must be sensitive to the culture of the people it serves.

Teaching Modules [Classes]:
The curriculum is organized into teaching modules, most of which take place in group settings. Many of the teaching modules have a "role-playing" component: they outline a tough social situation and together walk through the different ways youths can choose to deal with it. They teach how to say "no" in many ways -- to sex, to drugs, to alcohol. They encourage teens to be assertive and stand up for what they believe in: *"developing skills to resist group pressure."* These exercises are also used to help teens identify and learn to positively deal with their emotions -- anger, embarrassment, rejection, the need to be loved.

The following goals are promoted throughout the program: self-esteem and pride in individuality; physical and mental well-being; completing school; developing job skills and enhancing employability; sexual responsibility; self-control and handling inter-personal conflict, value of helping others and the community; responsible citizenry; family-life values/responsible parenting.

The program is sensitive to different developmental needs and abilities. Consequently the curriculum emphasizes knowledge, attitude, and awareness for early adolescents, and behavioral skills for older adolescents. Teaching modules include:

- Pre-Employment Training: *Designed to address basic skills needed to obtain, and retain, a job. Module addresses job readiness, career development, job attainment skills, and job survival. [12 weeks]*

- "Pro-Social" Skills / Alcohol and Drug Abuse Prevention: *Teaches skills to enable the participants to make positive life choices, such as: interpersonal relations, assertiveness skills [how to say 'no'], communication skills, decision-making, self-determination. It imparts a strong anti-drug message by improving knowledge and attitudes related to the effects of drug and alcohol abuse. [12 weeks]*
- Conflict Resolution Training / Violence Prevention: *Focuses on positive emotional development, self-control, victim awareness, and social responsibility. African-American males learn about the perseverance of famous African-American Role models [Martin Luther King, Jr.; Joe Louis.] [10 weeks]*
- Family Life Education: *To discuss the meaning of family and its roles and responsibilities through all stages of life. Emphasis on improving skills in decision making and standing up for personal beliefs: overall objective is to create positive attitudes towards abstinence and sexual responsibility [defined as abstinence or responsible use of contraception]. [15 weeks]*

There are also classes -- developed and named by the teens themselves -- to improve personal appearance and raise self-esteem. The young women named their module *CHARM: Choosing How to Adorn and Refine Myself* and the men named theirs *MATURE: Males Adorning, Thinking and Using Refined Energies.*

Activities / Services

In addition, IHAF offers a variety of on-going activities to assist the teens with school work and give them something to do in their spare time

- After-School Tutoring
- Computer Training
- Sports
- Art and Dance Activities
- Athletic / Recreational Events [Summer Olympics]

Entrepeneurship Program

One of the most popular programs helps teenagers learn more about the working world -- and about personal responsibility -- by giving them the tools to start their own small businesses in the communities where they live. They produce, market, sell, and distribute products to help their communities. They must open a bank account and deposit at least 10% of their earnings. To participate in the program, they also must sign a contract -- with their parents and the program -- agreeing to stay in school, maintain a passing average, not use alcohol or drugs, and not get pregnant or impregnate someone. This is a popular program, with a constant waiting list of teens who want to join.

Field Trips / Cultural Outings
IHAF makes a special effort to take the teens on trips both within and outside of Nashville. Many of these young people had never left Davidson County, TN. Now, they visit colleges, speak to successful African-American role models, and tour the nation's capitol. One year, some of the teens were taken to Atlanta, GA to speak to an African American millionaire about his life and education. Their view of the world -- and what their role in it can be -- grows with every trip.

Peer Counselor Program
After participating for a few years in the program, some of the teens are chosen to serve as peer role models, teachers, and "trend setters" for other young people in the program and in the community. They make presentations in the community on preventing teen pregnancy, alcohol and drug abuse, and conflict resolution.

VII. Staffing
The IHAF staff consists of a multi-disciplinary team that includes psychologists, nurses, public health education specialists, counselors, physicians, tutors and volunteers from the community and local colleges. The program is headed by Dr. Lorraine Williams Greene -- who joined as Dr. Foster's Deputy Director in 1989 and is now Director.

VIII. Results / Evaluation
Results are preliminary -- based on some limited, short-term data but largely anecdotal evidence. Thus far, the program has dedicated the majority of their resources -- not to research and evaluation -- but to investments in the teenagers. The true impact of IHAF can only be measured in the long term, as the very young adolescents go through the entire program, mature, and confront sexuality and life choices within the context of the program.

There was a internal evaluation -- organized and conducted by IHAF -- that interviewed the teens three times over a 30 month period. It compared the IHAF teens to two other housing projects with similar [but not identical] populations without the program. This survey showed statistically significant differences in the IHAF teens sense of self-esteem, responsibility, and positive options for the future. IHAF is extremely cautious about using these results though as there were differences [i.e., age] between the two populations. IHAF is actively seeking funding for longer-term outside research to track the participants over time.

Pregnancy
The 30-month internal study reported 1 known pregnancy among active participants in the two IHAF housing projects. The comparison data often cited -- i.e., 59 pregnancies at the two sites without the program -- may not be statistically significant as teens at the comparison site were older than IHAF teens. Regardless of the comparison, though, one known pregnancy in almost 3 years is an impressive statistic which speaks for itself.

High School Graduation

A surprise result of the life-options program was the number of inner-city teens that began going to college. In 1993, 9 IHAF participants graduated from high school. Of this number, 7 attended college and remain enrolled. In 1994, 24 participants graduated from high school and 16 of these went on to college. Another 4 entered the Armed Forces. The numbers in 1995 look to be even higher.

The program has also demonstrated a rare capacity to hold the attention of older adolescents. This is even true, surprisingly, for African-American males who are at the highest risk -- for violence, drugs, dropping-out -- and are traditionally very hard to keep involved in one program. Of the 16 students who went to college last year, 8 were males.

IX. Nationally-Recognized, Award-Winning Program:

Point of Light: IHAF's innovative approach to preventing teen pregnancy was honored by President George Bush who selected IHAF in 1991 to be one of America's *"Thousand Points of Light."* [Point #404] President Bush gave these awards to "*talented community leaders and successful initiatives that are solving the nation's most critical social problems."* In his letter, he said IHAF represented a *"shining example"* of serving others. [White House, 3/15/91]

Louis Sullivan, President Bush's Secretary of Health: *"It turns young people's lives around. [It's] the kind of program that the country needs."* [*"Teens Have A Future, Thanks to Foster Program,"* USA Today, 2/9/95]

American Medical Association: The AMA's National Congress for Adolescent Health gave an award to IHAF specifically for its approach to preventing teen pregnancy [Award was "Work in the Area of Sexuality"]

Tennessee Children Services Commission: Honored IHAF for its approach and named it one of only six "Model Teenage Pregnancy Programs" in the state.

X. Funding:

IHAF is funded by a diverse group of prestigious national and local organizations: Carnegie Corporation of New York, William T. Grant Foundation, Bill and Camille Cosby, State of Tennessee -- Department of Health [Alcohol and Drug Bureau], United Way of Middle Tennessee, Middle Tennessee Chapter of the March of Dimes

XI. Areas of Public Controversy

IHAF's Distribution of Contraceptives:

Most opposition has come in response to IHAF's distribution of contraceptives to sexually active teens, as well as challenges to the programs approach to teen pregnancy. Gary Bauer has said the IHAF approach *"is to say abstinence is best and in the next breath make it clear that birth control pills and condoms are available."*

[continued]

Response

1. The very first mention of sexually responsible behavior for teens states that the number one way is abstinence. It then says the second way is to responsibly use birth control but immediately returns to repeating its abstinence message: *"However it is best for children to postpone initiating sexual intercourse and other risky sexual behavior beyond the early childhood years."* [Family Life Module, p. 2]
2. 91% of parents asked that a teen pregnancy program make it easier for sexually active teenagers to get birth control.
3. Dr. Foster founded IHAF because he wanted an alternative to most teen pregnancy programs which only passed out contraceptives. IHAF is much much more.
4. Dr. Foster knows what it means to deal with the real issues of teenagers in the Nashville projects -- 75% of whom have sex before age 15; many of whom actively seek to have children soon after. They must have protection from AIDS, pregnancy and STDs.

IHAF Won't Release Modules:

Some complain that IHAF will not release copies of its curricula.

Response

IHAF released copies of its copyrighted, educational modules to the Labor Committee as soon as it was requested.

Brochure Doesn't Mention Abstinence:

Opponents claim that the eight-page IHAF brochure "stresses" condom availability but doesn't even mention abstinence once.

Response

- On page 1, long before the brochure mentions contraception, it says: ***"Previous efforts to prevent teenage pregnancy have focused in giving adolescents the capacity to control their fertility. It has been clear from pregnancy and fertility rates that many high-risk youth are not being reached effectively.*** *Those who have been at the forefront in the battle to delay early pregnancy and childbearing advocate enhancing self-image and presenting positive alternatives for the future."*
- That is what the program is about: *presenting positive alternatives for the future.* It is not a contraception program - and, in fact, clearly rejects such approaches. And it is much more than just an abstinence program. It is a life-options program which is what the brochure was designed to convey. IHAF does tell teens what to say "no" to -- but, more important to these impoverished teens, it gives them something to say "yes" to. That is what it means to have a future.

XII. Other Potential Problem Areas [Not yet criticized]

Nguzo Saba / Kwanzaa:

It's conceivable that opponents could seize upon the language used in the *Nguzo Saba* principles to characterize the program as having an anti-white, racist, or exclusionary focus. *[continued]*

Response

- The vast majority of the estimated 13 million Americans who celebrate Kwanzaa see it as a positive affirmation of African American culture, rooted in values and promoting the family. And the I Have A Future program, sensitive to this potential charge, has taken pains to define the terms for themselves -- clearly describing the ways the philosophy can be used to discourage violence and drugs, and help create positive images of themselves and their communities in impoverished African American youth.

DR. FOSTER'S *"MATERNAL AND INFANT CARE"* PROGRAM
Tuskeegee, Alabama

"In crowded cities and in places you can't even find on a map -- I have come face to face with real life and death challenges. . . Low birthweight babies born to mothers not yet old enough to drive a car. . . Low income women in the rural south with no access to prenatal care, and no one but a lay midwife at their side at the time of delivery.

I know that these impediments not only stunt the growth of children, they inevitably stunt the growth of this nation. There is nothing more in the national self-interest than the protection and nurturing of our children. And I have devoted my entire career to this goal."

Dr. Henry W. Foster, Nominee for U. S. Surgeon General[1]

LATE 1960s, SOUTH HAD LITTLE HEALTH CARE, MANY HEALTH PROBLEMS:

- Dr. Foster is one of the nation's leading experts on, and advocates for, maternal and child health. Immediately after completing his medical training, Dr. Foster returned to the rural south -- Tuskeegee, Alabama -- and began his lifelong crusade against infant mortality. At that time, rural areas suffered from a severe shortage of doctors; most poor women had no access to health care until it was time to deliver their babies with lay midwives at home. Many of the women had never seen a doctor.

DR. FOSTER FOUNDED PROGRAM TO ADDRESS HIGH INFANT MORTALITY:

- To address Alabama's high level of infant mortality, Dr. Foster applied for a grant from the Department of Health to expand the *Maternity and Infant Care Program* at Tuskegee Institute, and directed the development of this program from 1970 - 1973.

HEALTH CARE TEAMS WENT TO WOMEN WHO COULDN'T COME TO THEM:

- Dr. Foster developed a comprehensive approach to maternal and child health care -- involving teams of doctors, nurses, social workers and nutritionists -- with the ambitious goal of preventing health problems in mothers and newborn children. To reach these women, Dr. Foster sent the teams out into the countryside on buses, carrying with them all the supplies they would need.
- The teams worked with the rural communities to reach women early in their pregnancies, identify those women with a high potential for complication, and ensure they received specialized attention throughout their pregnancy and following the birth.

BECAME NATIONAL MODEL FOR HEALTH CARE IN UNDERSERVED AREAS:

- Dr. Foster's approach was well ahead of its time, becoming a national model for "regionalized perinatal care" -- a program involving extensive community outreach, specialized services for high risk women, and comprehensive care of mothers and infants both before and following birth. Dr. Foster was asked by the Robert Woods Johnson Foundation to replicate the program nationwide. Primarily because of this pathbreaking work, Dr. Foster was elected to the prestigious Institute of Medicine.

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[1] *Remarks at Sasha Bruce Foundation*, Washington, D.C., 3/3/95

MATERNITY AND INFANT CARE AT TUSKEGEE INSTITUTE

by

Henry W. Foster, M.D., F.A.C.O.G.
Chief, Obstetrics and Gynecology
John A. Andrew Memorial Hospital
Assistant Professor, Meharry Medical College

During the past twenty-four years, the obstetrical service of the John A. Andrew Hospital has been actively engaged in the conduct of a Maternal and Child Health Care Program. The original program which commenced in 1947, involved eight counties which are in close geographic proximity. It was financed with an unmatched Federal Grant under Title V, Part I, Sec. 502 (b) of the Social Security Act. The program's objective then was basically to treat complicated obstetrical patients and sick infants up to one year of age. It was not highly innovative nor really broad in scope. It functioned, however, in the capacity of only health care delivery for only a short period of time. The Macon County Medical Care of MCMC Program, as it became known soon, began to serve as a vehicle for training Tuskegee Institute nursing students both on an outpatient and inpatient basis. This was followed closely by the establishment of a certified school of nurse midwifery, and in 1949, an obstetrical residency affiliation was established with Meharry Medical College. The John A. Andrew Clinical Society utilized much of this MCMC Program in its continuing education for health practitioners.

Although this program quickly broadened in its scope and objectives, the funding was in no way proportionately increased. We now admit more than 2500 patients annually and we are anticipating nearly 2000 annual deliveries; our outpatient clinic has more than doubled. Nonetheless, we moved forward, and Tuskegee Institute with its keen sense of community responsibility bore most of this increased financial demand. However, it became more and more apparent that increased funding would be essential if we were to continue to function in an effective capacity. In 1970, a Maternal and Infant Care Grant Project #556, was funded by the Department of Health, Education, and Welfare with Tuskegee Institute putting up the required matching funds when no public funds could be found.

Today, our objectives are much broader in scope—our health care delivery is comprehensive in approach and our areas of teaching have increased. Our objectives now place primary emphasis on the prevention of maternal and infant complications through the early identification of patients with a high potential for complications. In addition to healthier mothers, there is a reduction in the incidence of mental and physical

retardation in the infants. This is quite a different concept than that of twenty-four years ago when we were funded to treat obstetrically complicated mothers and sick infants up to the age of one year.

Our method of health care delivery today is multidisciplinary involving, in addition to physicians, public health nurses, social workers, nutritionists, and a variety of supporting administrative and clerical personnel. Only this comprehensive approach can effectively achieve our objectives. Our Maternity and Infant Care Project is also unique in that unlike most existing M & I Programs, ours provides its own inpatient services thereby maintaining a total continuity of the patientts care.

Our Maternity and Infant Care Project presents an excellent vehicle for teaching both inpatients and out patients. Presently we continue to train Tuskegee Institute nursing students, In addition to training residents in obstetrics and gynecology, we have conducted a medical student affiliation with Meharry Medical College since 1967, and we are hopeful of establishing the same with Howard and Emory Universities. Nutritionist's aids are now training in our outpatient clinics as a part of RMP. A half dozen major publications have come from the obstetrics and gynecology service in the past five years thereby indirectly contributing to the continuing education of practicing physicians.

In spite of these accomplishments, however, our future needs are increasing and require increasing funds. There are two types of barriers that prevent health services from reaching the patient. First, attitudinal barriers which preclude the patient's being motivated to seek the needed service. This barrier in our part of the country, especially, is created primarily by cultural and economic isolation. The erosion of this barrier can be speeded with an increase in the total number of personnel in all disciplines but especially in the area of social workers. More direct barriers, however, are what sociologists refer to as organizational barriers—those obstacles that prevent the motivated patient from receiving the desired service. These barriers, which constitute a large unmet need are many, less intangible; and, consequently, more readily identifiable. Care for our infants now still terminates at the age of one year. C and Y or Child and Youth Programs are sorely needed, but they require additional specialized personnel. Our present program needs a more realistic salary in order to attract a dentist. Ultra-modern dental equipment is needed.

Funds for our present consultant services are woefully inadequate and no provisions are made for outpatient consultations.

The quality of patient care could be increased and the cost of this care decreased if establishment and effective usage were made of intermediate and extended care facilities.

With few exceptions, the physical condition of most of our outpatient clinics is deplorable.

Funds for patient transportation must be given very high priority. The magnitude of this problem is amplified when the population density is low.

Family Planning Services need expanding. More needs to be done in the area of infertility and interconceptional nutrition.

There is a need for the re-establishment of a nurse midwifery program now that this concept is no longer in disfavor.

Finally, there is a growing need for the expansion of staff education. These are but some of our needs. We have looked briefly at the past and present status of maternal and infant care rendered by the John A. Andrew Team. We are cognizant that the future presents many obstacles; however, with our past performance, our existing resources in this community and with ample funding we are confident that we can adequately meet this challenge.

Thank You.

Presented at the Veterans Administration
Hospital, Tuskegee Institute
July, 1971

While it is quite likely that tuberculous lesions will regress in the young, deterioration tends to occur in older people, particularly in men.

PRESENT STATUS OF TREATMENT OF DIABETIC RETINOPATHY

by

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During the past five years, persons with diabetic retinopathy have been treated with an increasing number of high energy light beams. Jepson at the University of Colorado and Meyer-Schwickeraft at the University of Essen, Essen, Germany have both used the xenon-arc, high intensity, white light instrument for the coagulation of haemorrhagic diabetic retinopathy. Jepson initially used treatments scattered over several visits and then changed to massive numbers of burns at one visit. Meyer-Schwickeraft, in a recent paper given at the Chicago Ophthalmological Society, continued to advocate judicious use of coagulation limited to areas of haemorrhage.

The postulated theoretical basis underlying large numbers of burns made on diabetic retinas is that the O2 demands of the retina are decreased by the resulting areas of atrophy.

The argon laser acts in a manner similar to the xenon light coagulator. The laser has an additional advantage in that its wavelength is more specific for retinal vasculature and areas of retinal haemorrhage. Because of the extreme coherency of laser light, it is possible to focus a large amount of energy into a very small area. The laser is being used to coagulate microaneurysms close to the macula; a feat which was not possible with the light coagulator because of the diffuse nature of its burn.

The choice of patients for light coagulation or laser coagulation is best limited those persons who have early diabetic retinopathy with a preponderance of microaneurysms and haemorrhages. Usually these persons have a visual acuity between 20/30 and 20/70. An effort is made to coagulate only those areas which are not included in the nerve bundle

National Organizations Supporting Dr. Foster
As of April 17, 1995

ADVOCATES FOR YOUTH
AFRICAN METHODIST EPISCOPAL CHURCH
ALPHA KAPPA ALPHA SORORITY
ALPHA PHI ALPHA FRATERNITY
AMBULATORY PEDIATRIC ASSOCIATION
AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCIATRY
AMERICAN ACADEMY OF DERMATOLOGY
AMERICAN ACADEMY OF OTOLARYNGOLOGY
AMERICAN ACADEMY OF PAIN PHYSICIANS
AMERICAN ACADEMY OF PEDIATRICS
AMERICAN COLLEGE OF CHEST PHYSICIANS
AMERICAN GASTROENTEROLOGICAL ASSOCIATION
AMERICAN GROUP PRACTICE ASSOCIATION
AMERICAN SOCIETY OF CATARACT AND REFRACTIVE SURGERY
AMERICAN FEDERATION OF STATE, COUNTY, AND MUNICIPAL EMPLOYEES
AMERICAN ASSOCIATION OF UNIVERSITY WOMEN
AMERICAN ASSOCIATION OF DENTAL SCHOOLS
AMERICAN COLLEGE OF PHYSICIANS
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
AMERICAN COLLEGE OF PREVENTIVE MEDICINE
AMERICAN JEWISH CONGRESS
AMERICAN MEDICAL ASSOCIATION
AMERICAN MEDICAL WOMEN'S ASSOCIATION
AMERICAN NURSES ASSOCIATION
AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, INC.
AMERICAN OSTEOPATHIC ASSOCIATION
AMERICAN PEDIATRIC SOCIETY
AMERICAN PSYCHIATRIC ASSOCIATION
AMERICAN PSYCHOLOGICAL ASSOCIATION
AMERICAN PUBLIC HEALTH ASSOCIATION
AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE
AMERICAN SOCIETY OF ANESTHESIOLOGISTS
AMERICANS FOR DEMOCRATIC ACTION
AMERICANS UNITED FOR SEPARATION OF CHURCH AND STATE
ASSOCIATION OF ACADEMIC HEALTH CENTERS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
ASSOCIATION OF BLACK CARDIOLOGISTS
ASSOCIATION OF MATERNAL AND CHILD HEALTH PROGRAMS
ASSOCIATION OF MEDICAL SCHOOL PEDIATRIC CHAIRMAN
ASSOCIATION OF MINORITY HEALTH PROFESSIONS SCHOOLS
ASSOCIATION OF PROFESSORS OF OBSTETRICS AND GYNECOLOGY
ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH
ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS
ASSOCIATION OF TEACHERS OF PREVENTIVE MEDICINE
ASSOCIAITON OF WOMEN'S HEALTH, OBSTETRICS & NEONATAL NURSES
BAPTIST MINISTERS ASSOCIATION
BLACK LEADERSHIP FORUM
B'NAI B'RITH WOMEN
CAMPAIGN FOR WOMEN'S HEALTH
CATHOLICS FOR A FREE CHOICE
CENTER FOR WOMEN POLICY STUDIES
CENTER FOR REPRODUCTIVE LAW & POLICY
CHILDREN'S HEALTH FUND
CLARA BELL DUVALL EDUCATION FUND
COALITION OF BLACK TRADE UNIONS
COALITION OF LABOR UNION WOMEN
COUNCIL OF UNIVERSITY CHAIRS OF OBSTETRICS AND GYNECOLOGY
COUNCIL ON RESIDENT EDUCATION IN OBSTETRICS AND GYNECOLOGY
DELTA SIGMA THETA SORORITY
ENDOCRINE SOCIETY
ECUMENICAL MINISTERIAL ASSOCIATION
HOLLYWOOD WOMEN'S POLITICAL COMMITTEE
HUMAN RIGHTS CAMPAIGN FUND
INTERNATIONAL WOMEN'S HEALTH COALITION
KAPPA ALPHA PSI FRATERNITY
MEDICAL STUDENTS FOR CHOICE
NATIONAL ABORTION AND REPRODUCTIVE RIGHTS ACTION LEAGUE
NATIONAL ABORTION FEDERATION
NATIONAL ALLIANCE OF BLACK SCHOOL EDUCATORS
NATIONAL ASIAN WOMEN'S HEALTH ORGANIZATION
NATIONAL ASSOCIATION OF COUNTY AND CITY HEALTH OFFICIALS
NATIONAL ASSOCIATION FOR THE ADVANCEMENT OF COLORED PEOPLE
NATIONAL ASSOCIATION FOR EQUAL OPPORTUNITY IN HIGHER EDUCATION
NATIONAL ASSOCIATION FOR PUBLIC HEALTH POLICY
NATIONAL ASSOCIATION OF PEOPLE WITH AIDS
NATIONAL ASSOCIATION OF PUBLIC HOSPITALS
NATIONAL ASSOCIATION OF SCHOOL NURSES
NATIONAL ASSOCIATION OF SOCIAL WORKERS
NATIONAL BAPTIST CONVENTION, INC.
NATIONAL BAR ASSOCIATION
NATIONAL BLACK CAUCUS OF LOCAL ELECTED OFFICIALS
NATIONAL BLACK CAUCUS OF STATE LEGISLATORS
NATIONAL BLACK CHAMBER OF COMMERCE
NATIONAL BLACK CHILD DEVELOPMENT INSTITUTE
NATIONAL BLACK NURSES' ASSOCIATION
NATIONAL BLACK WOMEN'S HEALTH PROJECT
NATIONAL COUNCIL OF JEWISH WOMEN

NATIONAL COUNCIL OF NEGRO WOMEN
NATIONAL COUNCIL OF SENIOR CITIZENS
NATIONAL EDUCATION ASSOCIATION
NATIONAL FAMILY PLANNING &
REPRODUCTIVE HEALTH ASSOCIATION
NATIONAL HISPANIC MEDICAL ASSOCIATION
NATIONAL MEDICAL ASSOCIATION
NATIONAL MINORITY AIDS COUNCIL
NATIONAL ORGANIZATION FOR WOMEN
NATIONAL OSTEOPOROSIS FOUNDATION
NATIONAL WOMEN'S LAW CENTER
NOW LEGAL DEFENSE AND EDUCATION FUND
OLDER WOMEN'S LEAGUE
100 BLACK MEN
100 BLACK WOMEN, INC.
OPERATION PUSH, INC.
PATHFINDER INTERNATIONAL
PEOPLE FOR THE AMERICAN WAY ACTION
FUND
PHYSICIANS FOR SOCIAL RESPONSIBILITY
PLANNED PARENTHOOD FEDERATION OF
AMERICA
PHI BETA SIGMA FRATERNITY
PRIMARY CARE DEVELOPMENT CORPORATION
PROGRESSIVE BAPTIST CONVENTION
RELIGIOUS COALITION FOR REPRODUCTIVE
CHOICE
SEXUALITY, INFORMATION AND EDUCATION
COUNCIL OF THE UNITED STATES
SOCIETY FOR ADOLESCENT MEDICINE
SOCIETY OF CRITICAL CARE MEDICINE
SOCIETY FOR INVESTIGATIVE DERMATOLOGY
SOCIETY FOR PEDIATRIC RESEARCH
SUMMIT '93 HEALTH COALITION
UNITED CHURCH OF CHRIST, OFFICE FOR
CHURCH AND SOCIETY
UNITED HOUSE OF PRAYER FOR ALL PEOPLE
UNITED METHODIST CHURCH, GENERAL
COMMISSION ON RELIGION AND RACE
UNITY FELLOWSHIP CHURCH MOVEMENT
VOTERS FOR CHOICE
WIDER OPPORTUNITIES FOR WOMEN
WOMEN'S LEGAL DEFENSE FUND
ZERO POPULATION GROWTH
ZETA PHI BETA SORORITY

I. STATEMENTS OF SUPPORT THAT ARE NOTEWORTHY

This section highlights the favorable comments from individuals who know Dr. Foster. Danny Rose with the White House Office of Public Liaison has organized all the statements from groups.

"I HAVE A FUTURE" PARTICIPANTS:

"My name is Gary Hicks and I have been in I Have a Future for three years ... The program teachs you not to have sex. On the other hand if you feel your ready for sex the leaders talk to you and make sure your ready for that decision ... Dr. Foster has put excitement into learning. Learning could be fun if you do it in a fun way ... Foster is doing a good deed by teach kids to wait before they have sex. Foster would rather the young kids not have sex at all, because they still have a lot of things to look forward to in life. The I Have a Future program teaches you that you don't have to do what everyone else is doing."

-- Gary Hicks

"I am a three year participant in the "I Have A Future" Entrepreneurship Program. Dr. Foster's program had greatly helped me. I have developed a positive attitude, good morals, confidence, and the willingness to become a strong, successful, black female through this extraordinary program. Dr. Henry Foster is a caring, honorable man who considers the welfare of others. He takes time out to understand and help those who may not be as fortunate. He is an inspiration to me ... If Dr. Foster can change the lives of hundreds of children and give them the chance to prove themselves, why can't he be given the same opportunity? He can also help make decisions to change our world if given a chance to prove himself ... I am not only speaking as a person who has been affected by Dr. Foster's goodness, but also as a concerned teenager who will be affected by the decisions made in government."

-- LaShonda Maryland

"...In these classes everyone can speak their minds on things that's happening in our neighborhoods, community, and in our world. I think that is good because so many teenagers walk around with hatred and mixed emotions bottled up inside of them and they release their anger in a negative and sometimes violent way. Talking is sometimes the best solution to problems and the "I Have A Future" counselors are always there when you need to talk".

-- Floyd Stewart

"As a member of the 'I Have A Future" program I have learned how to choose and make decisions that will have a positive effect on my life and benefit me as well as others around me. I learned that it is alright to be different because the only person I need to please is me."

-- Charmaine Harris

DR. FOSTER'S MEDICAL STUDENTS:

"I have known Dr. Foster for twelve years as a medical student, an obstetric and gynecology resident, and faculty colleague and can attest, without reservation to his integrity, credibility, and outstanding leadership qualities. He was an exemplary mentor during the years I trained under his leadership at Meharry Medical College. It was due to his encouragement and support that I sought and successfully completed sub-specialty training in Reproductive Endocrinology at Baylor College of Medicine in, Houston, TX. Dr. Foster has been an inspiration to students and residents who trained under his direction. He is a visionary who inspires those who work with him."

-- Lisa Pearsall Otey M.D., Houston, TX

"I graduated from Meharry Medical College, the class of 1974. I offer a unique perspective to Dr. Foster. He had tremendous influence on my desire to be an OB/GYN. He taught me while at Meharry, and at our rotation at Tuskegee Institute. His bedside manner was gentle, his surgical technique impeccable, his empathy for these young women having their babies exemplary. I would say it was he who had the most profound influence on me to go into Obstetrics. I offer, also, a unique perspective as I was one of about eight caucasian students in a class of about 90 Blacks. I was the minority. And yet, I couldn't have felt more comfortable, mainly because of the efforts of men like Dr. Foster. This man is not only a good man, he is a great man. He represents to me what every student, at whatever level they would be at, should have -- a professor who puts his arm around your shoulder, who cares about you both personally and professionally, who takes you under his wing, and as a student, you are proud to be under his wing. I have not seen Dr. Foster since I graduated from Meharry Medical College in June of 1974, but I have often thought of him as I have practiced medicine these past 17 years. To not allow him to serve this country would be a greater loss for our country than it would be for him."

-- Terry Cole, M.D., F.A.C.O.G., Ventura, CA

DR. FOSTER'S COLLEAGUES

"I have known Henry Foster for more than 40 years, since our undergraduate days at Morehouse College in Atlanta. Our lives have continually intersected: as classmates under the mentorship of the late Morehouse President, Dr. Benjamin Elijah Mays; as young physicians joining the National Medical Association; as medical educators in demanding fields of specialization; and later in life as presidents of two of the nation's four predominantly black medical schools. As well, I was pleased to represent the Bush Administration when Dr. Foster was given a "Points of Light" award for his work on behalf of Nashville's low income teenagers through the "I Have A Future" program. In each phase of our long association, I have found Dr. Foster to be an extremely capable scholar, vigorously dedicated to his patients, an inspiring teacher, an innovative administrator, and a trusted friend of young people ... Dr. Henry Foster would be an able, credible, and trusted advocate. His warmth and sincerity make him an ideal spokesperson for good health and behavior change. I am pleased to urge the committee to confirm the nomination of Dr. Foster as Surgeon General."

-- Louis W. Sullivan, President of Morehouse School of Medicine and Former Secretary of the Department of Health and Human Services

"I have known Dr. Foster since 1952 as a student at Morehouse College and remember vividly his scholastic and leadership accomplishments as well as his compassion for the disadvantaged ... I am personally thankful to Dr. Foster for the encouragement and professional support he gave both my daughter and son during their recent training at Meharry Medical College. He has high expectations of students and does not accept mediocrity. When encouraging words are important, Dr. Foster was there to offer that support."

-- Patricia Pearsall Sewing, Houston, TX

"...As one who worked closely with Dr. Foster at Meharry Medical College for almost 12 years, I believe I know Dr. Foster well as a human being and a professional ... Let me again say that I agree with all of those who have so enthusiastically spoken out in support of Dr. Foster's nomination. He is indeed a special human being – in his intellect, fairness, integrity, talent as a medical professional, and as Americans have most recently witnessed, his fortitude is exceptional" [This statement is four pages long and filled with positive remarks].

-- Dr. David Satcher, Director of the Centers for Disease Control and Prevention

"As a young faculty member some fifteen years ago at the University of Illinois in Chicago, I had the responsibility for medical student education in obstetrics and gynecology. A troublesome issue for me was the learning problems faced by Afro-American medical students. Early on I came to learn of Dr. Foster's expertise and I approached him at a national meeting ... Dr. Foster took time then and in subsequent meetings to share some of his knowledge and experience. This was one of the pivotal early experiences in my career; first, because of the invaluable information which he provided, and second, because of the role model I observed in Henry Foster: unassuming, quiet, competent, caring."

-- Charles R.B. Beckman, M.D., M.H.P.E., F.A.C.O.G., Kansas City, MS

"Dear Dr. Foster: I am a private solo practice pediatrician in Puyallup, Washington located thousands of miles from Nashville. Your influence has had a positive impact upon physicians in our community. We commend you for your efforts to reduce the spread of teenage pregnancy. We believe your philosophy of approach is proper and our community would stand behind any national effort led by you to help our adolescents."

-- DeMaurice Moses, M.D., Puyallup, WA

"Senator Kassebaum, Dr. Foster represents what all good obstetricians and gynecologists should be. He is the doctor I want for my daughter and granddaughters."

-- Melvin Gerbie, M.D., President, the Central Association of Obstetricians and Gynecologists

Los Angeles Times
February 19, 1995, Sunday, Home Edition

HEADLINE: TUSKEGEE STILL HOLDS DR. FOSTER IN ITS HEART

BYLINE: By RICHARD A. SERRANO, TIMES STAFF WRITER

BODY:

Dr. Henry W. Foster Jr. saved the life of the mayor's infant son. He talked a scared and confused Joyce German out of an abortion. He ran a network of prenatal clinics that persuaded young, poor women to abandon their midwives. And he delivered babies.

"Oh, the babies," recalled his nurse, Thelma Walker-Brown. "Lots of babies. Babies, babies, babies."

He was just out of medical school when he came to Tuskegee. Young, ambitious, trained in modern medicine. Among the poor, the uneducated and the sick living on the red clay soil of east-central Alabama, among the women who didn't know or couldn't afford to call a doctor, Foster was the best they had.

This was Alabama in the 1960s, a time and a place unlike the world today, long before the President of the United States would summon Foster to become the nation's surgeon general.

So great is the contrast between the political maelstrom of Washington and this community -- and what Foster meant to it -- that people in Tuskegee find it hard to grasp how the life of the "Dr. Hank" they grew to respect could be reduced to a question of how many abortions he may have performed in three decades of medical practice.

Indeed, the portrait of the young doctor that emerges in the recollections of old colleagues and others here serves as a sharp example of just how tortured the nation's struggle over abortion has become.

He is remembered in Tuskegee as the town "baby doctor" who, before Roe vs. Wade, performed abortions only in the rarest emergency of having to save a mother's life. As former colleague Dr. Thomas Calhoun said, he was not "an abortionist who works in an abortion clinic and all he does is abortions. . . ."

In the politics of this issue today, such distinctions tend to lose any meaning. Since Foster first acknowledged doing a small number of abortions, and later revised his estimate to 39, his chances of winning Senate confirmation next month have been in grave doubt.

Opponents do not argue that Foster did nothing good; those for whom abortion is an issue of uncompromisable morality believe that he was part of one thing so bad that

nothing else matters. And some contend that the Clinton White House's bungling -- particularly its failure to give an accurate, forthright account of Foster's record at the outset -- has contaminated the nomination process beyond repair.

Those arguments may be the ones that determine Foster's fate as a candidate for surgeon general.

But they seem remote to those who remember how he labored to open the rural poor to the advantages of preventive medicine. How, through his satellite clinics and other outreach programs, Alabama women learned to take better care of themselves and their unborn children.

When Foster was back in Tuskegee last year to address a conference on rural health care, he reflected on the work he and his staff had done.

"I spent nine years of my life here in this most unique community," he said. "We were ahead of our time."

The native of Pine Bluff, Ark., who served in the Air Force as a medical officer, came here in 1964 as the lone obstetrician-gynecologist at the John A. Andrew Memorial Hospital -- a 180-bed, three-story brick facility on the campus of the famed Tuskegee University.

He was an African American doctor serving a black population. Tuskegee was about 87% black, as it remains today, and so were the vast majority of cottonseed farmers and loggers in the surrounding Tuskegee National Forest east of Montgomery, Ala.

The median income when Foster arrived here was less than $2,500 a year. In the five-county rural area, families went without electricity, telephones and, in some cases, running water. Without jobs or education, how could you tell them modern health care was more important?

Foster took over for Dr. Joseph Mitchell, whom townspeople remember as overworked and stressed and who one day died of a heart attack.

"So Dr. Foster came in and he had all these pressures and he said he wanted to do it all," Walker-Brown said. "He said he was young and he could do it all."

His average caseload ran into the hundreds. He sometimes delivered three babies a day. In truth, the number of infants delivered under Foster's care simply cannot be counted.

Louis Rabb, administrator of the hospital before it closed in 1987, when too many charity cases drained its resources, remembered: "It was a tremendous number of babies. Probably thousands of them."

Taking in patients from Macon, Bullock, Russell, Lee and Elmore counties, Foster expanded Mitchell's program of women's clinics in the rural areas. Friends say he spent afternoons in his Chevrolet Corvair, driving out into the countryside and teaching young women how to care for themselves properly.

The task was often daunting, his colleagues say. Women would wait the full nine months before they called a doctor, if they called one at all. For generations they had gone to a network of midwives operating throughout the region.

Foster sometimes found himself performing emergency surgery to repair a crudely done abortion. Or trying to save women with advanced eclampsia -- a disorder that may occur late in pregnancy -- who were rushed to his hospital in convulsions or already in a coma.

"It's hard to even visualize now," Walker-Brown said. "Women didn't have running water. They didn't have indoor toilets. They didn't have any stable income.

"They were the poorest of the poor. Women who didn't have anything. Women who didn't come to the hospital until the last minute.

"And they were brought here sometimes by lay midwives. They would physically bring them here. Or they'd bring them here with their premature babies. I mean, they'd put those babies in boxes with hot water bottles and bring them to us and ask us to save their lives."

Against this backdrop was the matter of race. The local hospital served only whites, except for a few black emergency patients that it took in and assigned to rooms normally used as closets. So the John A. Andrew Hospital became a mecca for Alabama blacks.

During Foster's time here, Tuskegee, like much of the South, underwent a metamorphosis.

There were civil rights demonstrations on the Tuskegee University campus. A young black man named Sammy Young was shot to death by a white assailant at the town bus depot in an incident that sparked protest marches. Voter-registration gerrymandering that shut blacks out of the polls was overturned by the Supreme Court.

Then the year before Foster left, Johnny Ford became the first black mayor of Tuskegee -- an office he still holds. In front of the Confederate statue that graced the town square, he placed a red-white-and-blue sign proclaiming: "Welcome to Tuskegee, Pride of the Growing South."

Ford said he also feels deeply indebted to Foster. The doctor saved his son's life.

Before he became mayor, Ford worked in New Orleans. His wife, Frances, who was pregnant with their first child, developed complications. They quickly returned to Tuskegee and Foster's care.

"She was bedridden for a while because she was carrying the child low and if she stood up it would cause her to go into labor. It was a very delicate situation," Ford said.

"It turned out he had to deliver the child early, and it took his skill to know when to take the child at exactly the right time."

Later, when Ford became mayor, Jet magazine put him on the cover with his wife and son. Foster liked to point to John Jr.'s picture and tell everyone: "That's my boy." Ford says to this day: "I owe my son's life to Dr. Hank."

In her own way, Joyce German credits Foster with saving her child as well.

She was 20, a student at Tuskegee, unmarried and pregnant with her second child. She knew Foster from services at the Missionary Baptist Church here. One day she knocked on his door at the hospital.

"I didn't want to have another child," she said. "I asked for an abortion, but he refused. He said this child was a blessing to me. He said to have the child and it would turn out all right. Today I have a beautiful daughter who went on to become the valedictorian at her high school."

But also while in Tuskegee, Foster did come under criticism for his efforts to spread the use of birth control. At that time in the rural South, many suspected that the white power structure was pushing birth control as a way to curb the number of black births, and maybe to kill off the black race altogether.

"There has been an outcry by various groups that the intent of family planning is black genocide, and that the ultimate effect will be black genocide," Foster said in a speech while still in Tuskegee.

But he argued that acceptance of more birth control measures would only enhance the black population in Tuskegee, and bring it in line with modern life in the rest of the nation.

It was a delicate line for Foster, but one his colleagues said he balanced well.

"He was well-educated, but when he was with the people down here, he didn't set himself up in an ivory tower," said Dr. Calvin R. Dowe, who worked with Foster at the John A. Andrew Hospital.

Added Dr. Calhoun: "With Hank, we got a whole new dimension."

So when people in Tuskegee remember the good that Foster tried to accomplish, it becomes all the more troubling when they see the furor over his selection as surgeon general.

His uncle, William B. Hill, a 90-year-old retired farm extension service agent, saw his nephew come to Tuskegee and move on, and said he cannot understand what people would want in a surgeon general if not someone like Foster. Nor can his wife, 92-year-old Sadie Hill.

"We were all real poor people when Hank was here," Sadie said. "We were just people who needed help. He helped us."

SHOW: *All Things Considered* (NPR 4:30 pm ET)
February 17, 1995

HEADLINE: Dr. Foster's Work in Nashville Praised

GUESTS: WILLIAM HARVEY; PHIL BREDESEN; JOHN MAUPPIN; ELWIN GRIMES; JOE JENKINS: TANYA RUTLEDGE; FRANK GIBSON; BILL BOMGARDNER; AVON WILLIAMS III; INEZ CRUTCHFIELD; Rev. SHERMAN TRIBBLE;

BYLINE: JOANNE SILBERNER

HIGHLIGHT:
Dr. Henry Foster's work in Nashville, Tennessee with teen programs and upgrading the Meharry Medical College, brings praise from those who know him. He is known as a quiet, unassuming doctor.

BODY:

NOAH ADAMS, Host: For the last two weeks, President Clinton's nominee to be U.S. Surgeon General, Dr. Henry Foster, has been in the middle of the controversy. It centers on procedures he did as a gynecologist, hysterectomies on retarded women, and abortions. Dr. Foster has said he wants the chance to tell Congress, and the American people, who he really is. A poll this week showed that even though Americans may not be clear about that, more support the nomination than oppose it. NPR's Joanne Silberner visited Dr. Foster's home town, Nashville, Tennessee, this week, to find out what people there think about it.

JOANNE SILBERNER, Reporter: If you want to know about Henry Foster, go to Meharry Medical College where he spent 21 years teaching medical students, taking care of patients, and as an administrator. At Meharry's Hubbard Hospital, workers have ripped out most of the walls and ceilings. Here on the fifth floor, the water pipes, the electrical lines, the heating ducts are all exposed. Hubbard Hospital has just begun an 18-month renovation.

WILLIAM HARVEY, Meharry-Hubbard Hospital Administrator: It will be a 150-bed hospital, completely renovated throughout, all new equipment. It'll be- it'll be a gorgeous new hospital for the city of Nashville.

JOANNE SILBERNER: Hospital administrator William Harvey shows us around what will be the pediatrics ward. The renovation is the final step in a bitterly contested merger between Meharry's Hubbard Hospital and Nashville's General Hospital, a merger that's happening largely because of Henry Foster.

While the merger will save the city money, it means closing down the white-run public hospital and bringing patients and city money to black-run Meharry - something some

people in Nashville didn't want. The city went through months of public hearings on the merger. Republicans and Democrats both credit Foster with being able to bring all sides together. He worked behind the scenes in closed-door meetings, keeping people talking. Nashville mayor Phil Bredesen says Foster's quiet style worked.

PHIL BREDESEN, Mayor of Nashville, Tennessee: He has a very nice, low-key way of getting things done. What I found was that- that in a very political environment, which things like this merger were, he had a way of getting things done without being overtly political, that his kind of quietness and conservatism and competence was a very- it just was just a very politically effective approach.

JOANNE SILBERNER: For the merger to proceed, Meharry had to prove that highly qualified doctors would want to come to work here. John Mauppin [sp], head of Meharry, says it wasn't easy.

JOHN MAUPPIN, Meharry Hospital: Dr. Foster led that recruitment and brought some outstanding physicians from around this country who were dedicated to the mission of Meharry to serve the underserved and were willing to come to Nashville, Tennessee and work at General Hospital, even in the old facility. Most people didn't believe that we would be able to recruit people like that.

JOANNE SILBERNER: There are lots of reasons doctors might not want to come to Meharry. Some of the patients can't pay their doctors' bills at all, and many patients' bills are paid at low government rates. The medical school doesn't own a lot of fancy machines and didn't have enough patients to maintain accreditation for some of its teaching programs, and the emphasis here is on primary care, not the highly-specialized medicine that many doctors find more interesting. But Foster was able to meet the city's requirement of 56 doctors. One of the doctors who came was obstetrician-gynecologist Elwin Grimes [sp].

ELWIN GRIMES, Obstetrician-Gynecologist: First of all, he told me that he was going to present me with a challenge that would be one of the most difficult of my whole life. All right, and then he described the need that existed here, and from there, we got into discussions that have to do with what's important in regard to the contributions that we make as physicians. What are the things that we all do that make a difference?

JOANNE SILBERNER: What Foster is most known for in Nashville and what was supposed to sell him to the Congress is a local program called 'I Have a Future.'

JOE JENKINS, 'I Have a Future' Instructor: OK. Once again, welcome to family life education. Once again, for those who may have forgotten from week-to-week, I'm Joe Jenkins.

JOANNE SILBERNER: Twenty-five teens are sitting, boy-girl-boy-girl, in a classroom in a Nashville high school. It's an after school program Foster started eight years ago for teenagers from two city housing projects. Every day Joe Jenkins starts the class the same way.

JOE JENKINS: OK. Everybody understand this is a teen pregnant prevention program? Everybody understand the best way to prevent pregnancy is-

STUDENTS IN CLASS: Abstinence.

JOE JENKINS: Abstinence. Once again, always understand, no matter what you hear from everybody else, there are more people not having sex than there are having sex.

JOANNE SILBERNER: It's not just abstinence, the program also teaches birth control methods and sexual responsibility, something that conservatives raised concerns about the first day after Foster's nomination. But the focus of the program is life skills; teaching the teens how to conduct themselves in job interviews and on the job, having them run a small business, tutoring, taking them on trips, that sort of thing. The idea is to teach the teens that there are better ways to get attention than having a baby.

Tanya Rutledge [sp] is 17. She's been in the program eight years.

TANYA RUTLEDGE, 'I Have a Future' Student: I plan to graduate this year and go to college, and I want to own my own beauty shop.

JOANNE SILBERNER: If you hadn't been in the program, what do you think your life would be like?

TANYA RUTLEDGE: I think I would probably be like my other friends which have children or they're about to have a child.

JOANNE SILBERNER: What would that kind of life be like?

TANYA RUTLEDGE: It would be awful because I wouldn't be able to go to college and make the kind of money that I want to make.

JOANNE SILBERNER: More than 800 teens have gone through the program since Foster started it. There are no hard statistics on how well the program is doing, but during one 30-month period, only one girl got pregnant - much lower than in the past. In some circles, like the housing projects and the local medical community, Henry Foster is a hero. But citywide he is not that well known. Frank Gibson, political editor of one of Nashville's newspapers, The Tennessean, didn't expect even the nomination or what followed.

FRANK GIBSON, Political Editor, The Tennessean: I would- I would say that I was surprised, but only because I- I would not have thought about it. You know, he just did not have a very high profile in this community. No, you know- no controversy, certainly that this newspaper has known about and written about.

JOANNE SILBERNER: The national controversy over abortion, that started after the president named Foster, hasn't cost him support here. Gibson says the local community

is continuing to back Foster. There were no major questions about the hysterectomies Foster performed on retarded women. The only opposition in Nashville to Foster's nomination seems to come from people who don't know him personally. They, like some national leaders, strongly object to the abortions he's done. Bill Bomgardner [sp] leads the local chapter of an anti-abortion group, the Christian Action Council.

BILL BOMGARDNER, Local Leader Christian Action Council: I certainly have no personal ill will to Dr. Foster. I just think it's a poor decision to put a pro-abortionist on as the top doc. There are certain things that disqualify you, and this is one of those issues. Killing people is sort of permanent.

JOANNE SILBERNER: But not all abortion opponents feel that way. Avon Williams III [sp] is the son of the first African-American state senator in Tennessee, and has known Foster his whole life. Foster nursed Williams' wife through a tough pregnancy and delivered his daughter. Williams is a Republican, a member of the Christian right. He thinks abortion should only be considered when the mother's life is at stake. Williams says Foster shouldn't have done any abortions, but that all the other things that he has done would make him a good surgeon general.

AVON WILLIAMS III, Acquaintance of Dr. Foster: If you're going to make this a referendum on abortion, and on doctors who perform abortions, Hank Foster is probably the worst choice you could possibly make. I mean, from a standpoint of political strategy, as a pro-lifer, Hank Foster is not- would not be the guy I'd be trying to bring down. Hank Foster has not been an abortionist. He's been promoting life most of his career. Why would we choose somebody like Hank Foster to vilify? It just doesn't make sense to me.

JOANNE SILBERNER: On a cold and rainy Wednesday evening, the male chorus at the First Baptist Church on Nashville's Capitol Hill is rehearsing. Down the hall, the pastor Reverend Sherman Tribble [sp] has gathered a few people together to talk about Henry Foster. This is Foster's church. He's been a member since he arrived in Nashville in 1973. The congregation strongly supports him. Inez Crutchfield [sp] is a church member and a patient of Dr. Foster's.

INEZ CRUTCHFIELD, Patient of Dr. Foster: Because of him, I frequently say, 'I am alive today.' Because it was Dr. Foster who discovered that I had cancer at a very early stage, and it was Dr. Foster who did the surgery.

JOANNE SILBERNER: Crutchfield says she was thrilled when she heard her doctor had been nominated as surgeon general. But the political battle that began soon after upset her.

INEZ CRUTCHFIELD: I was very angry. I was just furious, to be very frank with you. That anyone would question- having known him as well as I did, I could not imagine persons questioning his professionalism, his reputation here, in Tennessee, in this city, was without blemishes, far as I- I would know.

JOANNE SILBERNER: Foster came back to the church last weekend. Reverend Sherman Tribble says he's in good spirits, his faith challenged, but not shaken.

Rev. SHERMAN TRIBBLE, Pastor, First Baptist Church: Sunday when we looked at our New Testament lesson, one of the verses from Luke, Chapter 12 said that, when persons come before the authorities to be tried, don't spend a lot of time concocting answers. Rely on the spirit, or the Holy Spirit to guide you. And as he looked at that particular verse, when we were leaving the service, he just kept pointing to it. He'd say, 'Reverend, that's it. That's it. That's it.' And, I guess, for him it said that, when I get a chance to present my views in the public forum, it'll be all right.

JOANNE SILBERNER: Foster began presenting his views this week. He spent two days on Capitol Hill in Washington, talking to senators, looking for the same kind of support he's gotten from his community. This is Joanne Silberner reporting.

Foster treatment angers Charlotte woman

Profile of her former doctor 'one-sided,' she says

By RICKI MORELL
Staff Writer

Jeannette Hight was 3½ months pregnant when she began bleeding in the middle of the night. Frantic, she called her obstetrician at home.

"He met us in the hospital in his bedroom slippers," Hight recalls.

With her doctor's careful help, Hight averted a miscarriage. That was more than 25 years ago. The boy who was born that December 1969 is now grown and married.

The place was Tuskegee, Ala. And the doctor was Henry Foster, President Clinton's nominee for surgeon general.

Hight, 57, who has lived in Charlotte for 19 years, wants the nation to know that the man who saved the life of her only child is no "abortion doctor."

She remembers Foster as a compassionate man committed to ushering in new life.

"What I've heard is a one-sided story," says Hight, director of Charlotte's Plaza Presbyterian Church day care center. "I haven't heard anything about all the lives that came into this world because of him. He is a man of great integrity."

Foster, 61, former acting president at Meharry Medical College in Nashville, worked at John A. Andrew Hospital in Tuskegee from 1965 to 1973.

Jeannette Hight and her husband moved to Tuskegee in 1965 from Baltimore. Charles Hight had been asked to start the architecture school at Tuskegee Institute. He is now dean of UNC Charlotte's school of architecture.

"My husband and I have both been very angry about what has been happening to Dr. Foster," Hight says. "My husband has con-

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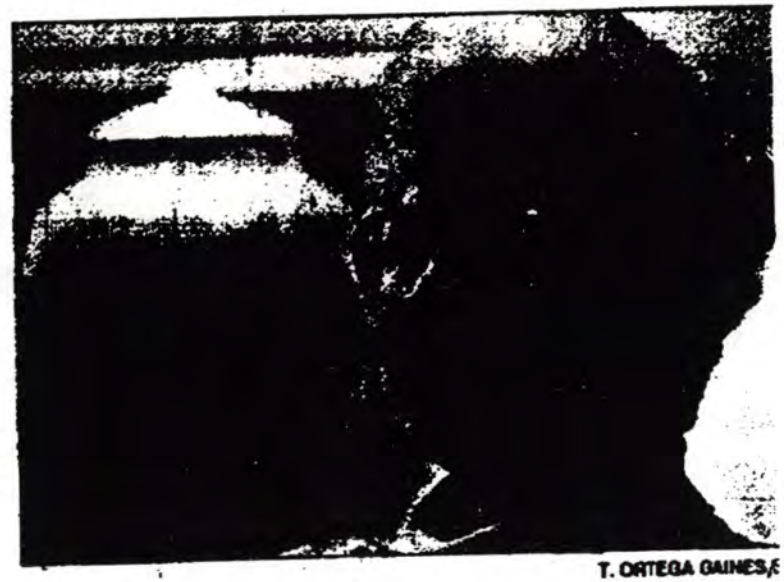
CRITICS OF FOSTER AREN'T EASING UP/PAGE 2A



T. ORTEGA GAINES/S

Jeannette Hight remembers surgeon general nominee Hen Foster as committed to ushering in life. He was her doctor Alabama 25 years ago and saved her from a miscarriage.

Treatment of surgeon general nominee angers Charlottean

Foster

Continued from page 1C

tacted all of our legislators. I've told everybody I know."

Clinton administration officials chose Foster because of his moderate views and impeccable medical reputation. But soon after they announced his nomination Feb. 2, anti-abortion activists attacked Foster because he had performed abortions. Clinton promises to stand by his nominee despite growing opposition.

Foster has defended a woman's right to an abortion and stressed that most of the abortions he performed were in cases of rape, incest or medical necessity.

Hight hadn't thought about Foster in years until she saw his picture in the paper 10 days ago. "I was just so excited for him," she says.

As the days passed, Hight says she watched the image of her doctor turn into a caricature of an "abortion doctor."

"That wasn't the doctor that I knew," Hight says. "I knew him as a doctor who would work as hard as he could to save a life. He was always available. He was easy to talk to. He didn't rush you in and out of your appointment. He was reassuring. And very calm."

Hight isn't a Clinton supporter — she's a registered independent who voted for Ross Perot. She supports Roe vs. Wade and a woman's right to choose an abortion. But she says, "I'm a pro-life person myself. For me, I could not have an abortion. For me I believe it is taking a life."

Hight is a member of St. Peter Catholic Church and worries she might be condemned for supporting abortion rights because the church opposes abortion.

"But I feel like it's the right thing to do," she says. "I don't care. I just feel like somebody had to say something for Dr. Foster."

Hight cared for Foster's children when she ran Tuskegee's preschool program. Her husband designed Foster's house in Tuskegee. When the Hights found out they were going to have a child, they asked Foster to be their doctor.

It was a difficult pregnancy. At six months, Hight went into early

T. ORTEGA GAINES/Staff

Jeannette Hight of Charlotte says surgeon general nominee Henry Foster is "a man of great integrity." He was her doctor in Alabama 25 years ago and saved her from a miscarriage.

On Dec. 27, 1969, Hight went to see him for her regular checkup. After he examined her, he said, "Woman, don't you know you're in labor?"

Her husband was home working. "Call Charlie," Foster told her. "You're not going home."

Three hours later, Christopher was born.

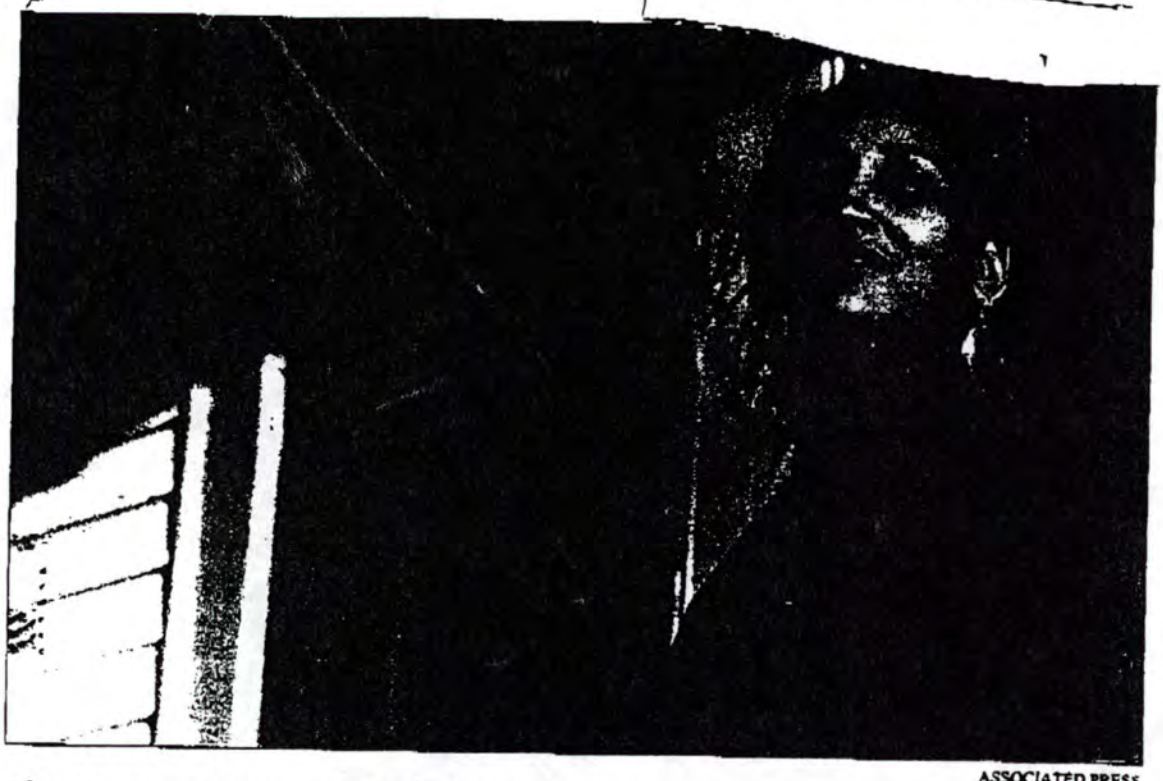
"He was a healthy boy. I was so excited we had a child," Hight says. "Dr. Foster had given us so much joy."

Until the abortion controversy, Foster was known for his efforts fighting teenage pregnancy. He founded a national program — "I Have a Future" — that was recognized by the American Medical Association and by President George Bush as one of his "thousand points of light."

On Friday, Foster noted to a group at George Washington University that his nomination fell on Groundhog Day and that he feels "a little bit like that groundhog."

"Ever since Feb. 2 . . . the descriptions of myself and my work that I have read in the papers and seen on TV have cast an unrecognizable shadow of the man I really am. Yes, I see a shadow, but it's not my shadow."

"A nomination like this should be above politics," she says. "I hope Dr. Foster will stick with it. I hope he will actually be our surgeon general. But I wouldn't hold it against him if he didn't want to be it anymore."



ASSOCIATED PRESS

Joyce German, 45, shown at her Tuskegee home, says surgeon general nominee Henry Foster refused to perform an abortion for her more than two decades ago.

Alabama woman says Foster refused her abortion request

Indebted: The woman's daughter says she owes her life to the embattled surgeon general nominee

THE ASSOCIATED PRESS

TUSKEGEE — A former patient of Dr. Henry Foster Jr. said the embattled surgeon general nominee once refused her request for an abortion, counseling instead that the unborn child was a "blessing."

Joyce German told the *Birmingham Post-Herald* in a story published Friday that critics of Dr. Foster are wrong for attempting to portray him as an abortion doctor.

"To even classify him as that ... was silly, it was ridiculous," said Ms. German, a laboratory scientist in Tuskegee, where Dr. Foster worked as an obstetrician from 1965 to 1973.

Ms. German's 23-year-old daughter said she owes her life to Dr. Foster's treatment of her mother more than two decades ago.

"If he hadn't said what he did, I wouldn't be here," said Anisha German, a doctoral candidate in behavior and neuroscience at the University of Alabama at Birmingham. "I guess he did save my life."

A Senate committee is expected to begin confirmation hearings soon on President Clinton's nomination of Dr. Foster to replace fired Surgeon General Joycelyn Elders, a longtime friend of Dr. Foster.

Abortion has been an issue in the nomination because of varied accounts of the number of abortions Dr. Foster performed as an obstetrician-gynecologist.

The doctor's admission that he had performed any abortions also became a point of contention. Abortion opponents contend no one who has performed the procedure should serve as surgeon general, while Foster supporters say he performed abortions only when medically necessary and generally opposes the procedure.

Ms. German said she and her husband were struggling to get through what is now Tuskegee University and care for an infant daughter in 1970 when she found out she was once again pregnant. They are no longer married.

Ms. German said she went to see Dr. Foster, her obstetrician and gynecologist, hoping he would terminate the pregnancy.

"He said, 'You can handle this,' " Ms. German, 45, told the newspaper in an interview this week. "'This child is a blessing to you. I'm not going to do anything to stop that.'

"I was hoping he would see it my way and say, 'Well, however you feel.' But he didn't blink. He would not do it."

Dr. Foster and Credibility

- Dr. Henry Foster's career in medicine has been a model of integrity and commitment to ethical conduct.

- It is, by now, well known that Dr. Foster has devoted his 38 years of practice to improving the health care of mothers and babies, reducing teenage pregnancy and caring for those who too often go without care.

- What may be less well known is that Dr. Foster has been recognized by his peers, time and again, as a leader in his profession, a man of unusual stature, a physician whose judgment is trusted in grappling with the ethics of medicine and medical practice. If the truest test of professional character is the esteem with which one is held by his colleagues, Dr. Foster stands in the top rank.

- <u>The Institute of Medicine</u>. Dr. Foster has served on the prestigious Institute of Medicine since 1972. The Institute was chartered in 1970 by the National Academy of Science to promote the advancement of the health sciences and the improvement of health care. The Institute was designed to enlist distinguished members of the medical and other professions in pursuit of these goals.

- The Institute is a highly selective professional body, with only 500 regular members, each of whom must be nominated by a current member and elected by the full membership. The Institute is governed by a Council of just 21 members, elected by the entire membership.

- In 1992, the full membership recognized Dr. Foster's distinguished service for the Institute -- where he has served on numerous committees and boards -- by electing him to the governing Council. The membership elected him to a second term on the Council in November 1994.

- <u>The Ethics Advisory Board</u>. In 1978, then HEW Secretary Joe Califano created the Ethics Advisory Board to examine the moral and ethical questions raised by the historic breakthroughs being made in the world of medical science. He appointed Dr. Foster as one of the Board's 15 members from a large group of nominations submitted by professional associations, scientific societies, public interest groups and Members of Congress.

- The Board was an extraordinary collection of doctors, lawyers, clinicians, researchers and even a leading theologian, Rev. Richard McCormick of Georgetown University. Members included James Gaither, a former advisor to President Johnson and subsequent President of the Stanford University Board of Trustees; Dr. David Hamburg, a former

President of the Institute of Medicine and now President of the Carnegie Corporation of New York; Dr. Daniel Tosteson, Dean of the Harvard Medical School for the past 20 years; and Dr. Sissela Bok, Harvard ethicist and philosopher.

- The Ethics Advisory Board was active from 1978 to 1980. In 1980, Congress established its own commission on medical ethics (the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research) and the EAB's appropriations were shifted to this new body.

- Nashville Academy of Medicine -- Ethics Committee. Dr. Foster is one of 10 members of the 1400-member Nashville Academy of Medicine who serve on the Academy's Ethics Committee.

- The function of the Ethics Committee is to act as a tribunal for the discipline of Academy members when complaints are received by other physicians concerning a member's professional conduct.

- According to the Academy's Executive Director, Dr. Foster was chosen by the Board of Directors to serve on the Ethics Committee because of his "outstanding reputation in the medical community." Dr. Foster has served on the Committee for 10 years.

- In short, those opponents of Dr. Foster's nomination who pretend to base their opposition on his lack of credibility or integrity are flying in the face of a career's worth of honorable and distinguished conduct, recognized as such by Dr. Foster's professional colleagues and peers.