Nomination of Henry W. Foster, Jr.

May 2, 1995

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STATEMENT BY SENATOR BILL FRIST ON DR. HENRY W. FOSTER, JR.
May 26, 1995

Last November, the people of Tennessee elected me to make difficult decisions. And this has been a decision I've struggled with. I know that thoughtful people honestly and fundamentally differ on whether Hank Foster should be Surgeon General.

What makes my statement different from those you have heard today? I know Hank Foster. I know him as a fellow Tennessean. I know him as a fellow physician and colleague, who worked 4 miles from my office. We are both members of the Nashville Academy of Medicine, on whose Ethics Board he has served. And I know him as a fellow Nashvillian, who has done what few physicians do -- step out of the clinic into their community to address the really tough problems in our society.

Since February 2, the day the President announced his choice, I've listened carefully to every conceivable argument for and against the nominee. And over the past 3 months, I've done my very best to remain neutral -- neither to blindly endorse Hank Foster because he is a fellow Nashvillian, nor to condemn him because of allegations drawn from the attics of his past. I have waited until final testimony was submitted just last Friday so that I could thoughtfully, and carefully, consider every aspect, every ramification, of his nomination. Several days ago, I again met with Hank Foster -- one-on-one, face-to-face -- to specifically and directly ask him about his plans as Surgeon General.

I asked him the tough questions. Would he be like his predecessor, Dr. Elders? Would he allow himself to be used as a political tool for an out-of-step President, who time and time again has promoted radical agendas? Or would he represent mainstream America and family values?

Dr. Foster told me, without hesitation, that his number one goal was to reduce teen pregnancy -- a problem that we as a people have done a miserable job addressing. It's a problem that literally threatens the very fabric of America. His approach? He looked me straight in the eye, and said "number one, build self-esteem; number two, promote abstinence; and number three, instill family values."

He told me that the other main issues on his agenda would include screening for breast cancer and prostatic cancer, addressing the AIDS epidemic, and teenage smoking. Dr. Foster stressed to me that he places primary emphasis on family, that he understands the importance of leading by building a consensus, and that he understands that his agenda as Surgeon General

must appeal to, and be embraced by, mainstream America.

Madame Chairman, many have told me that this nomination is no longer about Hank Foster, the man. They say it's about the inept way in which the Administration has handled his nomination. They say it's about the tardy and roundabout manner in which information has been provided to this Committee and to the American people. They say it's about a radical social agenda that is beyond the bounds of mainstream America and traditional values.

But, I don't buy it. I guess as a newcomer to this body, I see it all very differently. I believe it is about Hank Foster, the man -- the man who has delivered thousands of babies into this world; the man who has committed his life not to making money, not to promoting himself, but to serving others' needs; the man who has cared for and nursed to health thousands of women; the man who in addition to the practice of medicine, has courageously and unselfishly stepped out into his community to give others a chance to step out of a world of poverty; and the man who 4 days ago, looked me in the eye and described a fundamental commitment to the principles of self-esteem, personal responsibility, and family values.

As I stated at the Committee hearings, it should not be our purpose to search for every possible mistake or imperfection in Hank Foster's life. The question before us is a much more narrow one: does this man have the commitment, the intelligence, the training, the honesty, and the integrity to be the chief spokesman for Americans on matters concerning public health? These are the issues that I've considered, and I'm satisfied with what I've seen and heard.

Having known Hank Foster as a fellow Tennessean, having heard his testimony, having had the opportunity to talk to him extensively face-to-face, and having considered every aspect of his nomination very carefully, I believe his nomination should be referred out of Committee favorably and brought before the U.S. Senate And I also believe we should move forward with this process. We've got a lot of important business to attend to and the American people want this Congress to press on.

Madame Chairman, I think it is also important to mention, as I did in the Committee hearing, my belief that this confirmation process is not the place or the time to revisit our national policy on abortion. Americans of conscience will remain deeply divided over this issue regardless of who is appointed Surgeon General. It's important to remember that the office of Surgeon General does not set social policy, nor convey with it the right to vote on any legislation -- whether affecting abortion or otherwise. When this body confirmed Dr. C. Everett Koop as Surgeon General, a staunch opponent of abortion, that confirmation did not outlaw abortion. If this body confirms Hank Foster, that confirmation won't condone abortion.

No doubt, the unfortunate events that immediately followed Hank Foster's nomination cast a shadow on his viability to be Surgeon General. Conflicting information raised questions about his credibility. I, too, was angered that the Clinton Administration had badly mishandled yet another nomination by failing to adequately prepare Dr. Foster -- a physician who had never had to face such aggressive public scrutiny.

Questions arose about Dr. Foster's ability as an administrator, his involvement in 4 hysterectomies performed 25 years ago, and his knowledge of a study on black men conducted over a 40 year period in rural Alabama. These issues concerned many, and each and every one concerned me. But, I believe that Hank Foster's testimony, evidence submitted to the Committee, and my own one-on-one interviews with him, put to rest those concerns.

Dr. Foster, I feel, came through the hearing process with his credibility and integrity intact, and with his qualifications to be Surgeon General apparent.

In the end, when people ask me why I support Hank Foster's nomination, I'll tell them simply because he's qualified to carry out the duties of Surgeon General. I am confident that he will perform his job well.

Finally, Madame Chairman, I ask my colleagues to consider this nomination, not based on politics, but rather on qualifications and ability. In the past, the Democrats have so often brought politics into the equation -- we all remember the nominations of John Tower, Robert Bork and Clarence Thomas. I wasn't here, but as a private citizen, I recall the anger I felt and the disappointment in the process. Let us not make the same mistakes. The American people are tired of politics as usual -- that was the message of November 8.

For that reason, I urge all of my colleagues to view this candidate away from the distractions and the hype of political expediency, and without regard to who nominated him. Rather, look at his accomplishments, his qualifications, his statements, his goals, and the testimonials of others who know him.

And then -- based on serious reflection -- make your decision.

I've done that, and I choose to support Dr. Henry Foster.

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DRAFT

DR. HENRY FOSTER AND HIS RECORD ON ABORTION

Dr. Henry Foster is one of the nation's leading physicians and medical educators. During his 38-year career as an obstetrician/gynecologist, he has delivered thousands of babies and instructed hundreds of young physicians. From 1990-93, Dr. Foster served as the Dean, School of Medicine, Meharry Medical College in Nashville, after having served as the Chairman of the Department of Obstetrics and Gynecology and Chief of the Obstetrics Unit of the Hubbard Hospital for seventeen years. Before coming to Meharry, Dr. Foster served as the Chief of Obstetrics and Gynecology at the John A. Andrew Memorial Hospital at Tuskegee Institute, Alabama, where he also established and was the Director of the Maternity and Infant Care Project. In these programs and through the creation of the "I Have a Future" Program in lower-income areas of Nashville, Dr. Foster has worked to prevent unwanted pregnancies.

Much debate over the nomination of Dr. Foster to be Surgeon General of the United States has centered on the issue of abortion. Critics charge that Dr. Foster has promoted abortion, provided misleading accounts of his abortion practices, and has encouraged the development of drugs for abortion. This paper examines Dr. Foster's views on abortion, his practices, and his participation in a nationwide clinical trial funded by the Upjohn Company.

I. Statements and Writings

Critics contend that Dr. Foster has encouraged the use of abortion as a contraceptive and has promoted abortion in his speeches, writings and activities such as Planned Parenthood.

Dr. Foster has consistently advocated greater access to maternal and child health care, particularly for low-income communities. He also has encouraged both abstinence, as in the "I Have a Future" program, and family planning where appropriate.

However, he has explicitly disavowed the use of abortion as a contraceptive. In a 1975 presentation entitled "Family Planning and the Black Community," Dr. Foster voiced his belief that women should use birth control measures to prevent unwanted pregnancies, rather than rely on abortions.

Dr. Foster also has consistently supported adequate counseling for patients who are considering pregnancy termination. He has vocalized the need for informed consent for a patient to make this personal decision. As the account of one

former patient demonstrates, Dr. Foster has in fact counseled women not to terminate their pregnancy. [attach article?]

Dr. Foster's association with Planned Parenthood demonstrates his belief that Roe v. Wade struck an appropriate balance between the state's interest in health and the patient's interest in making a decision about her pregnancy. Dr. Foster has repeatedly voiced his concern that women be afforded their constitutional right to choose whether or not to terminate their pregnancies. He has stated that "abortions should be safe, legal and rare." In a speech to Planned Parenthood in 1984, Dr. Foster argued against overly burdensome state-imposed barriers to access to abortion, because they would have encouraged resort to unsafe, clandestine abortions.

Thus, an examination of Dr. Foster's statements, writings, and activities shows that he has supported access to abortion, but has not promoted the procedure as a substitute for abstinence, education or family planning.

II. Participation in Abortions

Dr. Foster has admitted that he made a mistake by guessing the number of abortions he performed without first consulting the medical records. To rectify that problem, he asked Meharry Medical College to search its records to determine the number of abortion procedures that he performed or participated.

As the attached letter from the General Counsel of the Meharry Medical College states, Meharry Medical College/Hubbard Hospital searched its records and found that Dr. Foster had performed or participated in 39 abortions during his tenure from 1973-1990. It should be noted that this period includes the entire post-Roe v. Wade era. Additionally, Meharry Medical College records indicate that for approximately three-quarters of these 39 patients, another physician or resident participated in or performed the abortion procedure.

The John Andrew Memorial Hospital in Tuskegee Institute has been closed for several years and records covering Dr. Foster's tenure were not available for a search.

III. Medical Research and the Upjohn Study

During the 1980's, the Upjohn Company sponsored an FDA-approved, multi-center clinical trial throughout the country to determine the safety and efficacy of a drug--methyl ester prostaglandin--for use in inducing abortions. Upjohn's study tested whether administering this drug in a suppository form could provide a safe and less expensive way of performing a legal, medically accepted procedure.

While Chairman of the Department of Obstetrics and Gynecology at Meharry Medical College and Hubbard Hospital, Dr. Foster served as the principal investigator for the Meharry site, one of numerous sites for the Upjohn study throughout the country. The clinical trial at the Meharry site was part of a research project conducted in an academic setting. All medical procedures were performed in the university hospital. All patients were volunteers who were legally approved for pregnancy termination in the State of Tennessee.

The clinical trial at the Meharry site was subjected to outside oversight and review. FDA regulations require that an institutional review board review and approve all clinical trials such as the Upjohn study. FDA regulations at the time required that the institutional review board consist of lay persons of various expertise and backgrounds. The Meharry site had such institutional review panels overseeing the Upjohn study.

Dr. Foster served as the principal investigator or grant administrator for the Meharry site. Residents administered the suppositories. As grant administrator, Dr. Foster did have certain responsibilities. FDA regulations specify that the duties of the investigator include ensuring the consistency of the investigation with the FDA-approved plan and applicable regulations, ensuring proper procedures are followed as well as protecting the rights, safety and welfare of those taking part in the clinical trial.

Dr. Foster published in 1985 an article summarizing the results of the administration of the Upjohn product to a group of 60 women who were eight or fewer weeks' pregnant. As discussed in the article, the study criteria for success included safety, efficacy and patient acceptability. Fifty-five of the women had successful results measured by these criteria; four women required hospitalization and follow up procedures. One woman withdrew from the study.

Dr. Foster's work as the principal investigator for the Meharry site was consistent with his responsibilities as Department Head to allow opportunities for research into methods for improving legal, medically accepted procedures. Such research projects also are consistent with the standards for accreditation of medical schools. Guidelines published by the Accreditation Council for Graduate Medical Education state:

> The quality of the educational experience within a department of obstetrics and gynecology is enhanced by an active research environment. It is highly desirable that every program encourage each resident to be involved in a research project.

Additionally, these guidelines provide that teaching staff should take part in scholarly activity, including research projects that result in publications.

As a postscript, it is worth noting that Upjohn eventually determined not to seek FDA approval for the drug that was the subject of the study.

DRAFT

ABORTION Q & A

MESSAGE: I am proud of my life and the choices I have made. My 38 year career as a doctor has been about bringing life into this world and helping our nation's youth achieve their full potential. I am not about abortion, although I believe strongly in a woman's right to choose. I believe abortion should be safe, legal, and rare. I have dedicated my life to trying to make sure none of my patients ever has to have an abortion.

I am also proud of my life-long record of integrity. In the 1970s, I was appointed to the Ethics Advisory Board of the Department of Health by Secretary Califano. I am currently serving my second term on the Ethics Committee of the Nashville Academy of Medicine -- a position that has to be voted on by my peers who have seen my every professional move for 20 years. When I first came to DC, I made a mistake which I sincerely regret by guessing in response to a question. I should have known I couldn't remember a 38 year career off the top of my head and I again apologize.

- I have dedicated my life to ensuring that none of my patients ever has to face that decision. When we discuss abortion, we enter the debate too late. We are already discussing a child that is not wanted. I want to get to teenagers before they have sex, before they get pregnant. My program for teens in Nashville's housing projects stresses abstinence and gives the teens positive options for their future so they delay sex and delay parenting until a more appropriate time.

- I believe in a woman's right to choose and think that a woman and her doctor -- not the government and not politicians -- should make these difficult decisions.

- I believe that abortion should be safe, legal, and rare. Safe and legal, because -- as a physician -- I've had to deal with the consequences of botched, back-alley abortions. Rare, because I believe in preventing unwanted pregnancies in the first place.

NUMBERS / CREDIBILITY

Q: How many abortions have you performed? Why do the numbers keep changing?

- Let me explain what happened. When I first started this process, I was asked, in the middle of a casual conversation whether I had ever performed an abortion. I said that I had and the one that I remember in particular involved a woman with AIDS. We went on to other subjects. A couple days later, I was asked if I had performed more than one abortion. I answered, "Yes. Most ob/gyns who have been practicing for as long as myself have performed abortions, which is a legal medical procedure." They asked me how many. And that's where I made a big mistake, Senator. I guessed. I relied on my memory from 38 years of medical practice and I was wrong. I regret that.

- Let me now be clear. So that I could give you a final, correct answer, I asked that the medical records from my twenty two years at Meharry Medical College be checked. Since I joined the staff of Meharry in 1973, I have been listed as the physician of record on 39 abortions.

Q: What about before that? Did you perform any abortions at Tuskegee?

- John A. Andrew Hospital -- where I worked while I was at Tuskegee -- did not provide abortion services. Our obstetrics department was not about abortion. In fact, we had a hard time getting women in for pre-natal care or to deliver their children. Most women did not come to us until late in the pregnancy and then if there was a problem.

- The only occasion where we would do a pregnancy termination was in a life threatening situation.

- I remember one occasion where this was necessary. A woman who had Meigs syndrome was rushed into the hospital in a traumatic state. She was dying and we rushed her into surgery. I had to perform an emergency hysterectomy to save her life. We discovered afterwards that she was in the early stages of pregnancy. I didn't think then and don't think now that was an abortion. It was an unfortunate termination of a pregnancy to save a woman's life.

Q: So you only did one?

- That is the only one that I remember.

Q: Is possible you did more – perhaps to gave the life of the woman again?

- I don't remember any others. I would be guessing and I have assured you I would not do that.

Q: Why didn't you check the Tuskegee records as you promised me in our courtesy call that you would?

- I have tried, Senator. As you may know, John A. Andrew Hospital, where I worked in Tuskegee, was closed 12 years ago and the records were put into storage. They were difficult to locate after all this time.
- When we finally did located them at Tuskeegee University, I consented -- and in fact requested -- to have them fully reviewed.
- The White House and HHS asked University officials to grant us permission to have professionals look through all the records from my 8 years there.
- The University President -- Benjamin F. Payton -- sent us a letter which I believe you have. After consulting with legal counsel, the University concluded that they could not grant access to the record due to legal concerns about patient confidentiality.

Q: [FOLLOW-UP Q&A ON TUSKEGEE] But Dr. Foster, you must remember if you performed even one abortion. I don't need the total, just give me an idea.

- Senator, I apologize but I cannot answer that question. It would be another guess. I did that when I first got to Washington and I made a mistake. I tried to answer from memory and I regret that. I don't want it to happen again.

Q: In the [date] HHS release where you claimed to have down "fewer than a dozen" abortions, you maintained that these were done only in the case of rape, incest, or to save the life of the mother. The first part was obviously incorrect, was the second as well?

- No Senator. As that statement says, the few abortions I have performed have primarily fallen under these categories.

- Let me tell you how I know this is true. You may know that most abortions take place outside of hospitals -- in clinics or other outpatient settings. Hospitals usually only provide abortion services for certain reasons, primarily health. If a woman came to me in the early stages of a healthy pregnancy and wanted to get an abortion, I would refer her to a service outside of the hospital. I never did performed abortion services outside of a hospital setting.

- The cases I did were therapeutic abortions, in the case of the life or the health of the mother or -- in very rare cases -- rape or incest. These are procedures done in a hospital.

*Q: **Why did you lie when you were first asked how many abortions you performed?***

- I did not lie, Senator. I am an honest man who is proud of my life-long record of integrity. I did make a mistake when I first got to Washington. I was asked that question and tried to answer from memory -- trying to remember my 38 years of practice. I regret that and I assure you that I won't let it to happen again.

*Q: **You have given several numbers in response to questions of how many abortions you've performed. You seem to have a credibility problem, Dr. Foster. Why should we trust you?***

- Because you should look at my record and my lifelong reputation of integrity. I was appointed to the National Ethics Advisory Committee for Secretary Califano-- Secretary of Heath under President Carter.

- I am currently serving my second term on the Ethics Committee of the Nashville Academy of Medicine. That appointment is actually more important than the national position because I was chosen by my peers -- who have had the opportunity to watch my every professional and personal move for over 20 years.

- I did give an incorrect answer at one point, Senator, and I regret it. I tried to answer from memory and made a mistake. But I can assure you, Senator, it was not out of any intent to deceive.

Q: [IF QUESTION AFTER QUESTION IS ABOUT NUMBERS] Why did it take you so long to provide an accurate estimate of the number of abortions you performed, and why the earlier discrepancies (first one abortion, then 12, then 39)?

- Part of it was miscommunication, and part of it was relying on my memory instead of hospital records. That was clearly a mistake -- which I regret.

- I am an obstetrician/gynecologist. As an ob/gyn, I offered -- and felt it was my obligation to offer -- women the full range of reproductive health services, including, on occasion, abortion.

- But more important, I am a baby doctor. That's what I'm about -- bringing life into this world. My hands have delivered thousands of babies. In fact, many times women came to me after being told that it would be impossible to bear their child to term, and I helped them deliver a healthy child. I call these my miracle babies; they are the reason I love being a doctor and am proud of what my life has been about.

- This debate is not about numbers. It's about a woman's right to choose. I happen to believe abortion should be safe, legal and rare. Safe and legal, because I've had to deal with the consequences of botched, back-alley abortions. Rare, because I believe in preventing unwanted pregnancies in the first place.

UPJOHN STUDY

Q: Aren't you really responsible for many more abortions? You have claimed responsibility for the Upjohn study which caused at least 55 abortions.

- Let me explain. As Chairman of the Department of Obstetrics and Gynecology, I was the principal investigator, or grant administrator, at Meharry Medical College for an FDA-approved clinical trial -- conducted in many medical centers throughout the country -- to test the efficacy and safety of an abortifacient suppository administered during early pregnancy. The trial was a research project conducted in an academic medical center, all medical procedures were performed in the hospital, and all patients were volunteers.

- I had responsibility for administering the contract. That meant that I administered the funds, assured that procedures were proper, and published results.

Q: Why did you do the study?

- I believe that abortions should be safe, legal and rare. I believe that when abortions are done, they should be performed in the safest manner possible. Therefore, as an expert in the field of maternal health, I support research into safer methods.

Q: Why did you say on Nightline that you had to do it for accreditation? This has since been widely disputed.

- My work as the principal investigator for the Meharry site was consistent with my responsibilities as Department Head to allow opportunities for research into methods for improving legal, medically accepted procedures. Such research projects also are consistent with the standards for accreditation of medical schools. Guidelines published by the Accreditation Council for Graduate Medical Education state:

> *The quality of the educational experience within a department of obstetrics and gynecology is enhanced by an active research environment. It is highly desirable that every program encourage each resident to be involved in a research project.*

Q: Do you support testing the "Morning After" Pill?

- I think abortions should be safe, legal, and rare. I support research that will make any medical procedure -- not just abortion --safer. As I understand it, the FDA is responsible for making the final determination in this case.

MORAL QUESTIONS

Q: Dr. Foster, if you are pro-choice – meaning you believe that a women can choose to have an abortion at any point – why do you consider an abortion a weighty decision? Why is it different from any other medical procedure, like a tonsillectomy?

- Abortion *is* a "difficult" decision. It is different than many other medical procedures. How? In my 38 years as a doctor, I have never seen a woman who has not given this decision a lot of thought and reflection. I have learned from years of experience that it is not a decision any woman comes to lightly. It's because it is such an important decision, Senator, that it should be made by a woman and her doctor -- not the government.

Q: Do you believe in abortion on demand?

- I believe in the right of a woman to choose. I also believe that abortions should be safe, legal and rare and have worked throughout my career to try to make them rare. I would like to ensure that none of my patients ever has to face the choice of abortion.

Q: If abhor abortion, why do you perform them?

- Because I believe in a woman's right to choose. I think that whether or not to have an abortion is a difficult decision -- made by a woman, with her doctor, her family, and her church. My goal as a physician has always been to ensure that none of my patients ever has to face that decision. That's why I've focused my efforts on preventing teen pregnancy. Our nation's goal -- and one of mine as Surgeon General -- must be to make abortion less necessary.

- But when a woman feels she must choose abortion, it is my responsibility as her doctor to provide her access to safe medical procedures.

Q: You are a doctor. You must have an opinion on this. When do you think life begins?

- I don't know, Senator. As you know, there is not a scientific consensus on this question. It is not something that is definitively known -- one way or the other. People make their own decisions based on their personal religious beliefs. I also have moral and religious beliefs but they are private and I would never impose that morality on anyone else.

Q: But you do know that it must have begun by the third trimester as you've stated that you believe a fetus is viable in the 3rd trimester?

- Abortion regulations in this country should follow the decision reached by the U.S. Supreme Court in *Roe v. Wade*. In *Roe*, the court ruled a state may ban abortion after viability - except in cases where the life or health of the woman is endangered. Prior to viability, states are not permitted to interfere with a woman's decision.

FEDERAL FUNDING

Q: Many people in this country have strong moral and religious objections to abortion. Do you think their tax dollars should be used to pay for abortions?

- I think we all agree that the fewer abortions our nation has, the better we all are. As Surgeon General, I will continue to work with our nation's young people to ensure they never have to face the choice of abortion. I think we also agree that when a woman has been raped or is the victim of incest or risks dying, the government has an obligation to help.

Q: But what about abortions for other reasons besides rape, incest or life of mother?

- I believe all women should have the right to choose. Whether the government pays for it, is for Congress to decide. I do, however, strongly support private facilities that provide these services and think we have a responsibility to protect the people that provide these legal services.

RESTRICTIONS [Consent / Notification / Waiting Periods]

Q: Do you support restrictions on abortion like parental consent and notification?

- I believe that parents should be involved when their teenage daughter faces a crisis pregnancy and will do everything I can to encourage that. The program I founded -- "I Have A Future" -- does everything possible to involve parents in the lives of their teenage children. But I believe that there are some cases -- such as abuse in the home -- where family communication is not possible. In those cases, I think there must be some other avenue for a teenager to get adult counseling or judicial approval.

Q: Do you favor mandatory waiting periods?

- It has been my experience from 38 years as a physician that by the time a woman chooses to have an abortion, she has already reflected deeply on the moral, ethical, and religious questions involved in that decision. I do not approve of further government mandated waiting periods. They only serve to delay the procedure, which the American Medical Association says increases the health risks to women.

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Questions Submitted
to
Henry W. Foster, Jr., M.D.
by
Chairman Nancy Landon Kassebaum

ACCREDITATION

1. You have indicated during your confirmation hearing that the OB\GYN residency program at Meharry Medical College was placed on accreditation probation in 1984 because of insufficient patient numbers. In that case, why was the Internal Medicine program at Meharry--which would be drawing from the same audit population--able to retain its full accreditation?

When compared with residency programs in internal medicine, which teach primarily cognitive skills, residency programs based on surgical skills, such as those in OB/GYN and general surgery, require a greater volume of patients in order to give physicians the required training. Therefore, when the patient volume declined, residency programs in OB/GYN and surgery were more vulnerable to losing their accreditation than the more cognitively-based programs. In addition, while certain residency programs benefitted when Meharry Medical College received limited access to patients at the Alvin C. York VA hospital in Murfreesboro, Tennessee, the OB/GYN program did not, because the VA hospital did not have patients requiring obstetrical and gynecological care.

2. As OB\GYN Department Chairman at Meharry for six of the seven years its residency program was on probationary status, what actions did you take to try to correct any deficiencies necessary to regain full accreditation, and when did you take them?

3. From information provided to the Committee, it appears that other residency programs at Meharry besides OB\GYN were also having problems. Once you took over as Dean in 1990, what actions did you take to make across-the-board improvements in and regain accreditation for Pediatrics, Psychiatry, Surgery, and Family Medicine?

Answer to questions 2 and 3:

The ultimate solution to the accreditation problem was merging Meharry with the city-run Metro General Hospital, and, after being appointed by Dr. Satcher to serve as his Special Assistant for Hospital Merger Planning and Development in 1989, the merger became my top responsibility. First, I worked with Dr. Satcher and Nashville's Mayor, Philip Bredesen, in negotiating the conditions under which the City would accept the merger. Second, I entered into negotiations with Vanderbilt University Medical Center which had been staffing Metro General.

Third, I was responsible for ensuring that Meharry met those conditions, such a recruiting an additional faculty of 56 physicians and 18 residents to staff the consolidated hospital, a task I accomplished ahead of schedule. Pending the completion of the merger, I found outside medical institutions, such as the Fort Campbell Army Hospital in Kentucky, to give our residents training opportunities they could not get at Meharry. Through such arrangements, our residents were able to get training required by the Accreditation Council for Graduate Medical Education. As I stated in my testimony, Meharry has applied for reaccreditation of its OB\GYN and Surgery residencies.

4. You said during your February 8, 1995, appearance on ABC's "Nightline" that Meharry's participation in the abortifacient research study for the Upjohn Company (1979-82) was necessary to maintain your accreditation status because "We have a responsibility to teach all residents how to manage the complications of abortion." Would you please explain the connection between the two?

My work as the principal investigator in the Upjohn Study was consistent with my responsibilities as Chairman of the OB\GYN Department and head of Meharry's OB\GYN residency program to pursue research aimed at improving legal and medically-accepted procedures. The Accreditation Council for Graduate Medical Education encourages OB\GYN residents to participate in such research projects. Such research projects also are consistent with the standards for accreditation of medical schools. Guidelines published by the Accreditation Council for Graduate Medical Education state: "The quality of the educational experience within a department of obstetrics and gynecology is enhanced by an active research environment. It is highly desirable that every program encourage each resident to be involved in a research project." Additionally, these guidelines provide that teaching staff should take part in scholarly activity, including research projects that result in publications. In order to maintain an accredited OB\GYN residency program, it was also necessary to train residents in the complications associated with pregnancy, including incomplete abortions.

STERILIZATION

5. You served as a member of the Department of Health, Education and Welfare (HEW) Ethics Advisory Board during the years 1978-80. That was the period during which HEW guidelines restricting federal funding of sterilizations were finalized. Were you as a Board member involved in any discussions on those guidelines, and if so, were you at odds with the outcome?

During its existence from 1978-1980, the Ethics Advisory Board (EAB) focused on three issues, at the request of then Health, Education and Welfare Secretary

Joseph Califano: (1) whether to recommend federal funding of research involving human in vitro fertilization; (2) whether to recommend federal funding for research involving fetoscopy for prenatal diagnosis of sickle cell disease; and (3) whether to grant requests from the Centers for Disease Control and the National Institutes of Health for limited exceptions from the Freedom of Information Act. To the best of my recollection, these were the only matters discussed at the EAB's meetings and hearings, all of which resulted in the issuance of EAB reports.

I HAVE A FUTURE

6. Does the "I Have a Future" program pay participants for coming to class? If so, please elaborate.

No. There is no payment for attending any of the IHAF activities. However, anyone trying to provide services to this high risk community knows that it is critical to keep the interest of the young people. To this end, we have incentives for good attendance. At times, these are vouchers that can be used to bid on items at our auction [e.g., school supplies.] Other times, it is the opportunity to go on a trip with the group and experience another city or tour college campuses.

It is important to note that, as part of the research and evaluation component, teens at both the control and intervention sites received a $10 stipend upon completing all of the research survey. This particular dimension of the research design is a significant incentive which motivates the youth to patiently and conscientiously participate in a testing situation requiring a minimum of two hours of their time to complete. These funds are standard and integral to such evaluations, and were factored into the initial budget calculations.

There are also some occasions where IHAF offers some of the teens an opportunity for service. For example, a few students are chosen each year to become peer counselors. Peer counselors are employed 10 hours a week by IHAF to tutor, make presentations in the community [e.g., on preventing alcohol abuse], and help oversee the "Latchkey" program for children aged 6-10. They must agree to remain in school, attend class, maintain a passing average, not get pregnant or impregnate someone, and not use drugs or alcohol.

IHAF also runs an Entrepreneurship program -- funded by the William & Flora Hewlett Foundation -- to help teens learn more about the working world by giving them the tools to start their own business. They produce, market, sell, and distribute products to help their communities and earn money through this venture [on average $20 per week.] They also receive between $50 and $100 in

I think
we should amend
the statement.
It will be 9-7
favorable.

"seed money" for their business. They must open a bank account and deposit at least 10% of their earnings, which cannot be withdrawn for two years. They thus learn responsibility and the value of saving for the future. Again, to participate in the program, they also must sign a contract agreeing to maintain a passing average, not use alcohol or drugs, and not get pregnant or impregnate someone.

Finally, "I Have A Future" participates in the summer JTPA program which enables teens to work in the summer at jobs throughout Meharry College.

7. When the difficulties with "I Have a Future" identified in the Carnegie Corporation evaluation (February 3, 1992, letter from Dr. Greene) were brought to your attention at your confirmation hearing, you spoke prospectively of several changes that might be instituted to correct them. However, you said nothing of remedial actions that were taken at the time they arose. Exactly what did you do when you first became aware of these problems in 1992?

I apologize if there was a misunderstanding during my testimony. I was attempting to outline several things we had already begun to do to improve the program. In my testimony, I then went on to describe a few areas where I would still like to see more improvement. I did not mean to give the impression that all of these suggestions remained to be implemented. For example, with the help of a Technical Assistance Team sent by Carnegie, which we requested, "I Have a Future" refined the Family Life Education Module by holding focus groups with the students to help them develop better decision-making skills in dealing with difficult situations. The young people are now more adept at problem-solving and may find it easier to say "no" in the face of difficult situations. Similarly, the program revised its pre-employment Module with input from the Vice President of Manpower New York.

As is the case in all projects which venture into uncharted waters, "I Have A Future" was an ongoing learning process between the staff at Meharry and the Carnegie Corporation throughout the duration of the grant. The extensive correspondence IHAF has sent you gives significant evidence of this interchange of ideas. On numerous occasions, Carnegie helped IHAF develop, modify, and improve the program. On other occasions, IHAF identified weaknesses on its own and took steps to correct them. For example, the program initially contracted out services by making arrangements for other organizations to teach the teens in our facilities. IHAF soon realized, however, that these outside organizations were not able to specifically address the culture and community that are an integral part of the teens' identity. Therefore, the program developed its own modules to reflect the values of Nguzo Saba [community, responsibility, family] which are based in the African American experience, to ensure that the cultural strengths of this community were highlighted.

Based on our ability to strengthen the program over time and as sign of their confidence and support after the 1992 exchange, Carnegie continued its funding until 1994, as proposed in our initial seven-year grant. In a letter released last week, Carnegie said they had *"worked with Meharry Medical College in developing the program, and Meharry has been responsive to recommendations for ways to improve the research design and curriculum. The Meharry team has courageously and thoughtfully tackled an important and difficult problem. "I Have A Future" should have useful lessons to impart to others attempting to enhance the life options of young people caught in adverse circumstances."* [Carnegie Corp., 5/3/95]

8. The "I Have a Future" program has been in existence for eight years. It has had over 700 study and control participants. It has had seventeen full or part-time staff. It has spent nearly $3,000,000. Yet you said at your confirmation hearing that it needs more time, more participants, more staff, and more money before it can be fairly and effectively evaluated--and show some meaningful statistical results on teen pregnancy prevention. How much more time, staff, and money are needed?

When I originally developed the proposal for "I Have A Future," it was intended to have two parts: 1) a service component to enhance the lives of impoverished inner-city teens in order to prevent teen pregnancy; and 2) a research component to measure our success. However, in implementing the proposal -- as the program was funded far below the original request -- we were forced to make some modifications. Only a small portion of the funding ever went to the research and evaluation activities; most went to services. For example, in the original proposal, we requested a full-time research coordinator, a full-time research assistant, and two part-time research clerks. In hindsight, that probably *under*estimated the actual needs, now that we know the challenges of data collection in this highly mobile, transient community. But IHAF was forced to use just a research coordinator and a research assistant, which was simply not enough.

To be frank, IHAF could have made other choices given the restricted funding -- for example, limiting services to just one housing project. We felt, however, that we had commitments to families and young people in both places. And, in addition, Carnegie -- IHAF's major funder -- specifically provided funding for services, not for research. We recognized immediately that the budget realities would result in a weaker evaluation process. At one point quite early in the grant, IHAF asked Carnegie to supply a researcher as part of their Technical Assistance Team to strengthen the evaluation component. They rejected that request because services for the young people were their priority.

Much of the initial funding therefore was used for program design -- as no models existed at that time to adopt materials from -- as well as training staff and sponsoring programs to involve the youth and their families in this new project.

Over time, most of the funds have been used to provide services [teaching modules, trips and activities, etc.] to this population. In addition, each young person is assigned a case manager, which is very labor intensive. And we feel that these services have paid off. Our evaluation has shown that IHAF teens have a more positive sense of their future options and higher self-esteem. This can be seen in the number of young people going to college, which was frankly one result of our intervention that we did not predict -- although it also accomplishes our primary goal of reducing teen pregnancy. By entering college, these teens are taking responsibility for their futures by delaying pregnancy until a more appropriate time.

To get the kind of results which we both would like to see, we would need -- as I said at my hearing -- a longitudinal, multi-centered study that would ensure similar participants at the control and intervention sites and follow them consistently for many years. However, the amount of money and staff this would require is difficult to ascertain at this point as it would depend on many factors such as the populations involved, their ages, the degree of intervention thus far, the hypothesis being tested, the proposed length of the study, and the ambitiousness of the intervention.

9. During your confirmation hearing, I made reference to a community-wide (teens, parents, schools, churches, workplace, media, civic and professional groups) prevention program in my state (Topeka, Kansas) that succeeded in reducing the number of teenage pregnancies by 23% in one year (1991-92). This was accomplished by serving a greater number of participants than involved in "I Have a Future" with only one full-time staff person and a budget of $50,000. Why is the "I Have a Future" program unable to demonstrate a comparable level of success?

Without knowing many more details about the particulars of this Topeka program [the socioeconomic background of the teens, the number of teens involved, their ages, etc.] or the particulars of the evaluation process, it would be impossible for me to compare the two approaches. I am, however, encouraged by the results you referenced. I particularly commend its community focus, which is also an integral component of "I Have A Future" and essential to any effort of this sort. If I am confirmed to serve as Surgeon General, I will be very interested in seeking out such successful programs across the country and, together with national leaders in this area, learning from these programs what works and what doesn't in fighting this epidemic of teen pregnancy.

TUSKEGEE SYPHILIS STUDY

10. You indicated you were "outraged" when you learned of the Tuskegee Syphilis study in 1972. Do you have anything in the way of contemporary media clippings, letters, memos, or other corroboration for that description of your reaction 23 years ago?

Two contemporary media clippings are attached. No other records from that time appear to exist. I understand that, after an exhaustive investigation, it has been determined that the minutes and other records of the Macon County Medical Society from that period were lost some time ago. I have not maintained any relevant letters or memoranda from that time.

11. When asked at your confirmation hearing what action you took as President of the Macon County Medical Society to demonstrate your outrage, you said you immediately called a meeting of your members and issued a statement. That statement read, "The members of the Macon County Medical Society have unanimously agreed to identify the remaining living members of this study and make available forthwith appropriate therapy." How long was it before those victims were so identified and treated--and by whom?

I called the meeting of the Macon County Medical Society in order to initiate efforts to identify and treat the men, not in order to express my outrage.

I do not have any records which would detail the specific dates of the identification of the men, or details of the course of treatment of any of them. As an obstetrician-gynecologist, I did not treat any of the men myself. As noted above, the records of the Macon County Medical Society from that period are no longer in existence, and I do not know if any special records were made. I cannot say with any assurance that any of the local doctors or the Society would have made special charts, memoranda or records of their own treatment of these men, beyond the individual medical records. The Society members would have provided treatment on an individual basis as they identified the men, and as the medical conditions of the individual patients warranted.

The Society fully cooperated with members of Dr. Broadus Butler's committee, the Tuskegee Syphilis Study Ad-Hoc Advisory Panel. To the best of my recollection, all of representatives of the Ad-Hoc Panel and other federal officials with whom the Society dealt at that point appeared genuinely interested in identifying and treating the men. Within a short period they stopped the study and recommended treatment of the men for syphilis. As an OB/GYN, I was not involved directly in the CDC treatment activities and cannot provide details as to the timing of treatment they provided. I left Tuskegee in May 1973 to become head of OB/GYN at Meharry Medical College.

Syphilis Decision Left to Macon, Records Show

By M. P. WEISSKOPF
Advertiser Staff Writer

The Alabama Board of Health, asked more than three years ago by federal officials whether the U.S. Public Health Service should continue its program of denying proper medical treatment to syphilitics in Tuskegee, avoided the issue by referring questions to Macon County physicians.

The formal motion at a state Board of Health meeting Feb. 19, 1969, suggesting that federal public health officials discuss pl. for pursuing the project, called the Tuskegee Study, with the Macon County Medical Society, was discovered Friday by The Advertiser in a review of board meeting records dating back to 1931.

According to minutes of the 1969 meeting, a search through records of the period, 1931-33, failed to show any indication of formal approval by the state Board of Health for the federal experiment started in 1932 in which 200 known syphilis carriers living in Tuskegee were denied treatment, to determine by autopsies what damage untreated cases of the venereal disease does to the human body.

The 18-line passage, under the subtitle, "Tuskegee Untreated Syphilis Project," is the only specific reference found in minutes of more than 40 years of board meetings to the Public Health Service study in which at least seven men have reportedly died as direct result of syphilis.

Dr. S.H. Settler Jr., secretary of the Macon County Medical Society, said by telephone Friday he recalls a society meeting in May of 1969 in which Dr. David J. Sencer, director of the Public Health Service's Center for Disease Control in Atlanta, asked members to endorse the continuation of a federal study of Tuskegee syphilitics.

Dr. Settler, a Tuskegee opthamalogist, said members agreed to continue the program, but consented under the assumption that the patients were receiving treatment for the disease.

"We were never really informed of a project in which people were not being treated," he said.

Dr. Sencer, reached at his home in Atlanta Saturday, said he had not attended the May, 1969 meeting in Tuskegee, but sent two center officials involved at the time in venereal disease control to discuss plans for continuing the program. The officials were, according to Dr. Sencer, Dr. William J. Brown, former chief of the center's venereal disease branch, and Dr. Alfonso H. Holguin, former director of the state and community division of communicable diseases.

Dr. Holguin, director of the Atlanta center's training program, said Saturday he remembers informing Macon County physicians in 1969 of the most recent developments in the Tuskegee Study including recommendations made by a special ad hoc study committee assigned earlier that year to review the project.

Dr. Holguin said there must have been some indication during the meeting that some of the syphilitics in the project had not received treatment because one of the recommendations discussed was that therapy as late as 1963 would not benefit the patients.

Dr. Brown, current director of venereal disease control in the Georgia Department of Health, confirmed Dr. Holguin's statement by telephone Saturday.

Dr. Brown conceded that there might have been a misunderstanding over certain details of the program discussed with Macon County physicians in 1969, but there was no intention on his or Dr. Holguin's part to mislead the society.

"This has been an open study going on for years," he said, pickup type beginning Dr. H. W. Foster

Dr. H.W. Foster, president of the Macon County society, said Friday he is under the impression that the Public Health Service will discontinue the project immediately.

The society drafted a statement at a meeting in Tuskegee Thursday night which said:

"The members of the Macon County Medical Society have unanimously agreed to identify the remaining living members of this study and make available forthwith appropriate therapy."

The Tuskegee surgeon suggested that very large doses of penicillin may be necessary in the therapy.

Minutes of the 1969 state health board meeting report that the Public Health Service had expressed concern whether to perpetuate the project "since the numbers are small, adequate treatment is now available and there have been many social changes in Macon County."

"The State Health Officer has suggested to the Public Health Service," the minutes go on, "that continuity of the program and patient care be discussed with local physicians before a decision is made."

A motion to refer the matter to the Macon County Medical Society carried by unanimous vote, according to the minutes.

State Health Officer Dr. Ira Myers, who presided over the 1969 board meeting, was not available for comment Friday.

The only possible indirect mention of the federal experiment found by The Advertiser in reviewing more than 40 years of records came at a meeting in 1943 when it was reported that a Public Health Service official who conducted a blood test for syphilis five years earlier at the Macon County Selective Service System received positive reactions in about 10 per cent of those tested.

Minutes of that meeting said the same public health officer had performed a similar test in 1937 and found positive reactions in 36 per cent of those sampled. For the next eight years, the records said, the official carried on a "very intensive treatment program."

There was no further description in the minutes of the treatment program lasting until 1937.

An official of the state Bureau of Preventable Diseases, Venereal Disease Division, said Friday that the Alabama Department of Health assisted the Public Health Service in its annual physical examination of syphilitic subects by providing referral services.

The official said the state public health representatives assigned to the Macon County area helped locate the patients and transported them to the county health department for checkups.

The state assistance continued from the beginning of the project in 1932 to the present time, he said.

Mtg. Advertiser — Sunday, July 30, 1972

Atla Const - 7/30/72

Syphilitics From Study Are Hunted

TUSKEGEE, Ala. (UPI)—Doctors in this small eastern Alabama town have started a search for elderly blacks who participated in a government sponsored syphilis experiment that started in 1933.

Dr. Henry Foster, president of the Macon County Medical Society, said Friday his group hopes to find as many of the participants as possible and give them treatment for the disease if it still was needed.

It was revealed this week that the program by the U. S. Public Health Service was never halted even when a cure for syphilis became available.

There have been charges that some 400 of the 600 original blacks that started the program were allowed to continue untreated. The program was designed to determine the long range effects of the disease.

Foster said the government agency would be asked to terminate the program.

A black state legislator charged that some of the participants did not know why they were being tested.

Rep. Fred Gray of Tuskegee, a civil rights attorney, said he had been retained to represent "several" of the participants. He declined to name his clients or say how many he represented, but said there was a possibility he would sue the Public Health Service to get damages for his clients.

ABORTION, SEX EDUCATION, AND FAMILY PLANNING

12. Near the end of a speech you gave to the Planned Parenthood Association of East Tennessee on September 7, 1984, you proclaimed that the future of abortion in this country may depend on the next nominee to the Supreme Court. That would seem to indicate that you have no problem with an abortion "litmus test" for Supreme Court Justices. Do you feel that such a "test" is equally appropriate for a Surgeon General nominee?

In my speech, I was simply emphasizing that judicial appointments would greatly affect case law regarding access to abortions. I did not and would not advocate any so-called "litmus test" for judicial appointees, nor would I advocate any such "litmus test" for a nominee to the position of Surgeon General.

13. Since 1973, you have been associated with Planned Parenthood of Middle Tennessee. During the period 1975-1981, you also held national level leadership positions with the Planned Parenthood Federation of America. If confirmed by the Senate, to what extent do you plan to promote the Planned Parenthood agenda as Surgeon General?

If confirmed, I shall endeavor to improve the lives of all Americans in the many different areas of health care and prevention needs. I will not promote the agenda as such of any private organization.

14. What is your position on laws which require parental consent or notification before a minor may obtain an abortion? Please be specific.

I believe that parents should be involved when their teenage daughter faces a crisis pregnancy and will do everything I can to encourage that. In fact, it has been my experience that most young women do tell a parent when they are considering having an abortion. The program I founded -- "I Have A Future" -- does everything possible to involve parents in the lives of their teenage children. But I believe that there are some cases -- such as abuse in the home -- where family communication is not possible. Therefore, while I support parental notification, I think there must be some other avenue for a teenager to get adult counseling or judicial approval.

15. Have you been associated at any point in the past with the Sex Information and Education Council of the United States (SIECUS)? If so, please elaborate regarding the nature and extent of your association.

I have not been a member of SIECUS nor have I had any direct involvement in the organization. SIECUS ia a coalition of more than 80 national organizations, including the American Medical Association, the American Nurses Association, American College of Obstetricians and Gynecologists, the Planned Parenthood

Federation of America and the Child Welfare League of America. I am a member of the AMA and ACOG and served on the national Board of Directors of the Planned Parenthood Federation of America from 1975 - 1981.

OTHER

16. Can you assure the Committee that rental property you own is well maintained and in compliance with health and safety codes?

I can assure this Committee that all of my rental property is well maintained and in compliance with health and safety codes.

Series I Questions
Submitted by Senator Abraham

1. An official transcript (page 180, lines 13-14) of a November 10, 1978 meeting of the Ethics Advisory Board of the U.S. Department of Health Education an Welfare quotes you as stating: "I have done a lot of amniocentesis and therapeutic abortions, probably near 700."

The White House initially suggested that the transcript was a fraud. Only after the authenticity of the transcript was established did the White House retract its charges of fraud.

a. Please identify and provide all documents you provided the White House concerning the transcript.

I did not provide any documents to the White House concerning the transcript.

When asked about the 700 therapeutic and amniocentesis abortions quote during your nomination hearings, you attributed the statement to the transcribers not being able to hear: "In the transcript, it was stated a couple of times that they had hired transcribers and they were having difficultly hearing." (FNS 5/2/95 at 121.) And you further said, "[T]he transcribers said that they were having trouble hearing. They said it. I did not. It was in the record. So you know it was there. And maybe they--they were hired people." (FNH 5/3/95 at 115.)

b. Please identify all places in the transcript where it says the transcribers were having difficulty hearing.

Places in the transcript of the Ethics Advisory Board meeting of November 10, 1978, where it indicates that the reporter was having difficulty transcribing:

1. **page 208, lines 19-21. The reporter said: "I don't know what happened, because everybody talked at once. You will have to watch that."**

2. **page 321, lines 19-20. The reporter said: "Too many people are speaking at once. We are not getting anything on the record."**

c. Please identify all portions of the transcript that demonstrate inaccurate transcription.

The transcript is a transcription of statements that were made at a meeting in November 1978, almost 17 years ago. I do not recall every statement made at the meeting or the exact words used by each speaker, so I am incapable of identifying portions of the transcript that demonstrate inaccurate transcription.

Also on Tuesday of the hearings, you stated: "My honest feeling is the word 'I' should have been 'they' and that makes all the sense in the world. It was Drew Hospital in Los Angeles that was applying for the grant."

But then on Wednesday of the hearing, you stated "[T]he people who are applying for the grant itself, that statement would have made all the sense in the world if it had said "we have done" and did not just say abortions, but said amniocentesis because that is what they were applying for the research for, and they did not have a huge service where they were doing this. That is what I said."

2. Please explain the meaning of both "we" and "they" as a substitute for "I" in the context of the entire paragraph on page 180 of the transcript.

In particular:

a. Please identify and provide documents concerning the number of amniocentesis abortions and therapeutic abortions that Drew Hospital in Los Angeles had done by 1978 and your knowledge thereof in 1978.

b. Please identify and provide documents concerning your knowledge of the number of therapeutic and amniocentesis abortions that Drew Hospital had done by 1978.

c. Please explain the relevance of the number of abortions Drew Hospital had done, to the rest of your remarks, including: your opinion that the Hospital's proposed 24 hour delay in abortion would be reasonable; your opinion that it was acceptable for the catheter to be left in place after the fetoscope is withdrawn; and your description of the techniques for continuous prostaglandin infusion.

d. If the word should have been "We," please explain why you would be referring to Drew Hospital in Los Angeles, where you have never worked, as "we."

3. Please state which word you now believe you said:

Answer to Questions 2 [a-d] and 3:

When I answered the question on Tuesday, I had a copy of the 1978 transcript before me. When I answered the question on Wednesday, I did not have a copy of the 1978 transcript before me, and became slightly confused about the context of the sentence in question. My answer on Tuesday is the accurate description of what I believe I may have said. I believe that I may have said:

"They have done a lot of amniocentesis and therapeutic abortions, probably near 700."

In this context, "they" would have referred to the grant applicants at Drew Hospital in Los Angeles. I cannot state with certainty that this is what I said. Whatever statement I made was made almost 17 years ago, and I saw the transcript for the first time in February of this year. I know I did not make the statement as it appears, and I know it does not reflect my record at that time or any time since. As I mentioned at the hearing, the then-Chairman of the Ethics Advisory Board has stated that had I made the statement as it appears, it would have engendered quite a bit of controversy at the meeting. It did not.

Because of the passage of time, it is difficult for me to explain why the transcript reads as it does. As I noted at the hearing, one plausible explanation is a transcription error, and that the word "I" appeared in the transcript although I said "they." This is only conjecture. I do recall that I was somewhat familiar with the work that was being done at Drew at the time, but I have no recollection that I had any precise knowledge of the number of amniocentesis and/or abortion procedures that had been performed at Drew. I may have had documents before me at the meeting that were presented in connection with the application, but I do not have such documents in my possession at this time and did not consult any such documents in trying to determine what might account for the statement in the transcript.

You have asked me to explain the relevance to the rest of my remarks of the number of abortions performed by Drew. Once again, I am trying to reconstruct what I was thinking 17 years ago. It is a difficult, if not impossible, task, particularly since I cannot now be sure what documents I had before me at the time. My conjecture is as follows: We were discussing the protocol proposed by Drew and the possibility of complications resulting from a 24-hour delay proposed in the protocol. The number of amniocentesis and/or abortion procedures performed at Drew would be relevant to my assessment of the ability of the applicants to gauge the magnitude of that risk and to perform the proposed procedures in a way that would minimize that risk.

4. Did you compose the February 3, 1995 written statement on your abortion record, which the White House issued in your name to the national press, in which you stated that you had "performed fewer than a dozen" abortions?

Yes, I composed the February 3, 1995, written statement with the assistance of several officials of the Department of Health and Human Services.

5. If not, who did the drafting?

I composed the February 3, 1995, written statement with the assistance of several officials of the Department of Health and Human Services.

6. Please identify and provide all documents concerning this statement and its drafting.

There are no documents concerning this statement and its drafting. As I stated in my testimony, I made the statement based on my best recollection at the time, without reviewing any records.

7. That written statement also said that all the abortions you have performed "were primarily to save the lives of the women or because the women had been the victim of rape or incest."

a. How many of the 39 abortions you now state you performed were done to save the life of the mother?

b. How many of these 39 abortions were in cases where the pregnancy resulted from rape?

c. How many of these 39 abortions were in cases where the pregnancy resulted from incest?

d. How many of these 39 abortions were elective?

e. Could you please identify and provide relevant records concerning these 39 abortions?

Answer for Question 7 [a-e]:

The 39 abortions on which I was listed as physician of record took place at Meharry Medical College/Hubbard Hospital. Hospitals, including Meharry/Hubbard, usually provide abortion services only under limited circumstances, primarily to preserve the health or life of the pregnant woman. If a woman had consulted me in the early stages of a healthy pregnancy and had requested an abortion, I would have counseled her and, as appropriate, referred her to a service outside the hospital.

Meharry Medical College is the custodian of all records relating to these 39 abortions. Attached is a letter from the General Counsel regarding these procedures.

MEHARRY MEDICAL COLLEGE
OFFICE OF THE GENERAL COUNSEL

To Whom It May Concern:

Pursuant to a request by Dr. Henry Foster, Jr., we have undertaken a search of the medical records of Meharry Medical College pertaining to operations performed by Dr. Foster during the years 1973-90. Our records indicate that Dr. Foster participated in or performed 39 abortions, not including termination of tubal pregnancies or follow-up procedures made necessary by incomplete and/or spontaneous abortions. Our records also indicate that in approximately three quarters of these procedures, at least one other physician or a resident performed or participated in the surgery, in addition to Dr. Foster.

Sincerely yours,

Richard E. Jackson, J.D.
General Counsel

REJ:sh

1005 D.B. TODD BOULEVARD
FAX (615) 327-6540

Tuskegee University

Founded by Booker T. Washington

Office of the President

April 20, 1995

The Hon. Abner J. Mikva
Counsel to the President
The White House
Washington, DC

Dear Judge Mikva:

This responds to your letter of April 10, 1995, and modifies my letter of April 13 to John D. Podesta concerning your request that Tuskegee University undertake or authorize a review of certain medical records. The contemplated review would encompass the records of all patients of the now-closed John A. Andrew Memorial Hospital, during the period from 1965-1973. We understand that the review has been requested by Dr. Henry Foster and the White House, for the purpose of determining the number of certain surgical procedures performed by Dr. Foster during the period in question.

Although we understand the purpose of the review, and support the goal of assuring that Dr. Foster receives a fair hearing on his nomination to be the Surgeon General, we now find that we cannot comply with your request. This conclusion supersedes the initial response in my April 13 letter to John Podesta. We have searched both our conscience and the law, and we are responding now as well to questions raised by some of Dr. Foster's former patients.

Our conclusion is based on the moral and legal principle that patients' records must remain confidential, and may not be disclosed to third parties without the patients' written consent. Were the hospital still in operation, conceivably hospital personnel could perform the review. Since it is no longer in existence, the review necessarily would have to be performed by third parties.

We fully understand that those who would be reviewing the records have promised not to record personal identifiers, that no copies would be made, and that the individuals performing the review would be bound by a promise of confidentiality not to disclose any information contained in the records. We also

(205) 727-8501

know that Dr. Foster has authorized the review. However, we have been advised by legal counsel that Dr. Foster has no legal authority to authorize release of patients' records to third parties. Under the circumstances, we believe that providing the records to the designated reviewers, in and of itself, may constitute a violation of the duty of confidentiality that is owed to the former patients of the hospital. National standards, such as those established by the Joint Commission on the Accreditation of Healthcare Organizations and the American Medical Record Association are unambiguous on this point. So, too, is Alabama common law, which holds that disclosure of medical information without the patient's consent constitutes both a violation of the fiduciary duty owed by health care providers to their patients, and a breach of an implied contract to maintain confidentiality. See, e.g., Crippen v. Charter Southland Hospital, 534 So.2d 286 (Ala. 1988); Mull v. String, 448 So.2d 952 (Ala. 1984); Horne v. Patton, 287 So.2d 824 (Ala. 1973, *reh'g denied*, 1974).

As you know, Tuskegee University is the leading institution in this community. It seems clear that we would violate the trust of this community, as well as our moral and legal obligation to the former patients of the John A. Andrew Hospital, if we were to permit third parties access to these highly sensitive records.

Despite the good faith and energetic efforts of the Department of Health and Human Services and your staff, I deeply regret that we are unable to assist you in the manner in which you requested. If you have any further suggestions as to how we could respond more favorably, without breaching our fiduciary duties, we would be glad to consider them.

Sincerely,

Benjamin F. Payton

Benjamin F. Payton

cc: Dr. Andrew F. Brimmer
Dr. Mary F. Berry

8. Please explain why none of your various calculations of the number of abortions you have done includes the 55 chemical abortions and at least four D&C abortions done as part of the abortifacient suppository experiment in the early 1980s in which you were the principal investigator.

I did not perform the procedures to which you refer that were part of the multi-center site clinical trial sponsored by the Upjohn Company.

9. Did the woman who later gave birth give birth to a healthy child?

The article published in the May 1985 issue of Obstetrics and Gynecology notes that one woman withdrew from the study and had a vaginal delivery of a baby. The article states, "There was no evidence of teratogenesis, and his development thus far remains normal."

10. Following the failure of the abortifacient suppository, did you or anyone else advise this woman that she should consider submitting to a surgical abortion?

Not that I recall.

11. How many abortions or terminations of pregnancies were you in the operating room for?

I have been listed as physician of record for 39 abortions during my tenure at Meharry Medical College from 1973 to the present. These cases were my direct responsibility although resident physicians were also listed on the records of 3/4 of the cases. I also described for the Committee my recollection of performing major surgery during my tenure at John Andrew Memorial Hospital in Alabama to save the life of a woman with Meigs' Syndrome that resulted in a pregnancy termination.

12. Please identify and provide all documents concerning any procedures involving the termination of a pregnancy in which you have been involved in your 38 years of practice, including prior to 1973 and including cases in which you were not the physician of record.

As noted above, Meharry Medical College has custody of all documents and records pertaining to the 39 abortion procedures in which I was listed as a physician of record. Attached are a letter from the General Counsel of Meharry, as well as a letter from Tuskegee University explaining the unavailability of any records regarding John Andrew Memorial Hospital, which is now closed.

13. Please identify and provide all calendars, appointment books, schedules, datebooks, and any other documents concerning your whereabouts during 1969.

I have not kept any calendars or other documents recording my whereabouts on specific dates during 1969, when I was a resident of Tuskegee, Alabama. I attach, however, two documents which are responsive to your question as to May 18-20, 1969.

You have said: "In recent years, there has been an outcry by various groups that the intent of family planning is black genocide and that the ultimate effect will be black genocide. I must admit that these apprehensions are quite understandable and often not without foundation."

14. Please explain your statement that "these apprehensions are . . . often not without foundation."

These remarks responded to various concerns about family planning services that were well established in black communities at that time when comprehensive health care was insufficient or absent. As indicated above, while I did not agree with the extreme conclusions some people drew from these concerns, I recognized that the concerns themselves reflected problems that deserved attention. For this reason, I identified the three basic conditions necessary to support family planning programs: (1) programs must be completely voluntary and noncoercive; (2) comprehensive health care must be a component of a family planning program; and (3) any family planning program for minorities must include the effective participation of minorities in policy and administration.

In Obstetrics and Gynecology, you wrote that of the 60 patients in your abortifacient suppository experiment, 58 (97%) were black. Foster, et al., Postconception Menses Induction Using Prostaglandin Vaginal Suppositories O&G, 65: 683, 1985]

15. What percentage of the 39 abortions you have done involved African-American women seeking to terminate a pregnancy?

Meharry Medical College and Hubbard Hospital are historically black institutions, established at a time when the races were segregated by law. Hubbard Hospital was established because of the official denial of access to Nashville General Hospital, the city-run facility, for Meharry staff and students on account of their race. The hospital has welcomed patients and staff of all races. Meharry and Hubbard share a strong commitment to providing services to all persons without regard to their race. That is a commitment which I fully share. Most but by no means all of the Hubbard Hospital patients have been African-American. It would be fair to assume that most of the 39 cases you refer to were African-Americans.

Statement of Minnie Capleton Jamison

My name is Minnie Capleton Jamison, and I am a resident of Tuskegee, Macon County, Alabama. I reside at 1307 Gregory Street in Tuskegee.

On the evening of May 19, 1969, I gave birth to my son, Steven Darryl Jamison. Dr. Henry W. Foster was my obstetrician and guided me along the entire course of my pregnancy and delivered the baby. It had been a difficult pregnancy. I was confined to bed for seven of the nine months, and during the fourth month it was necessary for Dr. Foster to perform a surgical procedure to prevent a miscarriage. I had had two miscarriages before this.

I went into labor on May 18, 1969. I was admitted to John A. Andrew Memorial Hospital in Tuskegee that evening, and I was given medicine to slow labor. My baby was delivered by Dr. Foster on the next evening, May 19, 1969. The delivery was by Caesarean section.

I remember the evening well, but I do not remember all of the specific details. I know that Dr. Foster looked in on me from time to time, but I do not recall exactly what time he looked in or exactly how often he checked on me. I remember that the delivery took place at night, and that I was in surgery for approximately two hours. I recall specifically that part of the procedure was at 7:00. I recall that I was very nervous and I was hyperventilating. I was doing breathing exercises and I tried to focus on a clock at 7:00 p.m. I remember that the anaesthesiologist was trying to calm me at the time, and that Dr. Foster joined and helped to calm me. I recall that all of this was before Dr. Foster started to operate, but I do not recall more specifically at what point this was in the procedure. I understand that the medical record indicates that the delivery took place at 9:17 p.m., and I do not dispute that record.

I also remember well what fine care Dr. Foster gave to me and my son. I remember that throughout a difficult time for me Dr. Foster was warm and attentive. I had been told by another obstetrician that I could never have a child. Dr. Foster told me that he would work with me and do everything humanly possible to make sure I could have a child, and he did. He was a very busy man with many patients, but he always took time and was always there to help. He was always very human and very professional. He is a fine man and will make a fine Surgeon General.

SIGNED: Minnie Capleton Jamison

Minnie Capleton Jamison

DATE: 4/28/95

STATE OF ALABAMA
DEPARTMENT OF PUBLIC HEALTH
DONALD E. WILLIAMSON, M.D. • STATE HEALTH OFFICER
CENTER FOR HEALTH STATISTICS
DOROTHY S. HARSHBARGER • DIRECTOR

March 4, 1995

Ms. Beth Nolan
Associate Counsel to the President
The White House
Washington, D.C. 20500

Dear Ms. Nolan:

At the request of Henry W. Foster, M.D., I have examined birth certificates filed in the Center for Health Statistics in the Alabama Department of Public Health for births that occurred in Macon County, Alabama on May 18, 19, and 20, 1969. While information on the individuals whose births occurred on those days is confidential, information on the attendant at birth can be released upon the request of that attendant.

In examining the paper certificates for the births, I found several documents that had what appeared to be the time of birth typed in the margin outside of the standard form. For the dates requested, the following birth certificates were found that had a stamped signature of Henry W. Foster, M.D., as the attendant at birth.

One birth on May 18 showing the time as 12:38PM

Two births on May 19 showing the times as 3:33AM and 9:17PM

Two births on May 20 showing the times as 1:32AM and 3:12PM

All of the births giving Henry W. Foster, M.D., as the attending physician occurred at Tuskegee Institute in John A. Andrew Hospital.

In addition, there was another birth occurring on May 19, 1969, at Tuskegee Institute, but the original certificate of birth for this event has been replaced by a new certificate of birth after a legal action to the record. The new certificate gives an

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abstract of the information, and does not show the attendant at birth. The original certificate of birth has been placed in a sealed file that can only be opened by an order from a court of competent jurisdiction. While the attendant at birth will probably be shown on the original certificate, the time will most likely not be shown since the margins were usually cut off when the paper records were replaced in the files. I would need a court order to open and look at that record to determine who attended the birth.

If you have questions or need additional information, please call me at (334)613-5426.

Sincerely,

Dorothy S. Harshbarger

Dorothy S. Harshbarger
State Registrar and Director

16. In your 1984 keynote address to Planned Parenthood, you commended the Supreme Court for striking down hospitalization requirements for second trimester abortions. You then stated: "We must work to prevent the erection of such barriers to late abortion access."

a. Please state at what stage, if any, in the development of a fetus, an intentional termination of the life of the fetus should be legally prohibited.

b. Please state at what stage, if any, in a pregnancy, you believe elective abortions should legally prohibited.

Answer to Questions 16 [a and b]:

I fully support the framework laid down by the Supreme Court in Roe v. Wade for determining the legality of restrictions on abortion.

Series II Questions
Submitted by Senator Abraham

1978 H.E.W. ETHICS BOARD MEETING

Dr. Foster, with respect to the transcript from the 1978 H.E.W. Ethics Board meeting, you claim that you must have been misquoted when the transcript on page 180 quoted you stating, "I have done a lot of amniocentesis and therapeutic abortions, probably near 700."

1. Do you also deny making the statement attributed to you on page 197, where you are quoted as saying, "Let me address one other question regarding therapy versus research. I have not seen the research proposals that John Hobbins had at Yale, or what Kan has done at U.S.C. But I do know that a lot of their fetoscopy was therapeutic , the work on thalassemia was clearly therapeutic. It was done for the same reasons we do amniocentesis, to decide whether or not the pregnancy should continue and to provide a therapeutic abortion. In fact, I know much of that."?

   The transcript relates to statements made almost 17 years ago. I do not recall making the statement attributed to me on page 197, but I do not deny making it.

2. If the answer to question #1 is "No," please provide a specific accounting (including date, location and your position at the time) of those instances in which you provided a therapeutic abortion after performing amniocentesis and what indications, based on the amniocentesis, warranted the performing of the ensuing therapeutic abortions.

   I cannot recall the number of instances in which I performed a therapeutic abortion after performing amniocentesis, but I can explain the role amniocentesis played in my treatment of patients. Amniocentesis is typically performed to detect genetic disorders such as Down Syndrome, Tay Sachs disease, thalassemia, and homozygous or doubly heterozygous sickle cell disease, as well as neural tube defects such as spina bifida. I used the information from the amniocentesis to help inform the patient as fully as possible about the condition of the fetus she was carrying, all the options available to her, and the risks and benefits associated with each of those options. The decision whether or not to terminate the pregnancy was always made by the patient (usually in consultation with her husband, family or other supportive persons). In the event the patient decided to carry the pregnancy to term, the information gained through the amniocentesis was very valuable to me in treating the woman in the manner calculated to bring about the best health outcome for her and the child.

Dr. Foster, on page 199 of the 1978 H.E.W. Ethics Review Board meeting transcript, you were quoted as saying, "The only thing that I do know is that the struggle has been to try and be able to diagnose sickle cell--homozygous **[sickle cell disease]**[1] at a point at which therapeutic abortions could be offered. Right now we don't have that capability, and it was my understanding that one of the thrusts of this research proposal was to help to try and find that capability."

3. Dr. Foster, do you deny making this statement at the 1978 meeting?

The transcript relates to statements made almost 17 years ago. I do not recall making the statement attributed to me on page 199, but I do not deny making it.

4. If the answer to Question #3 is "No," would you please provide a specific accounting of how many times you performed abortions after you had ascertained the existence of "sickle cell" disease.

5. If the answer to Question #3 is "No," would you please explain whether in those instances in which an abortion was performed following the diagnosis of sickle cell, did you ever counsel the women you were treating to obtain an abortion?

Answer to Questions 4 and 5

I cannot recall the number of instances in which I performed a therapeutic abortion following a diagnosis of sickle cell, but I can tell you how I approached the care of a patient who received a diagnosis that the fetus she was carrying suffered from sickle cell disease. I informed the patient as fully as possible about the disease, all the options available to her, and the risks and benefits associated with each of those options. The decision whether or not to terminate the pregnancy was made by the patient (usually after consultation with her husband, family or other supportive persons).

Not all patients who received a sickle cell diagnosis decided to terminate their pregnancies. In the event the patient decided to carry the pregnancy to term, the knowledge of the sickle cell problem enabled me to treat the woman in the manner calculated to bring about the best health outcome for her and the child.

---

[1]Deleted from the question, but contained in the transcript.

6. Have you ever performed "therapeutic abortions" after examining the results from amniocentesis in which you discovered indications of other genetic disorders such as Down Syndrome or Tay Sachs?

I do not believe that I ever performed a therapeutic abortion following an amniocentesis that indicated Down Syndrome or Tay Sachs.

7. Dr. Foster, do you believe that "therapeutic abortion" is a legitimate form of therapy for preventing birth defects such as Down Syndrome?

I believe that the choice whether to carry a pregnancy to term after diagnosis of a birth defect is one to be made by the woman (preferably in consultation with her husband, family or other supportive persons). Before making that decision, the woman should be informed by her physician as fully as possible about her condition and the condition of the fetus she is carrying, all the options available to her, and the risks and benefits associated with each of those options.

8. Dr. Foster, please indicate where in the transcript -- other than page 323 -- there is any indication the transcription reporter was having difficulty hearing clearing the discussion taking place at the meeting?

Places in the transcript of the Ethics Advisory Board meeting of November 10, 1978, where it indicates that the reporter was having difficulty transcribing:

1. **page 208, lines 19-21. The reporter said: "I don't know what happened, because everybody talked at once. You will have to watch that."**

2. **page 321, lines 19-20. The reporter said: "Too many people are speaking at once. We are not getting anything on the record."**

II. STERILIZATION

Dr. Foster, in your testimony before the Labor Committee, you stated that, with respect to obtaining the informed consent for the purposes of sterilizing the individuals mentioned in your 1976 article, that you assiduously followed whatever Joint Commission on Accreditation of Hospitals guidelines were in place at the time.

9. Dr. Foster, would you provide for the Committee the pertinent JCAH guidelines at the time you undertook the sterilization procedures and what specific actions you took in these cases to comply with those guidelines?

I performed the sterilization procedures discussed in my 1976 article prior to 1973. In response to your request, I have attached the Formulation of Medical Staff Bylaws, Rules, and Regulations of the Joint Commission on Accreditation of Hospitals from 1971.

The guidelines do not deal specifically with sterilization, but do call for informed consent for any kind of surgical care, including the consent of a parent or guardian in the case of surgery involving a minor or unconscious patient. As I testified, the article was based on literature review. In the two cases I recall performing, the patients were brought to me by their parents. I believed at the time that performing the sterilizations was the morally and medically right thing to do, and the manner in which I did so was fully consistent with prevailing rules governing informed consent. This was never questioned during the entire course of peer review of my 1976 article.

III. I HAVE A FUTURE PROGRAM

Dr. Foster, during the February 8th "Nightline" interview, you also made it clear that, even provided "parental involvement," you did not favor the widespread distribution of condoms. You also stated unequivocally, "I favor abstinence. Abstinence, that's what I favor. That's the bedrock of our program." However, in your article which appeared in the Summer 1990 issue of the Journal of Health Care for the Poor and Underserved, you described the "I Have a Future" program quite differently.

In that article, "A Model for Increasing Access: Teenage Pregnancy Prevention," you and two of your colleagues wrote that one of the principal objectives of the "I Have a Future" program was "to provide ready access to and to increase utilization of comprehensive adolescent health services." Later, you define "comprehensive health services" as "including contraceptive availability."

GUIDELINES for the Formulation of Medical Staff Bylaws, Rules and Regulations 1971

Non-Departmentalized Hospitals

Joint Commission on Accreditation of Hospitals

Adaptation Notes

(e) In instances in which the patient exhibits severe psychiatric symptoms;

(f) When requested by the patient or his family.

8. The attending practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. He will provide written authorization to permit another attending practitioner to attend or examine his patient, except in an emergency.

9. If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, she shall call this to the attention of her superior who in turn may refer the matter to the director of the nursing service. If warranted, the Director of Nursing may bring the matter to the attention of the chief of the service wherein the practitioner has clinical privileges. Where circumstances are such as to justify such action, the chief of the service may himself request a consultation.

D. GENERAL RULES REGARDING SURGICAL CARE

Comment

Policies, regulations and rules for the surgical suite should cover at least the following:

1. General considerations
2. Scheduling operations
   - (a) Priority
     - (1) Definition of priority time
     - (2) First priority
     - (3) Second priority
   - (b) Scheduling periods
   - (c) Assignment of priority
   - (d) Loss of priority
3. Reservations for operations
4. Information required to make reservations
5. Change of schedules
6. Emergency operations
7. Requirements prior to anesthesia and operation
   - (a) Identification of patient
   - (b) Pre-operative evaluation and documentation
     - (1) Medical record content, including diagnosis

Adaptation Notes

(2) Laboratory procedures 21

(3) Informed consent forms 22

(c) Time of admission 23

8. Starting time of operations 24

9. Out-patient operations requiring general anesthesia 25

10. Care and transport of patients 26

(a) To the surgical suite 27

(b) Within the surgical suite 28

(c) To the recovery room 29

11. Efficient utilization of operating rooms 30

12. Contaminated cases 31

13. Conductivity and environmental control 32

14. Radiation safety 33

15. Other 34

1. Except in severe emergencies, the preoperative diagnosis and required laboratory tests must be recorded on the patient's medical record prior to any surgical procedure. If not recorded, the operation shall be cancelled. In any emergency the practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery.

2. A patient admitted for dental care is a dual responsibility involving the dentist and physician member of the medical staff.

(a) Dentists' responsibilities:

(1) A detailed dental history justifying hospital admission.

(2) A detailed description of the examination of the oral cavity and a pre-operative diagnosis.

(3) A complete operative report, describing the finding and technique. In cases of extraction of teeth the dentist shall clearly state the number of teeth and fragments removed. All tissue including teeth and fragments shall be sent to the hospital pathologist for examination.

(4) Progress notes as are pertinent to the oral condition.

(5) Clinical resume (or summary statement).

(b) Physicians' responsibilities:

(1) Medical history pertinent to the patient's general health.

(2) A physical examination to determine the patient's condition prior to anesthesia and surgery.

(3) Supervision of the patient's general health status while hospitalized.

(c) The discharge of the patient shall be on written order of the dentist member of the medical staff.

Comment

When podiatrists have surgical privileges the method of patient management must be detailed in much the same manner as the above. Mechanism of admission is detailed in an earlier section. The discharge of the patient shall be on the written concurrence of both the podiatrist and the physician involved.

3. Written, signed, informed, surgical consent shall be obtained prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, these circumstances should be fully explained on the patient's medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken if time permits.

Comment

Should a second operation be required during the patient's stay in the hospital, a second consent specifically worded should be obtained. If two or more specific procedures are to be carried out at the same time and this is known in advance, they may all be described and consented to on the same form.

4. The anesthetist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient's condition.

5. In any surgical procedure with unusual hazard to life there must be a qualified assistant present and scrubbed.

Comment

The term "qualified assistant" must be defined in the rules and regulations. It is generally acknowledged that where a procedure predictably involves risk to the patient's life, the assistant should be a qualified physician.

6. All tissues removed at the operation shall be sent to the hospital pathologist who shall make such examination as he may consider necessary to arrive at a tissue diagnosis. His authenticated report shall be made a part of the patient's medical record.

10. Dr. Foster, how do you square your strong pro-abstinence, anti-condom distribution comments on "Nightline" with this article which ignores abstinence and promotes "ready access to" and "increase[d] utilization" of contraceptives for teenagers?

The article you mention does not ignore abstinence -- it actually mentions it three times ["abstinence," p. 142; "reducing the frequency of sexual activity," p. 143; "delaying sexual activity," p. 143] **-- highlighting the emphasis "I Have A Future" places on this important value. The main point of the article is neither abstinence -- although integral to IHAF's teaching -- nor contraception -- also a component of the program. The focus of the article is preventing teen pregnancy by giving teens hope, self-esteem, and life options.**

At the very beginning of the article, long before we discuss the role of contraceptives in the IHAF program, we clearly state that previous efforts to prevent teen pregnancy -- which basically provide access to contraception and/or sex education -- have <u>not</u> been successful. We say that *"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."*

That is what "I Have A Future" is about. The emphasis in the article -- and, indeed, in the program -- is on how we can raise the self-esteem of these teenagers and let them know that their futures are unlimited. Those who would call IHAF a contraceptive program miss the point entirely. Contraceptive only programs have <u>not</u> been successful. They address the *capacity* to have a child, but ignore the *desire* to have a child. I have seen that many impoverished teenagers in inner-city neighborhoods think their futures hold little hope other than having babies. That's why IHAF has a different approach. We address the reasons these children want to have children. The bedrock of our strategy to prevent teen pregnancy is to convince teenagers that their futures will be more full and more rewarding if they delay sex and delay pregnancy until a more appropriate time. We teach them what to say "no" to -- stressing abstinence throughout our curriculum -- but then give them something to say "yes" to -- responsibility, education, jobs.

IHAF does distribute contraceptives to those teens who ignore our advice and choose to have sex. It is by no means the purpose of the program, but it is one element in our effort to help these young people have positive futures. When we first went into the Nashville housing projects in 1987, we surveyed the parents in the community. And 91% of these parents asked us to provide contraceptives to sexually-active teens. Perhaps their response was so overwhelming because 73% of these mothers had their first children between the ages of 13 and 19 -- and they know the limitations early pregnancy places on teenage lives. We feel that, if the teens ignore our abstinence advice, it would be irresponsible as adults not to help our young people protect themselves from the horror of AIDS, the dangers of sexually transmitted diseases, and the epidemic of teen pregnancy.

11. Dr. Foster, was contraception distribution to minors a component of the "I Have a Future" program under your tutelage?

12. If the answer to Question #11 is "Yes," please describe in detail the types of contraception made available to minors, the age range of the minors who were recipients of contraceptive devices, specific details as to what steps were taken to obtain parental consent or notification before contraception was distributed to minors participating in the program.

13. Were birth control pills ever distributed to minor females as part of the "I Have a Future" program?

14. If the answer to Question #13 is "Yes," were parents ever notified before the birth control pills were dispensed to minors involved and was a doctor's examination and/or prescription necessary before the pills were dispensed?

Answers 11-14:

As I noted in response to question number 10, for those teens who ignore our abstinence advice and choose to be sexually active, the program has mechanisms for distributing contraceptives, including birth control pills. In checking with the program staff -- who are more involved in the day-to-day running of the program -- they inform me that birth control pills have not been given to a teenager younger than 15 [the program services teenagers up until age 18].

Tennessee State Law does not require parents to be informed regarding the distribution of contraceptives. However, we encourage our young people to talk about these issues openly and honestly with their families and involve their parents in these decisions. In addition, as mentioned above, the vast majority of the parents in the community have asked us to make this service available.

As you know, "I Have A Future" exists under the auspices of the Obstetrics and Gynecology Department of Meharry Medical College. A woman seeking birth control pills would receive a complete pelvic examination from qualified medical staff under the supervision of one of Meharry's Ob/Gyn physicians. A physician's prescription would also be necessary to obtain these contraceptives.

IV. DELETION OF PLANNED PARENTHOOD FROM BIOGRAPHY

15. Dr. Foster, at the time of the initial announcement of President Clinton's intention to nominate you, were you aware that your 17-year affiliation with Planned Parenthood had been deleted from the biography of you handed out to the press?

I was not aware that my affiliation with Planned Parenthood was not included in the biography handed out to the press. My curriculum vitae is 26 pages long. I assume that much of the information it contains was not included in the condensed biography handed out to the press, but that my entire curriculum vitae was made available to any interested person.

16. Whose decision was it to delete the reference to Planned Parenthood from your biography?

I do not know.

17. Did you ever inquire as to why this was being done or why it had been done?

18. What rationale was given to you as to why your affiliation with Planned Parenthood was deleted from your biography?

Answer to Questions 17 and 18:

Since I was not aware of the situation, I did not make any inquiries relating to it, and so sought and received no rationale.

V. VETTING OF NOMINEE

19. Dr. Foster, in the course of your preliminary discussions with Administration officials about your being nominated to the position of Surgeon General, was the issue of you being an OB-GYN or your having performed abortions ever raised?

Yes.

20. If the answer to Question #19 is "Yes," what information did you provide the Administration prior to your being publicly announced as the nominee for the position of Surgeon General?

I discussed my practice as an Ob/Gyn and discussed the fact that I had performed or participated in abortion procedures during my 38 years of practice.

21. Prior to the initial announcement ceremony at the White House, were you ever told by anyone in the Administration -- including the President -- that they desired to use your nomination as a referendum on choice or to raise the issue of abortion rights to a higher profile in our national political discourse?

No.

Additional Questions For Dr. Henry Foster
From Senator Mike Dewine

STERILIZATIONS

In August, 1970, the executive board of the American College of Obstetricians and Gynecologists issued the following statement of policy:

> "If an operation to accomplish sterilization is recommended by the physician for medical indications, the recorded opinion of a knowledge consultant should be obtained."

1. Were you aware of this statement of policy? If not, why not?

   I was generally aware of ACOG policies, but I do not recall specifically when I became aware of that statement of policy.

2. What is your understanding regarding the obligation of a member of the American College of Obstetricians and Gynecologists to be informed of, and comply with, the policy statements of the American College of Obstetricians and Gynecologists?

   A member of any medical association should seek to be informed of association policy statements, but such statements are not binding.

3. Did you obtain the **recorded opinion** of a consultant prior to performing the sterilizations on the four mentally retarded women just prior to 1974?

   In the two cases I recall performing, I do not believe I obtained the recorded opinion of a consultant. I was the only doctor in that part of Alabama to whom the parents of these severely retarded women could turn; a second medical opinion was not readily available. At the time I performed these procedures, I believed that performing them was the morally and medically right thing to do, and the manner in which they were performed was fully consistent with prevailing rules governing informed consent. This was never questioned during the entire course of peer review of my 1976 article.

On July 19, 1973, in response to the public reaction to the involuntary sterilization of two young girls in Alabama, the U.S. Department of Health, Education, and Welfare (HEW) issued proposed guidelines for sterilization procedures. Those guidelines read, in part:

> A review committee comprised of 5 individuals, must review and approve a sterilization of a minor or legally incompetent person, and consider:

1. the medical, social and psychological information regarding the patient, including the age, alternatives in family planning;
2. the sufficiency of consent; and
3. whether the proposed sterilization was in the best interest of the patient.

And, **a court of competent jurisdiction** must review the committee recommendation to permit sterilization if an individual was legally incompetent.

4. When did you become aware that two Alabama girls, Mary Alice Relf and Minnie Relf, were involuntarily sterilized?

My best recollection is that I learned of the sterilization of the Relfs from news accounts sometime after I had moved to Tennessee in May, 1973.

5. Were you aware of these proposed HEW guidelines for sterilization procedures? If not, why not?

The proposed HEW guidelines for sterilization were issued after I performed the sterilization procedures described in my article. I do not recall when I became specifically aware of the HEW proposed guidelines.

6. Do you know whether the sterilizations you performed on the four mentally incompetent women were provided under Medicaid or other federally funded programs?

I do not believe my patients were covered by Medicaid or other federally funded programs.

On January 8, 1974, U.S. District Judge Frank Johnson, in Wyatt v. Aderholt, entered an order setting sterilization standards for the state of Alabama that read in part:

A determination must be made that:

1. the proposed sterilization is in the best interest of the patient;
2. the patient has consented in writing;
3. if the patient cannot consent in writing, a court of competent jurisdiction must determine that the patient is, in fact, incompetent;
4. a review committee must approve such sterilization; and
5. a court must find that the sterilization is in the best interest of the patient.

7. Were you aware of Judge Johnson's order regarding sterilizations? If not, why not?

I do not recall when I became aware of Judge Johnson's order in *Wyatt v. Aderholt*, which was issued on January 8, 1974. I moved to Nashville, Tennessee in 1973, and I was no longer practicing in Alabama at the time Judge Johnson's order was entered.

8. We understand fully that Judge Johnson's order dealt with Alabama state institutions. Understanding that Judge Johnson's order dealt with minimum acceptable standards for state action, what was the duty, if any, of an Alabama obstetrician-gynecologist -- practicing at that time -- to be informed of, and to meet, the standards enunciated by Judge Johnson?

I am not able to offer an opinion about any duty Judge Johnson's order might have imposed on Alabama obstetrician-gynecologists practicing at that time. As my answer above indicates, I was not practicing in Alabama at the time the order was entered. As your question suggests, however, it is clear that the order applied to the sterilization of patients under the care of the state in institutionalized settings, specifically "mentally retarded residents of the Alabama retardation facilities," [the Partlow State School and Hospital], and not to Alabama doctors generally. *See Wyatt v. Aderholt*, 368 F. Supp. 1383 (M.D. Ala. 1974).

PARENTAL CONSENT

In response to a question from Senator Abraham regarding parental consent with regard to abortion in the case of minors, you said:

> **"I am going to be honest with you, Senator. The concept, I support. I would have to see the legislation."**

Attached is a copy of the Ohio statute regarding parental notification of an unmarried minor's intention to have an abortion.

9. Do you support this specific parental notification statute?

10. If not, which specific provision do you find objectionable?

I have had an opportunity to review the Ohio statute and -- from my vantage point as a doctor -- I am pleased to see that it makes provisions for a judicial bypass as well as for notification of several categories of adults in addition to parents. Effective bypass procedures are necessary to protect young people who may have abusive situations in the home. I am also, however, not an attorney and am unqualified to comment on the constitutional validity of this law.

11. Do you support parental notification regarding the provision of contraceptives to minors?

As I said at the hearings, I believe that parents should be closely involved in the lives and decisions of their teenage children. The program I founded -- "I Have A Future" -- does everything possible to involve parents in activities with IHAF teens and to foster open communication within the families in our community. We encourage our teens to discuss these sensitive issues openly and honestly with their parents and involve them in the decision-making process. However, I do not think it is necessary to require parental notification regarding the provision of contraceptives. This view -- promoted by organized medicine, including the American Medical Association, over the years -- is reflected in current state law.

TEEN PREGNANCY PROGRAMS

12. Do you believe that we could reduce teen pregnancy rates in the U.S. -- as a part of a larger effort that includes abstinence -- by making prescription contraceptives available over-the-counter?

I am not certain whether making prescription contraceptives over-the-counter would reduce teen pregnancy in the United States. As public health officials have come to realize over the years -- and as we recognized in developing the "I Have A Future" program -- there are many, many issues that factor into the epidemic of teen pregnancy that the United States is experiencing. These range from tangible, measurable factors such as socioeconomic background to other, more difficult factors such as self-esteem and sense of positive future options. It is impossible to determine which of these factors is strongest and how to best address each one. I personally think that programs which focus solely on addressing the *capacity* to bear a child -- and by this I mean contraceptive programs such as you suggest -- cannot be successful. Any successful attempt to solve this problem will address the *desire* of teens to bear children by showing them the future rewards to postponing sex and pregnancy.

13. Do you believe that we could reduce teen pregnancy rates in the U.S. -- as a part of a larger effort that includes abstinence -- by providing school-based contraceptive services?

Again, my strategy for attacking the teen pregnancy problem will first attempt to address the *desire* of teens to bear children by building their self-esteem and showing them that their futures can be more successful if they delay sex and pregnancy until they are married.

I'm again uncertain as to whether your proposal would result in reduced rates, as it does not address the reason many of our young people *choose* to have babies when they see nothing else in their futures. I do believe strongly, however, that school-based health services are a matter for local communities and parents, in conjunction with their local school districts, to determine for themselves. These decisions should not be made by the federal government.

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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.

- The Institute of Medicine. 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.

- The Ethics Advisory Board. 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.

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DR. FOSTER: A LIFETIME OF LEADERSHIP

It is ironic that questions have arisen about Dr. Foster's leadership. In fact, Dr. Foster has an exemplary record of leadership in his community and his profession.

I Have a Future -- Innovation and Response

Dr. Foster has shown leadership in creating the I have a Future program, earning a "Point of Light" from President Bush. He also has looked for and implemented ways in which to improve the program. In response to the program's evaluation, he refined Family Life Modules and developed new modules, and obtained the help of a Technical Assistance Team for the program. The reaction of the funding source was unequivocal:

> Meharry has been responsive to recommendations for ways to improve the research design and curriculum. The Meharry team has courageously and thoughtfully tackled an important and difficult problem.

Tuskegee -- Taking the Initiative

The real story of Tuskegee is Dr. Foster's leadership and real ingenuity in addressing the problems of an underserved community, whether in bringing first-time medical services to poor women in the rural South, in understanding the need for an "ounce of prevention," or in developing a model pre-natal care program. In the Maternal and Infant Care Program he developed and administered, Dr. Foster directly addressed root causes of infant mortality, mental retardation and birth defects, and brought comprehensive pre-natal and post-partum care to thousands of needy women in a three-county area.

When the Tuskegee Study came to light, Dr. Foster moved immediately, not to recriminate but to provide treatment. It took eight months for HEW to act. It is simply unfair to blame Dr. Foster for HEW's delay.

A Leader in His Community

Dr. Foster's life is a testiment to his willingness to take on tough problems and his ability to inspire others.

- When Meharry and Hubbard Hospital faced complex patient volume and financial problems, Dr. Foster looked toward a structural solution, not a band-aid approach. He overcame racial and political divisions and built a consensus to bring to pass an exceptionally difficult hospital merger.

- Elected to the Institute of Medicine, 1972 (one of the youngest physicians ever so honored). Twice elected by his peers to the Board of the Institute.

- Man of the Year, March of Dimes Foundation, Nashville, 1982.

Dr. Henry Foster Honors and Awards (Continued)

- Faculty Award for Excellence in Science and Technology, first White House Initiative on Historically Black Colleges and Universities, 1988.
- Dean of the School of Medicine, Meharry Medical College, 1990-1993.
- Honorary Doctor of Science, University of Arkansas, 1993.
- Physician, Teacher and Scholar Award, National Medical Association, 1993.
- Acting President, Meharry Medical College, 1993-1994.
- In addition to the "Point of Light" award from President Bush, Dr. Foster's I Have a Future program has received the National Congress of Adolescent Health Award from the American Medical Association.

PROMINENT REPUBLICANS CALL FOR FOSTER FLOOR VOTE

"It'll be a sad day if he's defeated, but a very, very sad day if we don't give Henry Foster a vote on the floor of the United States Senate."
Sen. Arlen Specter [PR Newswire, 5/9/95]

Dr. Foster testified for two full days before the Senate Labor and Human Resources Committee. He thoughtfully and thoroughly addressed each of the questions that have been raised about his nomination -- defining and defending himself well. After the hearing, Dr. Foster answered additional written questions submitted by Senators.

Dr. Foster now deserves a vote by the entire Senate. Republicans and Democrats alike agree. He's earned it. It's fair. And it's the tradition of the United States Congress. As Majority Leader Dole said in February, *"The general rule is that the President is entitled to his nominees, and that's been the general rule around here forever."*

SENATOR BOB DOLE

- In February, Senate Majority Leader Bob Dole refused to play politics: *"Let's see what the testimony is... We shouldn't shoot down somebody before they've even had a hearing. ... The general rule is that the President is entitled to his nominees, and that's been the general rule around here forever."* [Meet the Press, 2/5/95]

SENATOR JUDD GREGG

- "Even many of Foster's opponents say he deserves a vote on the floor. Sen. Judd Gregg said he recently spoke with Dole, and *'I just said I thought we should have a vote on him, that we might as well put it out and have a vote on it.'"* [Associated Press, 5/9/95]

SENATOR JOHN CHAFEE

- *"'I say, let's get on with it,'* said Sen. John Chafee (R-RI), one of the Senate's leading experts on health care, said Tuesday. *'I think that he's a person with suitable experience. He's made efforts in areas that I believe are important -- doing something about teen-age pregnancy. The fact that he's performed an abortion doesn't bother me. I guess the amazing thing is he's done so few abortions over such a long period.'"* [Associated Press, 5/9/95]

SENATOR BOB PACKWOOD

- *"I think he's a qualified man. His background I think is excellent from a standpoint of what we'd be looking for, and I'm going to support him. . . My hunch is on this one the filibuster won't last."* [*Meet The Press*, 5/14/95]

SENATOR BILL FRIST

- *"The American people want Doctor Foster to be given a fair shot, even if they disagree with him vehemently. And secondly, I think they do want it to come to a vote in the United States Senate. I'm not sure if that was the case three weeks ago, but as the way things have evolved, the American people would like to see a vote."* [CNBC, *"Equal Time,"* 5/4/95]

SENATOR JAMES JEFFORDS

- *"I am confident in my own mind that you ought to be approved by this committee, and I hope you are approved by this committee and I hope that you do go before the full Senate and let them examine the facts that we all have here."* [Closing Statement at Dr. Foster's Hearings, 5/3/95]

SENATOR ARLEN SPECTER

- "*It'll be a sad day if he's defeated, but a very, very sad day if we don't give Henry Foster a vote on the floor of the United States Senate.*" [PR Newswire, 5/9/95]

SENATOR FRED THOMPSON

- When asked whether a strong performance by Dr. Foster at the hearing would make a difference, "Tennessee senator, Fred Thompson, says, with regret,. . . *`I'd like to say yes, but I really don't know. At this stage of the game it might not. . . Frankly, I think that presidential politics is part of the picture.'"* [The Commercial Appeal, 5/1/95]

SENATOR JAMES INHOFE

- "...freshman Inhofe of Oklahoma calls it '*shallow on courage*' to deny him his chance." [Wall Street Journal, 5/9/95]

SENATOR RICHARD LUGAR

- "*Even Foster opponent. . . Lugar. . . say(s) he deserves a floor vote.*" [Wall Street Journal, 5/9/95]

SENATOR NANCY KASSEBAUM

- "...Mrs. Kassebaum, who remains uncommitted on the Foster nomination, said she wants it to go to the Senate floor and believes there are enough votes to override a filibuster." [Washington Times, 5/4/95]

SENATOR JOHN MCCAIN

- "*Even Foster opponent...McCain say(s) he deserves a floor vote.*" [Wall Street Journal, 5/9/95]

SENATOR BEN NIGHTHORSE-CAMPBELL

- "As for Nighthorse-Campbell, press secretary Alton Dillard said, *'He will support the nomination, and he doesn't favor any filibuster, any blockage of action, anything like that.'*" [Associated Press, 5/9/95]

SENATOR ALAN SIMPSON

- "*It's about a person's reputation. It's like Bob Bork. You may not have liked Judge Bork, but at least he got to come to the floor for a vote.*" [Washington Post, 5/4/95]

SENATOR OLYMPIA SNOWE

- *"Overall, I found him to be an impressive individual. A very dedicated professional, and very thoughtful."* After meeting with Foster at her office, Snowe said the White House nominee deserves *"a full and fair confirmation hearing."* [Bangor Daily News, 3/2/95]

JACK KEMP

- *"(Republicans) shouldn't demonize him. He is a decent, honorable person. I'm pro-life. I think the Republican Party should remain pro-life....(But) I think it would be unseemly to filibuster this. As far as I'm concerned, it ought to go to a vote."* [Washington Times, 5/4/95]

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I HAVE A FUTURE:

Preventing Teen Pregnancy Through Abstinence and Hope

INNOVATIVE PROGRAM FOUNDED IN INNER-CITY HOUSING PROJECTS:

- In 1987, Dr. Henry Foster -- then Chairman of the Ob/Gyn Department at Meharry Medical College -- founded a program for teenagers in two housing developments in Nashville, Tennessee. It was 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 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 giving teens *reasons* to delay pregnancy by presenting positive alternatives for the future.

IHAF GIVES TEENS REASONS TO WANT TO DELAY SEX & PREGNANCY:

- Dr. Foster founded IHAF because he saw that most teen pregnancy programs at that time were limited to advocating contraception. But these programs did not have a significant impact on teen pregnancy because they only addressed the *capacity* to have a child, without addressing 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.
- Dr. Foster was convinced that a much broader approach was needed, one that empowered inner-city teens to take control of their own futures -- giving them incentives to delay childbearing until a more appropriate time. IHAF was designed on the premise that changes in behavior should be addressed within a framework that provides strategies for positive decision making, while enhancing self-image.
- In this way, I Have A Future 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. But, equally importantly, it also gives them something to say "yes" to -- education, jobs, and successful futures within their reach.

FAMILY AND COMMUNITY INVOLVEMENT AT ALL LEVELS:

- Dr. Foster wanted the community to play a key role in designing the program from the start, so that they would have ownership of it. He met with key community leaders and the Presidents of the Resident Associations. He then commissioned a *Community Needs Assessment* -- asking parents and community leaders the main problems 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, and sexual education.
  - -- And 91% of the parents responded that they would like the program to make it easier for sexually active teenagers to get birth control.

-- The survey also revealed 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.

WHO? WHAT? WHERE? WHEN? HOW? – THE DETAILS

- *Who May Join*? Any teenager, aged 10 - 17, who lives in or near the *John Henry Hale* or the *Preston Taylor* housing projects may participate in IHAF -- which attracts an average of 150 youth each week. More than half of the participants are African American males. Over 850 youths have participated since the program was founded.
- *When Is It Open*? IHAF is open in the afternoon, on weekends, and all summer -- times when teenagers are not in school, often get in trouble, and need a place to go.
- *Values*: IHAF is a value-based program, with these values permeating all aspects of the curriculum -- self-esteem; physical and mental well-being; completion of school; abstinence; sexual responsibility; self control; ability to handle inter-personal conflict; and the value of helping others.
- *Curriculum*: 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. Classes include:
  - After-School Tutoring / Computer Training
  - Pre-Employment Training [Job Readiness/Career Development]
  - Alcohol And Drug Abuse Prevention
  - Conflict Resolution Training / Violence Prevention
  - Sports
  - Comprehensive Adolescent Health Services (including contraceptives)
- *Activities*: IHAF makes a special effort to take the teens on trips outside of Nashville. Many of these young people had never left Davidson County. Now, they visit colleges, speak to successful African-American role models, and tour the nation's capitol. Their view of the world -- and what their role in it can be -- grows with every trip.
- *The Entrepreneur 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 businesses in the communities where they live. 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.

THE RESULTS SPEAK FOR THEMSELVES – FEWER MOMS, MORE GRADS:

- **Thus far, the program has dedicated the majority of their resources -- not to research and evaluation -- but to investments in the teenagers. Based on internal evaluations however, preliminary results show significant differences between young people in the IHAF program and those who did not participate. Teens who actively participate in IHAF had higher self-esteem, fewer pregnancies, a stronger sense of responsibility, and a greater sense of a promising future. IHAF is actively seeking grants to fund outside research that would track the participants over time.**
  - **<u>*Fewer Pregnant Teens*</u>: One 30-month internal study reported <u>only one</u> known pregnancy among active participants in the two IHAF housing projects.**
  - **<u>*More College Students*</u>: A surprise result of the life-options program was the number of inner-city teens that began going to college, demonstrating the program's rare capacity to hold the attention of older adolescents. This is traditionally very difficult, particularly in the case of African-American males. In 1994, 24 participants graduated from high school. And -- even more impressive -- 16 of these inner-city youths, including 8 males, went on to college while another 4 entered the Armed Forces.**

IHAF IS A NATIONALLY RECOGNIZED AWARD-WINNING PROGRAM:

- **<u>"Point of Light"</u>: 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."* They were designed *"to honor those people . . . who have worked together to rebuild families and to revitalize communities."* [White House Fact Sheet, 6/22/89]**
  - **-- In his April 15, 1991 letter to the IHAF program, President Bush commended the program as a *"shining example"* for the nation. [White House, 4/15/91]**
- **<u>Louis Sullivan, President Bush's Secretary of Health</u>: *"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,"* <u>USA Today</u>, 2/9/95]**
- **<u>American Medical Association</u>: The AMA's National Congress for Adolescent Health gave an award to IHAF specifically for its approach to preventing teen pregnancy**

FUNDED BY PRESTIGIOUS ORGANIZATIONS AROUND THE COUNTRY:

- Carnegie Corporation of New York
- William T. Grant Foundation
- Bill and Camille Cosby
- State of Tennessee, Department of Health, Alcohol and Drug Abuse
- United Way of Middle Tennessee
- The Middle Tennessee Chapter of the March of Dimes

May 20, 1995

Dear Colleague:

In establishing the "I Have A Future" program in Nashville's housing projects in 1987, Dr. Henry Foster showed the vision and the leadership that qualify him so well for the position of U.S. Surgeon General. He knew that young people in Nashville's poorest neighborhoods could see few positive choices for their futures, so they allowed themselves to fall into the established patterns of teen pregnancy, drug abuse, and violence that have come to characterize these neighborhoods. Current programs were having no apparent effect. Dr. Foster saw that he needed a new approach to break this pattern -- by showing these young people that their futures could be bright and unlimited, if they took responsibility for their lives.

Dr. Foster did not try to impose his ideas on the community; rather he went to the families and community leaders *first* and asked them what programs they thought their teens needed. "I Have A Future" was born of those discussions and, over the last seven years, has touched the lives of hundreds of young people. Dr. Foster's approach to preventing teen pregnancy was recognized by President George Bush who chose "I Have A Future" to be one of America's *"Thousand Points of Light"* as well as by his former Secretary of Health who said, "*It turns young people's lives around. [It's] the kind of program that the country needs.*"[1] And it is.

The latest tactic of Dr. Foster's opponents -- employed first in his hearing and escalating last week as momentum seemed to turn in favor of the nominee -- has been to suggest that Dr. Foster's "I Have A Future" program does not really have a strong abstinence message. Some have gone so far as to claim that no materials have been made available to support this claim.[2] This is just not true. Even a cursory look at the many materials that have been provided to the Committee provides overwhelming evidence to the contrary. To permit members of the Senate to move beyond this diversion, I have taken the liberty of compiling selections from IHAF's teaching modules, as well as from the many supplemental materials [brochures, videos, games, posters] that the program uses to promote its message of abstinence and sexual responsibility. The IHAF program has made all of these materials available to the Committee.

---

[1] USA Today, 2/9/95
[2] Senator Coats, Washington Times, 5/17/95

Following please find a small sample of the abstinence language found throughout the IHAF curriculum:

In the *Staff Manual* for IHAF's Family Life Module, the very first mention of sexually responsible behavior for teens states that the number one way is abstinence: *"Responsible sexual behavior is defined as abstinence..."*[3] Staff are later instructed to teach the teens how to say no and stand up for their beliefs:

> *"Emphasize that when we choose tough values such as abstinence, our choice may not be the most popular choice. We are likely to receive little positive reinforcement for these choices. Therefore, we must develop the capacity to praise ourselves for courage in living the values we believe are best for us."*[4] [and]
>
> *"There is no reason for adolescents to feel different or strange if they say 'No'. Because of peer pressure, adolescents need to master the assertive communication skills of knowing how to say 'No'. They may often worry about hurting friends' feelings if they say 'No'. Hurt feelings go away but an unintended pregnancy and a baby don't go away."*[4]

The training manual for Meharry Medical College residents, who provide health services in the program, teaches residents how to counsel the teens against sexual activity and to "*Legitimize [the] decision not to have sex. . .*"

Brochures distributed to the teens state that:

> *"[... if I decide not to have sex?]* ***Congratulations!!*** *Contrary to rumor, so have lots of other teens. It's not so hard to say "NO" and still remain friends if you are careful not to hurt the other person. For example you might say: ...`I don't believe in having sex before marriage. I want to wait.'"*[5]

And a game purchased by the program instructs teenagers that:

> *"Sexual abstinence is important because it provides an opportunity to practice self-control, self-respect, respect for others and other important moral and religious values. It decreases the occurrence of teen pregnancy and sexually transmitted diseases and increases your opportunity to complete educational and vocational goals."*[6]

The list goes on and on. I have attached 26 pages, outlining some of the ways a strong message to delay sexual activity has been integrated into the curriculum.

---

[3]Family Life Education Module, October 1994, p. 2
[4]Family Life Education Module, October 1994, p. 28, p. 70
[5]"*Many Teens Are Saying `No'*" U.S. Department of Health and Human Services, 1986
[6]"Crossroads -- *Teen Relationships And Teen Sexuality*" [Diane Bailey, Ph.D., no date]

Dr. Henry Foster – A Leader in the Battle Against Teen Pregnancy

Dr. Foster has long been at the forefront of the battle to prevent teen pregnancy by giving young people reasons to delay sexual activity. As early as 1984[7], Dr. Foster testified before a Congressional Committee that *"early childbearing is a significant problem for our nation,"* recognizing the need for a new way to approach the problem of teen pregnancy. In his testimony, Dr. Foster clearly rejected traditional teen pregnancy programs (distributing contraceptives or sex education) which only addressed how to control the *capacity* to get pregnant, 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. Dr. Foster saw that a successful strategy to prevent teen pregnancy must begin by challenging this sense of hopelessness.

Each of you should read the 1984 testimony. Ten years ago, Dr. Foster rejected programs that solely *"provide access to contraception"* in favor of programs that focus on ways to *"improve marketable skills."* The article made eight recommendations to solve the teen pregnancy problem -- none of which mentioned contraception. Instead he wrote of offering positive alternatives to early sexual activity. The very first suggestion was: *"Provision of incentives to teenagers not to get pregnant and not to impregnate, e.g. the provision of such rewards as scholarships, jobs and job training opportunities."* He also suggested *"communicating the values of deferred gratification"* and *". . . sharing resources to counteract negative group persuasion"* [i.e., learning to stand up to peer pressure]

Again, in "I Have A Future's" promotional brochure, Dr. Foster says on page 1 that traditional birth control teen pregnancy programs have failed high-risk teens. It continues: *"The program was built on the premise that changes in sexual behavior should be addressed within a framework that provides strategies for positive decision-making while enhancing self-image."* That is what "I Have A Future" is all about -- giving these teenagers values and self-discipline while raising their self-esteem. IHAF addresses the reasons these children want to have children. The bedrock of their strategy to prevent teen pregnancy is to convince teenagers that their futures will be more full and more rewarding if they delay sex and delay pregnancy until a more appropriate time. Thus, IHAF teaches them what to say "no" to -- stressing abstinence thought the curriculum -- and then gives them something to say "yes" to -- education, jobs, responsibility, and values.

It is important to note that the program does not just say the word "abstinence" a few times and leave it at that. "I Have A Future" devotes considerable time and effort to giving teens the tools they need to be responsible, to make good decisions and then stand up for what they believe in, and, most important, to resist social pressures to engage in sexual activity.

---

[7]"Legislative Forum Statement on Teenage Pregnancy, 7/20/84

Also attached, please find a compilation of quotations from the "I Have A Future" teens themselves -- drawn from news accounts and statements they provided to the Committee. In addition, many newspapers sent reporters to Nashville to research the program and selections from their stories are also attached.

I am hopeful that this abundance of material will clear up some of this misinformation once and for all and allow Senators to focus on the real issues before us: the vision and leadership Dr. Henry Foster has exhibited throughout his 38-year career and his impressive qualifications for the position of United States Surgeon General. The "I Have A Future" program and the difference Dr. Foster has made in the lives of these inner-city teens -- who are now delaying pregnancy, graduating from high school, and going to college -- is powerful evidence of that.

Sincerely,

Senator Christopher Dodd

"I HAVE A FUTURE":
USING ABSTINENCE TO PREVENT TEEN PREGNANCY

An examination of *"I Have A Future's"* teaching modules -- as well as the many supplemental materials [brochures, videos, games, posters] they utilize -- evidences the strong abstinence message that is integral to the program. IHAF promotes abstinence to prevent teen pregnancy in several ways:

- First, by stressing the value of abstinence and explaining *why* it is so important.
- Second, by involving the family and community in promoting this value.
- Most important, the program does **not** just say the word "abstinence" a few times and leave it at that. IHAF devotes considerable time and effort to giving teens the tools they need to be responsible, to make good decisions and then stand up for what they believe in, and, most importantly, to resist social pressures to engage in sexual activity.

This compilation has been divided into the following categories:

I. IHAF'S CURRICULUM

A. FAMILY LIFE EDUCATION MODULE [Staff Manual]

Final Copyrighted Version; September 1994

Abstinence Message:

- *"Responsible sexual behavior is defined as abstinence or acting upon the decision to participate in sexual intimacy while maintaining a healthy body and exercising assertive family planning."* [p. 2]

- *"It is important for people to practice responsible sexual behavior. . . 1) Refrain from having sexual intercourse. . . However, it is best for children to postpone initiating sexual intercourse and other risky sexual behaviors beyond the early adolescent years."* [p. 2]

- Kujichagulia [Self-Determination] - *"...one needs to have Kujichagulia (Self-Determination) in order to cope with the negative peer pressure toward early sexual intercourse, and careless sexual activity."* [p. 58]

- *"Adolescents often have the impression that 'everyone is doing it'. Surveys show that more than half of all adolescents do indeed say 'No' to sex."* [p. 70]

- "*Discussion:* `*Encourage the participants to do their best to postpone having sex at an early age. Before making up their mind to have sex now or wait, they should ask themselves the following questions*:

  1. *"Can I take full responsibility for my actions?"*
  2. *"Am I willing to risk STDs, pregnancy, future infertility?"*
  3. *"Can I handle being a single parent or placing my child for adoption?"*
  4. *"Am I ready and able to support a child on my own?"*
  5. *"Can I handle the guilt and conflict I may feel?"*
  6. *"Will my decision hurt others? My parents? My friends?"*

  [p. 60]

- *"DECISIONS ABOUT SEX MAY BE THE MOST IMPORTANT DECISIONS ONE WILL EVER MAKE. SO, THINK BEFORE YOU ACT!"* [p. 60-1]

- One exercise is called the "STD Handshake." It asks the teens to pick an index card from a bag. Some say *"STDs"* and others say "*Abstinence.*" The point of this exercise is that Abstinence is the only way to completely avoid the risk of Sexually Transmitted Diseases. [p. 65]

- "***Young men and women can say 'no' and postpone sexual intercourse.*** *But, if they do intend to have sex, they must be informed of the possible consequences of sexual behavior. [If participants are not ready for the responsibility of parenthood, they must consider the various ways of acting sexually responsible.]"* [p. 58]

- *"There are two ways of exercising responsible sexual behavior. One can abstain from sexual intercourse or one can use contraceptives/condoms effectively."* [p. 75]

- *"In order to promote the value of sexually responsibility, it is critical that the community seeks to uplift this value in a unified manner.* [p. 32]

- *"Each participant is encouraged to discuss values around sexuality with their parents and/or other adults whose values are important to the participant."* [p. 32]

- *"Educate participants regarding responsible sexual decision-making."* [p. 11]

- *"The teenage years are a good time to assist others with child care responsibilities but not to take on the full responsibility of being a parent."* [p. 46]

- *"It is important to remember that the purpose of being a teenager is to finish the process of becoming an adult and not to create children before achieving adulthood."* [p. 53]

- To show teenagers what having a baby can do to their lives, one of the exercises is a "*Job Interview for Parent."* It discusses issues like financial resources, time required, emotional needs, etc. to try to convince teenagers to postpone early sex and pregnancy until a more appropriate time. [p. 50]

Teaching Teens To Say No:

- *"There is no reason for adolescents to feel different or strange if they say 'No'. Because of peer pressure, adolescents need to master the assertive communication skills of knowing how to say 'No'. They may often worry about hurting friends' feelings if they say 'No'. Hurt feelings go away but an unintended pregnancy and a baby don't go away."* [p. 70]

- *"Goals: `Using assertiveness skills to avoid unwanted sexual behavior [and to insist that contraception be utilized.]'"* [p. 70]

- Motto: *"IF YOU DON'T STAND FOR SOMETHING, YOU CAN FALL FOR ANYTHING."* [p. 32]

- *"To provide participants with options for confronting pressure to do something that they are uncertain they want to do."* [p. 35]
- *"Definition of Assertive: `to exhibit confidence and adherence to decision despite others' opinion.'"* [p. 38]
- *"Example of an assertive technique is to `Use broken record technique (Keep repeating a simple* ***negative*** *response, don't provide excuses).'"* [p. 38]
- *"Emphasize that when a person feels good about him/herself, that person can express themselves openly, honestly, and assertively."* [p. 39]
- *"Remind participants that their purpose is to develop positive assertive skills for responding to pressure as an adolescent and an adult."* [p. 39]

B. FAMILY LIFE EDUCATION MODULE [Staff Manual][1] November 1991

Abstinence Message:

- *"Responsible sexual behavior is defined as abstinence or acting upon the decision to participate in sexual intimacy while maintaining a healthy body and exercising assertive family planning."* [p. 3]
- Kujichagulia [Self-Determination] - *"...one needs to have Kujichagulia (Self-Determination) in order to cope with the negative peer pressure toward early sexual intercourse, and careless sexual activity."* [p. 58]
- *"Adolescents often have the impression that 'everyone is doing it'. Surveys show that more than half of all adolescents do indeed say 'No' to sex."* [p. 70]
- *"<u>Discussion:</u> `Encourage the participants that they should do their best to postpone having sex at an early age. Before making up their mind to have sex now or to wait, they should ask themselves these questions:*

  1. *"Can I take full responsibility for my actions?"*
  2. *"Am I willing to risk STD, pregnancy, future infertility?"*
  3. *"Can I handle being a single parent or placing my child for adoption?"*
  4. *"Am I ready and able to support a child on my own?"*
  5. *"Can I handle the guilt and conflict I may feel?"*
  6. *"Will my decision hurt others? My parents? My friends?"* [pp. 60-61]

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[1]Many of these quotes also appear in the final [September 1994] version of the Family Life Module.

- *"DECISIONS ABOUT SEX MAY BE THE MOST IMPORTANT DECISIONS ONE WILL EVER MAKE. SO, THINK BEFORE YOU ACT!"* [p. 61]

- One exercise is called the "STD Handshake." It asks the teens to pick an index card from a bag. Some say *"STDs"* and others say "*Abstinence."* The point of this exercise is that Abstinence is the only way to completely avoid the risk of Sexually Transmitted Diseases. [p. 65]

- "***Young men and women can say 'no' and postpone sexual intercourse.*** *But, if they do intend to have sex, they must be informed of the possible consequences of sexual behavior. [If participants are not ready for the responsibility of parenthood, they must consider the various ways of acting sexually responsible.]"* [p. 58]

- "*There are two ways of exercising responsible sexual behavior. One can abstain from sexual intercourse or one can use contraceptives/condoms effectively."* [p. 75]

- "*Educate participants regarding responsible sexual decision-making."* [p. 11]

- *"The teenage years are a good time to assist others with child care responsibilities but not to take on the full responsibility of being a parent."* [p. 46]

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- To show teenagers what having a baby can do to their lives, one of the exercises is a "*Job Interview for Parent."* It discusses issues like financial resources, time required, emotional needs, etc. to try to convince teenagers to postpone early sex and pregnancy until a more appropriate time. [p. 50]

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- *"Remind participants that their purpose is to develop positive assertive skills for responding to pressure as an adolescent and an adult."* [p. 39]

C. FAMILY LIFE EDUCATION MODULE [Staff Manual][1] September 1989

Abstinence Message:

- Suggests handing out pamphlet: *"Many Teens Are Saying No"*[2]

- *"The Family Life Education Module is designed to help...generate attitudes and values positive toward contraception and abstinence."* [1st page after course outline, no page #s]

- *"Deep love between close friends can exist without the presence of open or conscious sexual desire... Sex is not what makes a relationship work. Sharing thoughts, beliefs, feelings, and most of all, mutual respect, is what makes a relationship strong."* [Session IX]

- *"Sexual feelings may be expressed in a variety of ways, only one of which is sexual intercourse."* [Session IX]

- *"Decisions about sex may be the most important decisions you'll ever make. So, think before you act!"* [Decision-Making Handout]

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[2]This pamphlet -- produced by HHS in 1986 -- has been given to the Committee and is excerpted on pps. 10-11.

- *Should you have sex now or should you wait? Ask yourself these questions before making up your mind?*

  1. *"Can I take full responsibility for my actions?"*
  2. *"Am I willing to risk STD, pregnancy, future infertility?"*
  3. *"Can I handle being a single parent or placing my child for adoption?"*
  4. *"Am I ready and able to support a child on my own?"*
  5. *"Can I handle the guilt and conflict I may feel?"*
  6. *"Will my decision hurt others? My parents? My friends?"*

Teaching Teens To Say No:

- *"Let the youth know that it's okay to say 'no'. There is nothing wrong with saying it. Even more important, there is no reason for them to feel different or strange if they do say 'no'."* [Assertive Communication]

- *"Because of pressure from their friends (peer pressure) the youngsters need guidance in knowing how to say 'no'. Young people often worry about hurting friends' feelings if they say 'no'. Hurt feelings go away but an unintended pregnancy and a baby don't."* [Assertive Communication]

D. PROSOCIAL SKILLS MODULE [Staff Manual] October 1994

- *"Emphasize that when we choose tough values such as abstinence, our choice may not be the most popular choice. We are likely to receive little positive reinforcement for these choices. Therefore, we must develop the capacity to praise ourselves for courage in living the values we believe are best for us."* [p. 28]

- *"To provide a framework for adolescents to understand that to say 'no' is not abnormal but normal."* [p. 19]

- *"Emphasize the need to make your own decisions and to take responsibility for the outcome."* [p. 19]

- *"To assist participants in developing skills to resist group pressure."* [p. 28]

- *"To increase participants' positive refusal skills."* [p. 28]

- *"To teach participants how to look beyond the immediate benefits and consider the long-term consequences."* [p. 28]

- *"To assist participants in developing coping strategies when their peer group does not positively reinforce him/her for standing up for his/her beliefs."* [p. 31]
- *"To teach participants how to cope with group pressure."* [p. 33]
- Quote from Malcolm X: *'It is always better to form the habit of learning how to see things for yourself, listen to things for yourself, and think for yourself; then you are in a better position to judge for yourself.'* [p. 36]

E. PROSOCIAL SKILLS MODULE [Staff Manual][3] November 1991

- *"Emphasize that when we choose tough values such as abstinence, our choice may not be the most popular choice. We are likely to receive little positive reinforcement for these choices. Therefore, we must develop the capacity to praise ourselves for courage in living the values we believe are best for us."* [p. 28]
- *"To emphasize that even when you make a decision, you are not always totally locked into that decision if you have reservations."* [p. 19]
- *"To provide a framework for adolescents to understand that to say 'no' is not abnormal but normal."* [p. 19]
- *"Emphasize the need to make your own decisions and to take responsibility for the outcome."* [p. 19]
- *"To assist participants in developing skills to resist group pressure."* [p. 28]
- *"To increase participants' positive refusal skills."* [p. 28]
- *"To teach participants how to look beyond the immediate benefits and consider the long-term consequences."* [p. 28]
- *"To assist participants in developing coping strategies when their peer group does not positively reinforce him/her for standing up for his/her beliefs."* [p. 31]
- *"To assist participants in confronting those feelings which may prompt them into responding impulsively and giving in to the group."* [p. 31]

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[3]Many of these quotes also appear in the final [October 1994] version of the Prosocial Skills Module

- *"Emphasize that no one has to fall prey to persuasion. By getting the facts, one can make their own decisions and define for themselves what they will do and who they will be."* [p. 33]

- Quote from Malcolm X: *'It is always better to form the habit of learning how to see things for yourself, listen to things for yourself, and think for yourself; then you are in a better position to judge for yourself.'* [p. 36]

F. "I HAVE A FUTURE" PROGRAM EVALUATION: Renewal Grant Proposal to W.T. Grant Foundation April 1991

- One Goal [Hypothesis] of The Program: *"Active participants will delay the initiation of sexual intercourse longer than youth who do not participate and comparison site youth."*

II. BROCHURES

As Dr. Foster mentioned during his hearings, since its inception "I Have A Future" has distributed brochures to the teenagers -- and even to their parents -- that have a strong abstinence message. A variety of brochures have been used over the years, as can be seen below. IHAF staff is always looking for new brochures and teaching materials to catch the teens attention and get the message out in different ways.[4]

A. "MANY TEENS ARE SAYING `NO'" [*U.S. Department of Health and Human Services*, 1986][5]

- *"DON'T BE FOOLED into thinking most teenagers are having sex. THEY AREN'T!! There's a lot to know before you say 'yes' to having sex."*
- *"Face it! Sex for young people is pretty risky!"*
- *"Sexual feelings can be pretty strong! So think before you act. Think about your future. Think about the consequences. In other words,* ***think about yourself!*** *Ask yourself, 'Am I ready to have sex now?' To answer this question you need to decide which is more important to you -- giving in to your sexual feelings or being true to your inner feelings that may be telling you to 'wait.'"*
- *"There's a lot to know before making your decision about whether or not to say "yes" to sex:*
  - -- *Is having sex in agreement with my own moral values?*
  - -- *Would my parents approve of my having sex now?*
  - -- *If I have a child, am I responsible enough to provide for its emotional and financial support?*
  - -- *If the relationship breaks up, will I be glad I had sex with this person?*
  - -- *Am I sure no one is pushing me to have sex? [...]*

  If any of your answers are NO, then you'd better WAIT."

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[4]The new brochures Dr. Greene ordered in March 1995 were the first she had seen which a) showed African American role models; and b) had a message targeted specifically to teenage *males*. The publisher of the pamphlets said in a letter to Senator Dodd that *"I have long known Dr. Foster to be a strong advocate for abstinence . . . When these pamphlets were first published. . . I immediately requested my staff to send copies to his program because I knew they would be interested in seeing them... His program immediately purchased and began using them . . . reflection of their interest in keeping their program up to date..."* [May 5, 1995 letter from Journeyworks Publishing]

[5]This pamphlet is referenced in the September 1989 draft of the Family Life Education Module [Staff Manual] which was given to the Committee

- *"Decisions about sex may be the most important decisions you'll ever make. So, think before you act."*

- *"What should I know if I decide not to have sex? Congratulations... contrary to rumor, so have lots of other teens. It's not so hard to say "NO" and still remain friends if you are careful not to hurt the other person. For example you might say:*

  -- *`I like you a lot but I'm just not ready to have sex'*
  -- *`I don't believe in having sex before marriage. I want to wait.'*
  -- *`I enjoy being with you but I don't think I'm old enough to have sex.'*
  -- *`I don't feel like I have to give you a reason for not having sex. It's just my decision.'*

- *"Also, there are different ways to show affection for another person without having sexual intercourse."*

- *"Try to avoid situations where sexual feelings become strong. "Stopping" is much harder then."*

- *"Talk about your feelings and what seems right for you. If you and your partner can't agree, then maybe you need to find someone else whose beliefs are closer to your own."*

- *"Will having sex really make you more popular, more mature, more desirable? Probably not. In fact, having sex may even cause your partner to lose interest. The one sure thing about having sex is that you may be in for problems you don't know how to handle."*

- *"Sex is not what makes a relationship work."*

- *Watch out for lines like, "If you care about me, you'll have sex with me."*

  -- *You don't have to have sex with someone to prove you like them.*
  -- *Sex should never be used to pay someone back for something . . . all you have to say is, "Thank you."*
  -- *Sharing thoughts, beliefs, feelings and most of all mutual respect is what makes a relationship strong.*
  -- *Saying "No" can be the best way to say, "I love you."*

B. "AIDS AND SEX: WHAT YOU SHOULD KNOW"
[*Tennessee Responds to AIDS*, December 1992]

- *"WHAT DO I DO?: First, understand it's okay to say 'No' to sex. Get to know the person better. Date. Don't be afraid to talk about your choices with your friends. Have respect for your body. This way, you can avoid HIV and problems like unplanned pregnancy and other sexually transmitted diseases like gonorrhea and syphilis."*

C. "AIDS: WHAT YOU SHOULD KNOW"
[*Tennessee Responds to AIDS*, July 1989]

- *"HOW CAN I PROTECT MYSELF... The only way to be absolutely safe is to avoid all drug needles and not have sex until you are in a marriage or permanent relationship with a faithful, uninfected partner.*

  Until this is possible . . . Say 'No' to sex."

- *"REMEMBER: Alcohol and drugs make it harder to say no to dangerous behavior."*

D. "AIDS AND TEENS: WHAT YOU SHOULD KNOW"
[*Tennessee Responds to AIDS*, June 1991]

- *"HOW DO I PROTECT MYSELF? Don't have sex. Express your affection in other ways such as holding hands or hugging."*

- *"The safest way to protect yourself from becoming infected with HIV is by avoiding sex and drugs. Because this is your life and your body, you have a right to say NO. Remember, you can't tell by looking at someone if they are infected with the virus."*

- *"Remember the best protection against getting HIV is to avoid sex and drugs. Both drugs and alcohol will affect your judgment and you will be less likely to take steps to protect yourself."*

E. "AIDS AND THE BLACK COMMUNITY: WHAT YOU SHOULD KNOW"
[*Tennessee Responds to AIDS*, June 1991]

- *"HOW DO I AVOID HIV?*
  -- *Say `No' to sex.*
  -- *Alcohol and drugs make it harder to say no to dangerous behavior."*

F. "A PARENTS' GUIDE TO THE FACTS: ***TO HELP MOTHERS AND FATHERS TALK TO THEIR TEENAGERS ABOUT SEXUAL RESPONSIBILITY*****"**
[*American College of Obstetrics and Gynecology (ACOG)*, 1986]

- *THE FACTS: NO. 1: YOUNG PEOPLE CAN POSTPONE SEX.*

- *"Fact: Today's youngsters often have the impression that 'everyone is doing it.' Surveys show that more than half of all teenagers do indeed say 'no.' The 'everyone is doing it' comment is typical big talk by young people who want to make themselves look important in the eyes of their friends."*

- *"Let your children know that it's okay to say 'no.' There's nothing wrong with saying it. Even more important, there's no reason for your children to feel different or strange if they do say 'no'."*

- *"Because of pressure from their friends your children need guidance* ***in knowing how to say 'no.'*** *Explain to your children that the best way to say 'no' is to decide before they get into a situation that might force that decision."*

- *"Young people often worry about hurting friends' feelings if they say 'no.' Hurt feelings go away but an unintended pregnancy and a baby don't."*

- *"WRAPPING UP THE FACTS: When parents can establish themselves as the best source of information on sex, the chances of misinformation are reduced. . . When they (your children) have the Facts, you can help guide them in making the decisions that are best for them. They can say 'no' and postpone having sex. . . "*

G. "A MESSAGE FOR TEENS FROM TEENS"
[*March of Dimes Birth Defects Foundation*, November 1986]

- *"We all know how difficult peer pressure can be -- people our own age telling us to do something that we don't really feel good about doing. We don't want to feel different. We don't want to feel left out. But there is such a thing as positive peer pressure. Our true friends wouldn't want us to do anything that would hurt us or get us into trouble."*

- *No one should try to rush you into anything. That's not the way to express your love for someone."*

- *"Guys take it less seriously because they're not the ones who get pregnant."*

H. "SEXUALLY TRANSMITTED DISEASES"
[*March of Dimes Birth Defects Foundation*, October 1986]

- *"Obviously, there is no risk of infection if there is no sexual contact."*

III. SUPPLEMENTAL TEACHING MATERIALS

A: GAME: CROSSROADS – *TEEN RELATIONSHIPS AND TEEN SEXUALITY*

1. OBJECTIVE:

- *"The objective of CROSSROADS is to encourage sexual abstinence, goal-setting, parent-teen communications, strong moral values, self-control, responsibility, self-respect, and respect for others."*

- *"Sexual abstinence is important because it provides an opportunity to practice self-control, self-respect, respect for others and other important moral and religious values. It decreases the occurrence of teen pregnancy and sexually transmitted diseases and increases your opportunity to complete educational and vocational goals."*

- *"Teens should be very careful about the selection of their peers. They should choose friends and dates who value sexual abstinence and other positive moral standards."*

2. SAMPLE GAME CARDS[6]

a. "If parents find out that their son or daughter is sexually active, they should discuss birth control because it is too late to discuss abstinence. TRUE OR FALSE

Answer: False...It is never to late to discuss abstinence."

b. "It is important for both males and females to keep their virginity because (a) it decreases the chances of getting sexually transmitted diseases (b) takes away the possibility of unwanted children (c) both a and b

Answer: (c)"

c. "What is the best method a teen may use to keep from getting a sexually transmitted disease? (a) condoms (b) abstinence (c) frequent visits to the doctor

Answer: (b)"

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[6]These are only a small selection of the cards focusing on abstinence. Many more were given to the committee. The game also had cards addressing AIDS and STDs.

d. *"Why do you think a male or female teen would choose to abstain from sex until marriage? Explain your answer..."*

e. *"Which two methods can be used to control your sexual feelings? (a) maintain the value of abstinence (b) take a cold shower (c) don't deny your feelings, talk to your parents (d) ignore your feelings, they will go away*

Answers: (a) and (c)"

f. *"What are the advantages for males and females who abstain from sex until marriage? (a) no advantages (b) they can set goals and achieve them through self-control (c) no children born before marriage" Which statement was INCORRECT?*

Answer: (a)"

g. *"What is SEXUAL ABSTINENCE? Please explain your answer...*

Answer: Sexual abstinence means to refrain from sexual activities, including the more advanced stages of petting and sexual intercourse."

h. *"Can you truly love someone and abstain from premarital sex with that person? Yes or No?*

Answer: Yes... Love is a strong affectionate bond that consists of respect, trust and commitment."

B. VIDEO: *"WHO DO YOU LISTEN TO? CHOOSING SEXUAL ABSTINENCE"*
Note: ***There is no date on the invoice [which was enclosed in the video sent to the Committee.] A fax – apparently sent to the program from the video company – is dated 8-21-92.***

- *"It gives them the facts and feelings teens must confront in order to take responsibility for their own sexual activity, and presents a healthy option for them to consider -- sexual abstinence before marriage."*

- *OBJECTIVES: "To help students: [...]*
  -- *Explain the physical, emotional, and psychological risks of premarital sexual activity.*

  -- *Make more responsible decisions about their sexual behavior."*

- *DISCUSSION TOPICS AND ACTIVITIES: [...]*

  4. *Psychological Risks: Consider the psychological risks involved in having sex before marriage, such as feelings of guilt, doubt, fear, disappointment and even the pain of being used. Why do these feelings often follow pre-marital sex? Could they possibly interfere with your ability to concentrate on other things, like building friendships, studying or working?*
  5. *Physical Risks: Consider some of the physical risks involved in having sex . . .*
  6. *Practicing Sexual Abstinence: Discuss the advantages and disadvantages of practicing sexual abstinence before marriage . List some concrete reasons for saying "no" to pre-marital sex that you have learned from the video. . . Why would it be a good idea to refrain from sexual activity, despite what your body may be saying to you? List four activities that can constructively channel your time and energy.*
  7. *Saying No: What are the most common ways others might try to convince you that you should have sex? Practice avoiding the pressure to have pre-marital sex by coming up with reasons to say "no".*

- *SUGGESTIONS FOR GROUP LEADERS*

  -- *Share some adult pressures that you face, such as belonging to a certain club, going out for a drink when you'd rather not, etc. Tell a story illustrating an effective way that you have handled peer pressure, and ask your group to tell you about situations they have seen or been involved in having to do with peer pressure.*

  -- *Encourage adolescents to talk to their parents, school counselors, health teachers or physicians . . . Offer a supportive environment for them to share the information they find. Encouraging them to discuss these issues with their parents can help bridge any embarrassment they may feel regarding these intimate matters."*

C. VIDEO: *"IT ONLY TAKES ONCE"*[7]

The main theme of this video is abstinence, following a young woman -- who has decided with her boyfriend not to be sexually active -- through a variety of social settings. She speaks to a group of teens saying that it's possible to be a virgin and still be cool. [referenced in Family Life Module, p.59]

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[7]The Committee has the only copy of this video so I was not able to quote directly.

D. <u>AIDS POSTER</u>: ***"WITH AIDS AROUND, GONORRHEA, SYPHILIS & HERPES ARE FAIR WARNING"***

- Poster shows a STOP sign and at the bottom it says: ***"You want to be risk-free from AIDS? Don't have sex.*** *And as long as you aren't shooting drugs, you'll be fine. No worries about who's slept around, who's had blood tests, and whether your condoms are latex are not."*

IV. MEDICAL STUDENT HANDBOOK

As "I Have A Future" falls under the Department of Obstetrics and Gynecology at Meharry Medical College, medical residents and students often rotate through the program's clinics. The IHAF staff prepared a handbook[8] to train the residents before they begin their rotation. The handbook gives specific guidelines for providing counseling -- stressing abstinence as the first and best option.

- *DISCUSSION OF QUESTIONS ON "PERSONAL INFORMATION FORM"*

  "The following questions are sensitive and emotional and could take much more time than is available at the clinic. It is important to schedule a special session with the client to talk in more depth if necessary." [...]

  "2. Have You Talked to Either of Your Parents About Coming Here?

  - *"Determine teen's comfort level in talking with parents" [...]*
  - *"Provide teen with "Can I Tell My Parents?" brochure and encourage her to tell her parents in the future. Emphasize that parents can be a source of support for them. If they can't talk to them now, maybe they will be able to some time later. (Don't give up!) [...]*

  "4. Have you ever had sexual intercourse?

  - *If yes, discuss how she made the decision to have sex and ask how often she has intercourse. If the teen felt pressure to have intercourse, let her know that she can stop if it doesn't seem right for her. You can say "no" after saying "yes".*
  - *You shouldn't have sex: 1) just for another person or 2) to be like your friends. What you really want is most important. This is your decision. . .*
  - *If no, discuss teen's feelings about her decision. Legitimize decision not to have sex . . ."*

  "15. The goal of this [sic] questions is to increase the client's realistic understanding of how a pregnancy would affect her life. . .

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[8]*Final Report To Health Of The Public;* Submitted by "I Have A Future", Department of Obstetrics & Gynecology, Meharry Medical College; October 1992

- *Have you thought about when you will be ready to have a baby? Deal with a pregnancy? When do you think you will be ready? Imagine for a moment that you were pregnant? How would you feel?*

- *Discuss wide range of emotions involved in hearing news like this. What kind of reaction would she have? Who could she turn to for information and support? What options would she have?*

- *Have she and boyfriend discussed possibility of pregnancy with sexual relationship?*

- *How would pregnancy/parenthood affect their goals?*

- *Possible role-play situation [unplanned pregnancy]*

"INITIAL VISIT INTERVIEW/COUNSELING SESSION

- *CONTRACEPTION AND STD'S (USING PROTOCOL GUIDELINES):*

The manual lists a number of options for avoiding Sexually Transmitted Diseases -- the first of which is *"abstinence."*

"Provide the following brochures for the teen to take with her:
-- *AIDS Brochure*
-- *What Every Teen Needs To Know*
-- *Your Pelvic Exam -- the 1st or 21st*
-- *Can I tell my Parents?*
-- *The Facts [STDs]*
— ***NO and Other Methods of Birth Control"***

V. LISTEN TO TEENAGERS WHO ARE IN THE PROGRAM...

"But if you let the youngsters tell it, there is less sexual activity among those in the program. Part of it is knowing they are not the only one deciding on abstinence. Part of it is having adults they can talk to openly. Part of it is realizing the repercussions of early sexual activity."
[The Tennessean, 2/5/95]

RHIANNON WILSON:

- *"In 'I Have A Future' I have learned why it's best to abstain from sexual activities through a class called Family Life. With me being a young lady, this class and all the other very **positive** things we do has helped me realize that I truly do have a future and a bright one at that."* [Personal Statement]

- *"Dr. Foster always tells us that abstinence is what we should follow."* [Testimony to Senate Committee]

JASON GORDON:

- *"The program stresses abstinence to the fullest extent, it is the major goal of the program."* [Testimony to Senate Committee]

- "The program taught him one thing most of all, [Jason Gordon, 18] said. *'I know I'm not ready to have a child.'"* [New York Times, 2/11/95]

- *"I Have A Future tells inner-city youth that their futures can be more positive and more successful if they delay sex and pregnancy until they are adults and can handle the responsibilities of a family."* [Statement at White House, 5/1/95]

- *"I know that I would not be where I am if I had gotten shot, gotten someone pregnant, or dropped out of school. That is what IHAF tells us -- if we stay out of trouble, abstain from sex, and avoid drugs and alcohol, our futures can be anything we want. Having a child can limit us forever. Taking responsibility for our lives puts us in charge and lets us define our lives ourselves."* [Statement at White House, 5/1/95]

- *"It's a lot more than just delaying pregnancy and not having sex. It's a lot about responsibility, about having dreams, about having goals."* [AP, 5/1/95]

DEANNA GARRETT:

- *"The 'I Have A Future' program tries to teach the teens that abstinence is the only way that we can put a stop to teen pregnancy, the spread of sexually transmitted diseases, and the transmission of the HIV virus."*. [Testimony to Senate Committee]

GARY HICKS:

- *"Dr. Foster is doing a good deal by teaching kids to wait before they have sex. He 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."* [Testimony to Senate Committee]

TERRELL CARTER:

- Terrell Carter said the program has given him a new perspective on interaction between the sexes. *"I thought that having sex was part of everyday life. It showed me abstinence is cool . . ."* [The Commercial Appeal, 2/14/95]

- Terrell Carter, 18, credits the program for teaching him that fathering a child is *"nothing to be proud of."* He now has *"more respect for girls. They're not just sex objects."* [USA Today, 2/9/95]

CHARMAINE HARRIS:

- Charmaine Harris, 18, says that the program taught her skills she could use to resist pressure to have sex: *"Let's say you have a date, dancing, and things start getting hot. Are you going to be passive or stand up for what you believe in?"* [The Tennessean, 2/5/95]

- *"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."* [Testimony to Senate Committee]

TONYA RUTLEDGE:

- Tonya Rutledge, 17, thinks that her life would be different if she hadn't been in the program. *"I think I would probably be like my other friends which have children or they're about to have a child...."* [USA Today, 2/9/95]

AMELIA TURNER:

- *"When I first moved to Nashville. . . I was confronted daily with negative influences such as pressure to have sex and use drugs and alcohol. Fortunately, people like Dr. Foster realized those kinds of pressures, and they did something about it. Joining 'I Have A Future' gave me a safe alternative to doing those negative things. It taught me how to resist the peer pressures in order to be the best person I can be by not letting others pull me down."* [Statement at D.C. Arrival Event, 5/1/95]

- *"'It kept me busy. I had friends trying to take me in the wrong direction,"* said Amelia Turner, 18, who joined the program when her family moved to Nashville five years ago. *'[The program leaders] constantly stressed the importance of higher education... having a child is down the road.'"* [The Commercial Appeal, 2/14/95]

- *"This would be a nice program to have in other cities,"* said Amelia Turner, who wants to major in both medicine and biomedical engineering. *"In the little town I came from, there is nothing to do, so you may go over to your boyfriend's house. This takes you away from that. You don't have time to do crazy things."* [The Boston Globe, 2/10/95]

- Eighteen year old Amelia Turner says that in her life she is under *"a lot of pressure"* to have sex. I Have A Future counselors *"let us know that if you want to have sex, here's what you can use. But,* ***the best sex is no sex.***" [USA Today, 2/9/95]

FLOYD STEWART:

- Floyd Stewart has been in the "I have A Future" program for 4 years and says that unfortunately most people *"don't know about how [Dr. Foster] preaches abstinence."* [Testimony to Senate Committee]

JOHNETTA NELSON:

- Johnetta Nelson, a student, believes that the program taught her many things. "*I chose to further my education, and I knew that if I was to become impregnated that it would probably hold me back. And I know that I want a lot of things out of life, so I figured that it's not the time.* [CNN, 2/13/95]

- *"I owe a great deal of credit to "I Have A Future" for keeping me active and busy. The program helped me keep my focus on my future and kept me from straying away. It taught me that your education comes first and having children comes later."* [Statement at D.C. Arrival Event, 5/1/95]

MELISSA HUNTER:

- "Melissa Hunter . . . said [Dr. Foster's] brainchild gives her and her friends a choice they seldom had before. A few make it out of the projects and their teen-age years without a baby and the limitations that babies bring, purely on strength of character alone, she said. But it is hard. *'Here they keep you too busy to get into trouble.'"* [The New York Times, 2/11/95]

LATARA GOOCH:

- The "I Have A Future" program has *"taught me how to think of myself, and not let everyone think for me. It also has kept me from making a big mistake in my life. The mistake is having sex at an early age."* [Personal Statement]

TYRECA BOWERS:

- *"I have been in the 'I Have A Future' program for approximately 2 years. This program has helped me to prepare for the real world. It teaches me to be responsible."* [Personal Statement]

LASHONDA MARYLAND:

- *". . . the program helps build skills that are essential in everyday living. By acquiring these skills many of the children who go through the program have higher self-esteems, better manners, respect for themselves and others, excellent communication skills, and the ability to cope with problems."* [Testimony to Senate Committee]

TASAUNDRA DOOLEY

- "Tasaundra Dooley, 16, said, *`They taught us that we don't have to be pregnant.'* Although birth control and abstinence are part of this plan, what the program really does is give her a reason not to join the ranks of unwed mothers, she says." [New York Times, 2/11/95]

MELISSA HUNTER:

- *"'I Have A Future' has helped me escape the peer pressure that takes over most children in our community."* [Personal Statement]

NAKEETA HUNTER:

- *"I've been in 'I Have A Future' for 3 years. 'I Have A Future' has been a great help to me. We call it 'The Future'. 'The Future' talks about just what it says, 'The Future'"* [Personal Statement]

VI. QUOTES FROM MEDIA:
OBJECTIVE SOURCES CONFIRM IHAF'S ABSTINENCE FOCUS

Many members of the media -- objective voices in this ideological battle -- traveled to Nashville and interviewed the staff and students of the "I Have A Future" program. It was clear to all observers that abstinence is a major focus of the program.

- **The Tennessean:** *"R-E-S-P-E-C-T, It Means A Lot to 'Future' Kids,"* 11/14/94[9]

  "The goal was to get kids age 10-17 to **forgo risky behavior, like having sex** and using drugs, that could alter their lives forever. In doing so, values like self-esteem, respect for others and responsibility are instilled...For example, Nelson said she learned a lot from an exercise where she cared for an egg as though it were a child. It helped illustrate that she wasn't ready to have a baby."

- **The Tennessean:** *"Teens Say Foster's Vision Brightens Future,"* 2/5/95

  "We deal with issues such as how to be in relationships, how to be intimate with someone and not necessarily have intercourse, Green explained. *"How do you deal with social situations where you find yourself needing to refuse things?"* Or as Charmaine Harris, 18, said: *"Let's say you are on a date, dancing and things start getting hot. Are you going to be passive, or stand up for what you believe?"*...Greene says their message to the young people is simple: Sex just doesn't fit into your lives right now. But it's not just talk, Greene added. Counselors give teens reasons to want to delay sex and parenthood. Youths are kept busy with field trips, after school activities such as dance and karate classes, support groups, tutoring sessions and jobs... **But if you let the youngsters tell it there is less sexual activity among those in the program. Part of it is knowing they are not the only one deciding on abstinence. Part of it is having adults they can talk to openly. Part of it is realizing the repercussions of early sexual activity."**

- **National Public Radio:** *"Dr. Foster's Work In Nashville Praised,"* 2/17/95

  "NPR:. . . *Every day Joe Jenkins [IHAF Instructor] starts the class the same way.*

  JOE JENKINS: *Once again, welcome to Family Life Education. . . 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."***

---

[9]Pre Doctor Foster's February 1995 nomination.

- **New York Times:** *"Nominee's School Program Offers Alternatives to Teens,"* 2/11/95

  ". . . I Have A Future, an after-school program that teaches teen-agers to delay sex and childbearing, allowing them to build careers and lives...Dr. Lorraine Green, the project's director, stressed that the program does not work with pregnant girls or offer abortion counseling. Rather, she said counselors teach the young people about **abstinence**, responsibility and self-control. . . It addresses much more than sex, said Dr. Satcher and teen-agers involved in the program. It is based on common sense and self-esteem, and slowly, steadily -- through informal classes almost every day after school -- teaches them how a baby can forever limit their lives, and how to value their own lives...*'They felt that if they could do that, the teen-pregnancy problem would be taken care of, too, because the* ***young people would have a reason for delaying sexual behavior.*** *You weren't just saying,* ***'Say no to sex.'*** *You were saying, 'You have a reason to value yourself.'"*

- **Washington Post:** *"In Nashville, A Portrait of Compassion,"* 2/12/95

  "Just two weeks ago, Foster was mainly known for the seven-year-old program preaching values such as cooperation and personal esteem that he had brought to teenagers . . . in Nashville's public housing projects. . . Again and again he heard the same story: Just as much as good health, the kids of the projects needed hope, a commodity in short supply in the drug-ridden, violent neighborhoods. . . Based in the housing projects it serves, **the program preaches sexual abstinence and a strong** anti-drug message, and stresses such values as cooperation, personal responsibility and self-esteem. . . The program has earned national recognition. President George Bush named the program one of the thousand 'Points of Light.'"

- **USA Today:** *"Teens Have A Future, Thanks to Foster Program,"* 2/9/95

  "A takeoff on Martin Luther King Jr.'s 'I Have a Dream,' the program was founded in 1988 to stress abstinence and responsibility to adolescents . . . When Foster and others started IHAF, says David Satcher, director of Centers for Disease Control and Prevention, *'They sat down with the parents and found out what they wanted. They came out really pushing abstinence, but they also had condoms available.' . . .* Amelia Turner, 18. Program counselors *'let us know that if you want to have sex, here's what you can use.* ***But the best sex is no sex.'***

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MALPRACTICE RECORD

Dr. Foster has been named as a defendant only once in his 38-year career in a malpractice suit. For an obstetrician/gynecologist, this number falls well below the average. On average, obstetrician/gynecologists have had almost three lawsuits filed against them, according to the American College of Obstetricians and Gynecologists. Moreover, nearly eighty per cent of all obstetricians/gynecologists have had at least one lawsuit filed against them.

In the 1984 lawsuit where Dr. Foster was named as a defendant, the defendants included other physicians and Meharry Medical College/Hubbard Hospital. Any claims against Dr. Foster were dismissed without prejudice by agreement of the parties. No money was paid on Dr. Foster's behalf to the plaintiffs. In that case, parents complained that Dr. Foster and the other physicians at Meharry Medical College had negligently delayed performing a caesarean section and had failed to take proper care of an infant who died less than twenty four after being delivered. The case was settled and dismissed by the remaining parties.

For a career in which Dr. Foster has delivered thousands of babies, including many in high-risk situations, this record is remarkable. Obstetrician-gynecologists have been plagued by vulnerability to lawsuits, forcing many family physicians to discontinue obstetrics because of the high cost of liability insurance. As of 1992, over twelve per cent of obstetrician-gynecologists had given obstetrics due to the liability concerns and nearly twenty three per cent had decreased the level of high-risk obstetric care they provide (according to the American College of Obstetricians and Gynecologists). In his teaching and in his commitment to providing quality maternal and child health care to underserved populations, Dr. Foster has served as a role model for those entering his profession.

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MEHARRY FINANCES-ACCREDITATION

Meharry Medical College plays a special role in American medical life, educating 40 percent of the nation's black doctors and medical faculty, and sending 75 percent of its graduates to provide medical care to underserved areas. As President Reagan wrote in 1983, "the 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." The leadership Dr. Foster displayed in surmounting those obstacles illustrates his fitness to be Surgeon General.

From its founding, Meharry has faced severe financial pressure as a result of external forces. The years prior to integration forced the school to undertake costly, duplicative burdens, including running Hubbard Hospital, where unreimbursed care for indigent patients was the source of a $2 million annual deficit by the time Dr. Foster arrived in 1973. Declining downtown population and the movement of doctors and patients to convenient suburban hospitals, together with the high number of hospitals in Nashville -- the fourth highest ratio of any major U.S. city -- drove down patient volume. One-way integration added to patient loss, with some whites reluctant to use the historically black facility.

These national trends drained the school finances and pulled patients from both Meharry and the competing city-run downtown hospital, and led to a withdrawal of accreditation of three of Meharry's residency programs, including OB/GYN in 1991. The loss was due to the low patient volume, not to the quality of teaching. Accreditation specifically requires that residents handle a large patient volume and are exposed to a wide variety of medical procedures. The Meharry student body doubled from 1966-1976, the time of Dr. Foster's arrival, at the same time the inner city patient base was shrinking, compounding the problems of patient volume.

Facing an array of structural problems, Meharry devised a structural solution. Dr. Foster took charge of a plan to merge Hubbard and the city's downtown hospital into a single, Meharry-staffed facility. The plan saved the city the cost of replacing an aging physical plant.

Many opposed the plan, doubting that Meharry, as a black institution, could attract enough additional high-quality doctors to provide a high standard of care. Meharry asked for a chance to prove itself. The city set detailed quality recruitment goals and a rigorous timetable for meeting those goals. The responsibility fell on Dr. Foster to meet those goals. He succeeded. The new staff is excellent, and includes nationally recognized physicians. Dr. Foster's role in addressing these complex, potentially divisive issues demonstrates qualities that will make him an outstanding Surgeon General.

THE MEHARRY-METRO GENERAL MERGER

Since its founding in 1876, Meharry Medical College has dedicated itself to providing health care to the poor and underserved and to educating health care professionals who would carry on this tradition. Because of its unique and critical role in American medical education, Meharry has been recognized as a "national resource," and in 1983, President Reagan wrote: "The 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."

Unfortunately, Meharry's commitment to serving those most in need brought with it tremendous financial insecurity. Due to segregation policies, Meharry's repeated requests for staffing and teaching privileges at the city hospital were rebuffed, and, therefore, Meharry was forced to build and operate its own facility, the George W. Hubbard Hospital. It was not until 1948, when Meharry threatened to close Hubbard, that the city agreed to reimburse Meharry for indigent care. But the city's payments were never adequate, causing Meharry to lose millions of dollars every year in unreimbursed care for its indigent patients. Meharry was in danger of following the lead of dozens of other collapsing health care institutions.

The solution to Meharry's problem of maintaining an inner-city hospital while competing with the city-financed Metro General was clear: the two institutions must merge. The merger would benefit both Meharry and the city. Metro General was an old facility which the city needed to replace. The merger, therefore, would save the taxpayers the cost of building a new hospital, roughly $100 million. At the same time, Meharry would be relieved of its financial drain associated with caring for Nashville's poor, and it would gain an increased patient volume. Most significantly, this important institution's survival would be ensured.

Meharry proposed the merger to the Nashville city council in 1988: in essence, the city would lease Hubbard from Meharry and Meharry, replacing Vanderbilt's School of Medicine, would staff the merged hospital. Dr. Henry Foster, named Dean of Meharry's School of Medicine and Vice President for Health Services in 1990, worked with then Meharry President Dr. David Satcher to negotiate with the city council and Metro General.

Initially, the city council opposed the merger primarily because it doubted whether Meharry could attract sufficient staff to serve the institution's expanded patient pool. In light of these concerns and at the suggestion of Nashville Mayor Philip Bredesen, the city council would test Meharry's mettle by making final acceptance of the merger contingent on Dr. Foster's recruiting a full faculty of 56 physicians and 18 residents to staff the consolidated hospital. The plan was accepted by the city council in August 1992, and Dr. Foster was given one year to accomplish the task.

Dr. Foster played a key role in every element of the process: communicating with medical school deans throughout the nation and attracting an applicant pool of over 400 physicians,

interviewing candidates, and working to ease the transition of the prospective faculty members and their families. Keeping within the timetable set by the city council, Dr. Foster recruited top-flight physicians from throughout the country and assured the council that the merged hospital would provide the people of Nashville with the high quality of patient care it demanded while preserving the city's resources. The merger marked the first time a public hospital merged with a historically black hospital.

The people most familiar with the merger, attribute the merger's success to Dr. Foster's leadership.

> Dr. John Maupin, Meharry's current President, said, "Dr. Foster led that recruitment and brought some outstanding physicians from around the 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. Cleo Carter, a former chief of Obstetrics at Meharry who trained under Dr. Foster, recognized, "Probably without him or somebody with his abilities . . . the merger would have fallen by the wayside."
>
> Henry A. Moses, Meharry's Director of Continuing Education said, "It's unbelievable . . . the people he brought on. It's a tribute to his leadership."
>
> Even opponents of the merger, such as William Willis, a Nashville lawyer and former chairman of Metro General, applauded Dr. Foster's tenacity and negotiating skills.

Largely due to Dr. Foster's leadership and vision, the merger of Meharry and Metro General will succeed, resulting in the establishment of a thriving health services campus pledged to providing the highest quality health care to the citizens of Tennessee. Meharry continues to be a national resource, and the city of Nashville will be more prepared than ever to meet its responsibilities to its poorest citizens.

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PLANNED PARENTHOOD

Planned Parenthood is a health care organization which manages nearly 1,000 health centers in 49 states and the District of Columbia. Planned Parenthood serves four million women and men each year, making it the nation's largest provider of comprehensive reproductive health care, including breast examinations, PAP tests, testing and treatment for sexually transmitted diseases, infertility services, birth control methods and counseling, and comprehensive sexuality education. Dr. Foster has served on local and national Planned Parenthood boards since 1974.

Planned Parenthood and Dr. Foster share the mission of resolving our nation's most troubling health crises by providing effective solutions which focus on prevention and responsibility. Throughout his career, Dr. Foster has been a driving force in the prevention of teen pregnancy and a leader in the field of public health. The highly effective, "I Have a Future" program, which Dr. Foster developed, stresses sexual responsibility, self-control, education, and job skills and provides positive alternatives to having children. Similarly, Planned Parenthood's medical and educational services help prevent nearly half a million unintended pregnancies each year.

Although Dr. Foster does not advocate abortion as a substitute for family planning, he supports Planned Parenthood's efforts to provide abortion services when a woman chooses to have the legal, constitutionally-protected procedure. Dr. Foster has repeatedly voiced his concern that all women have access to reproductive health care, including abortion. He also has supported Planned Parenthood's efforts to secure the passage of the Freedom of Access to Clinic Entrances Act, legislation designed to protect patients and staff at women's health care centers.

While Dr. Foster was a member of the organization's Board of Directors, the Nashville affiliate filed a lawsuit challenging a Tennessee law requiring parental notice before a teenage girl could obtain an abortion. Dr. Foster has sought to involve parents in their children's decisions to obtain contraceptive or abortion services and strongly believes that parents should be involved in these decisions. He has worked to limit the number of abortions performed on teenagers by promoting abstinence and alternatives to having children through programs such as the "I Have a Future" program. Dr. Foster realizes, however, that some young women cannot notify their parents, because they come from homes where physical violence or emotional abuse is prevalent or because their pregnancy is the result of incest. Dr. Foster opposed the Tennessee law because it required parental notice for a minor seeking abortion with no exception for minors from abusive homes and no bypass mechanism as required by the United States Supreme Court.

To prevent unwanted pregnancies and to provide alternatives to sexual activity, Dr. Foster looks primarily to parents and families. He encourages parents to educate their children about sexuality and reproductive health and to promote the need to postpone premature sexual activity. Dr. Foster also realizes that schools may play an important role in the process and advocates developing age-appropriate educational programs which promote abstinence and which prepare teenagers for responsible sexual involvement as adults.

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Removal of the Normal Uterus*

HENRY W. FOSTER, JR., MD,† Tuskegee, Ala

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Removal of the Normal Uterus*

HENRY W. FOSTER, JR., MD,† Tuskegee, Ala

ABSTRACT: The uterus is often justifiably removed when anatomically it is a normal organ. Unfortunately, such surgery often is viewed with suspicion because there is failure to communicate the justification to patients and uninformed critics. An effort is made in this manuscript to categorize procedures and thus more clearly delineate the indications for removal of the normal uterus. Reviewed is a total of 485 hysterectomies performed over a ten-year period in a medical school affiliated hospital providing training in obstetrics and gynecology for second-year residents and for third- and fourth-year medical students. Eighty-two of the 485 uteri removed (16.9%) were considered anatomically normal by the criteria set forth. The morbidity associated with these cases was minimal.

OBSTETRICIANS AND GYNECOLOGISTS must guard vigilantly against the injudicious and indiscriminate removal of the normal uterus. Failure to do so will only serve to reinforce much of the hostility and suspicion currently directed toward our discipline. However, much of the hostility and suspicion is unneccesary and exists because there is failure to communicate the concept that removal of the anatomically normal uterus can be completely justifiable. In fact, in some circumstances it is imperative that this normal organ be extirpated. Consequently, efforts must be made to inform patients and uninformed critics.

Basic textbooks of gynecology make little or no reference to removal of a normal uterus per se. Therefore, I wish to delineate more clearly those conditions under which removal of the normal uterus constitutes acceptable surgical practice. I am cognizant that this involves much that is subjective and philosophical and that there will not be unanimous agreement with the opinions presented. I hope, though, that these opinions and judgments will serve as a point of reference to place this controversial subject in better perspective and to improve communications between physicians and patients regarding this surgical procedure.

To determine what constitutes a normal uterus is not always a simple task. Nonetheless, some criteria must be set. It is estimated that the adult nulliparous and parous uteri have average weights of 60 and 90 gm respectively. It also is estimated that one out of five women past the age of 30 has either clinical or subclinical myomas.[1] For the purpose of this paper, any uterus weighing less than 150 gm, possessing no myomas greater than 4 cm in diameter, and showing no abnormal microscopic change is considered normal.

It is believed that the first hysterectomy was performed in 1843 by Charles Clay of Manchester, England, although his patient died on the 15th postope tive day. The first completely successful hysterecto was done by Dr. Walter Burnham of Lowell, Mass, 1853.[2] However, it was well into this century bef this procedure approached any acceptable mortal and morbidity figures. Thanks to the 20th Centu advances in surgical technics, blood banking and fection control, hysterectomy has become a basica safe procedure, although mortality and morbidity h by no means been reduced to zero. In a large, w respected training hospital in this country, the m tality from this procedure was 0.5%.[3]

Moreover, the associated nonfatal complications not to be taken lightly. Though infrequent, the m common serious complication of hysterectomy is ble ing requiring postoperative suturing in 0.8%.[4] Ot frequently encountered complications occur in urinary tract. A study in 1962 reported a 1% incide of unilateral ureteral ligation associated with to hysterectomy.[5]

Fistula formation frequently complicates hyster tomy. Ureteral-vaginal fistula is rare except when ureters are skeletonized as with radical cancer surge Also, rarely, rectovaginal fistulas result from injury the sigmoid colon or rectum in the course of h terectomy.

It has been shown that laceration of the urin bladder occurs in 2% of hysterectomies.[6] Fistula for tion here, however, can be essentially eliminated the injury is recognized promptly and repaired pr erly.

Significant morbidity is thus a real threat whene hysterectomy is undertaken and is reason enough demand great care in patient selection.

INDICATIONS FOR OPERATION

The justification for removal of the normal ute is clearer in some instances than in others. Tabl lists what I have termed *established* indications removal of the normal organ, as well as *relative* dications for this procedure.

Although hysterectomy, usually vaginal, is emplo

TABLE 1. Indications for Removal of the Anatomically Normal Uter

Established Indications	*Relative Indications*
Ovarian cancer	Sterilization
Oviduct cancer	Mental retardation
Vaginal cancer	Ectopic pregnancy
Chronic pelvic inflammation	Familial history of cancer
Endometriosis	Pelvic pain
Genital prolapse	Hydatid mole
	Postirradiation of uterus
	Benign ovarian disease
	Pelvic tuberculosis
	Postpartum hemorrhage
	Dysfunction bleeding

*Read before the Section on Obstetrics and Gynecology, National Medical Association, Seventy-ninth Annual Meeting, New Orleans, La, July 29-Aug 3, 1974.

†From the Department of Obstetrics and Gynecology, John A. Andrew Memorial Hospital, Tuskegee, Ala. Dr. Foster is now with the Department of Obstetrics and Gynecology, Meharry Medical College, Nashville, Tenn.

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for sterilization it is not a universally accepted practice. Most gynecologists perform hysterectomy for sterilization only when there are other, more generalized indications for removal of the uterus. Recently, I have begun to use hysterectomy in patients with severe mental retardation. Hysterectomy can be done either for sterilization or to eliminate the menses, which is of significant hygienic benefit in these severly handicapped individuals.

Hysterectomy often is the procedure of choice in both interstitial pregnancy and ectopic pregnancy when a single remaining tube is involved and must be removed.

Whether to perform hysterectomy for dysmenorrhea or generalized intractable pelvic pain is a difficult decision because of the subjectivity of this complaint. It is recommended that a psychiatric perspective be sought when no organic cause for pain can be found.

More liberal use of hysterectomy in the presence of the normal uterus could be warranted in patients with a strong family history of genital malignancy, ie, in a sibling or parent. Such a change in philosophy may be plausible, and it is interesting to note that more women now die annually in this country from ovarian cancer than from cervical carcinoma.[7]

Fortunately, the intracavitary use of radium for the control of benign uterine bleeding has been abandoned. Studies have revealed a relatively high occurrence of carcinosarcoma in patients treated in this manner; consequently, prophylatic hysterectomy appears justified.[8]

Also, after evacuation of a molar pregnancy in a woman who has borne as many children as she desires, even in this day of effective chemotherapy, I can see no advantage in uterine conservation.

Possibly, in the patient over 35 with benign ovarian neoplastic cysts, hysterectomy should also be done. Secondary malignant degeneration may occur in any of these neoplastic tumors and they all possess a varying capacity for bilaterality.

Hysterectomy may be indicated in patients with diabetes mellitus. This consideration seems reasonable since it has been shown that the coexistence of this disease and endometrial carcinoma is frequent. It has been reported that 20% of all patients with endometrial carcinoma have overt diabetes and one half of these patients have abnormal glucose tolerance curves.[9]

The modern treatment of genital tuberculosis is active and prolonged therapy with streptomycin and isoniazid. However, operation becomes necessary if there is no change in the pelvic findings after four months of this regimen.

In the woman with severe dysfunctional bleeding, the number of children she has had should determine whether a hysterectomy is in order.

Again, reproductive desires dictate the course of action in severe postpartum hemorrhage. In the young patient who has further procreative desires, ligation of the internal iliac artery should be done. If necessary, both ovarian arteries in addition to both hypergastric arteries should be ligated. Pregnancy and delivery can follow these procedures and are completely uncomplicated.[10]

TABLE 2. Ten-Year Experience With Hysterectomy

Time Period Studied	Total No. Cases	Anatomically Normal Uteri	
		No. Cases	% of Total
May 1963 – May 1964	64	8	12.5
May 1964 – May 1965	49	7	14.2
May 1965 – May 1966	38	7	18.4
May 1966 – May 1967	43	9	20.9
May 1967 – May 1968	50	13	26.0
May 1968 – May 1969	47	5	10.6
May 1969 – May 1970	51	6	11.7
May 1970 – May 1971	53	10	18.8
May 1971 – May 1972	38	11	28.9
May 1972 – May 1973	52	6	11.5
Totals	485	82	16.9

MATERIAL AND DISCUSSION

I have reviewed my experience with hysterectomy over the past ten years at the John A. Andrew Memorial Hospital in Tuskegee, Alabama (Table 2). Between May 1963 and May 1973, 485 hysterectomies were done. Of these, by the criteria set forth in this manuscript, 82 (16.9%) of the uteri removed were normal. Of these 82, 41 (50%) fell into the group defined as having established indications (Fig 1).

Pelvic inflammation by far was the most frequent

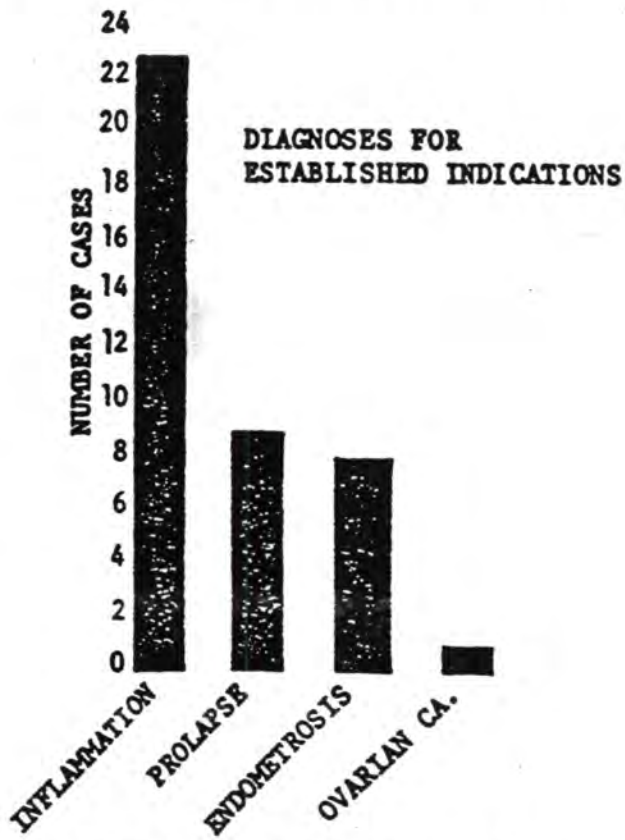

FIGURE 1. Diagnoses for established indications (n=41).

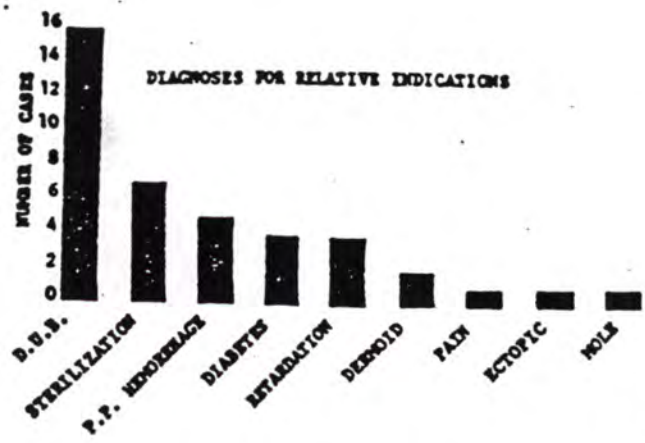

FIGURE 2. Diagnoses for relative indications (n=41).

indication for removal of the normal uterus. All nine hysterectomies for genital prolapse were by the vaginal route and were combined with anterior and posterior colporrhaphy. Of the eight cases of endometriosis (9.8%), only one patient was white. I believe the disease occurs more frequently in blacks than the literature suggests. The single case of ovarian cancer was a unilateral serous cystadenocarcinoma.

The 16 cases (19.5%) of dysfunctional uterine bleeding constituted the most frequent diagnosis in the group of relative indications (Fig 2). Admittedly, some may choose to put this diagnosis in the group of established indications. It is interesting that only one hysterectomy (1.2%) was done exclusively for intractable pelvic pain. Certainly, many of these patients had varying degrees of pain but when more than one symptom was present, only the predominant or primary symptom was recorded as the indicated cause for operation. The single hysterectomy done for ectopic pregnancy (1.2%) was a case of intraligamentous pregnancy.

There were no fatalities among the patients having normal uteri removed. In addition, there was only minimal morbidity. Only one patient (1.2%) developed significant postoperative bleeding, which was easily controlled with several sutures placed vaginally. There was no known injury of the urinary tract, and none of the 82 patients developed any clinical thromboembolic disease.

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OPERATIVE GYNECOLOGY

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and

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tion can be divided into four groups: (1) psychiatric, (2) medical, obstetric, and gynecologic, (3) socioeconomic, and (4) potential fetal defect.

Psychiatric Indications. Psychiatric problems may be an indication for sterilization on either a mandatory or a voluntary basis. Several potential risks may present: the possibility of transmission of deficiency or susceptibility to mental illness to the child, the provision of a poor and damaging environment for children, and the exacerbation of maternal psychiatric illness by the stress of increasing responsibilities. Myerson, in summarizing the report of an investigation by a committee of the American Neurological Association, points out that though there are possibly some hereditary bases for schizophrenia, manic-depressive psychoses, some epilepsy, and feeblemindedness, heredity is by no means the whole picture. Such hereditary risk alone is often not definite enough to constitute strong indication for sterilization. Other factors are more evident and measurable, and certain practical considerations will indicate a reasonable course in most cases.

Young girls who are minors and childless should not be sterilized except under extreme circumstances. With psychological testing showing mental age under 6 years in individuals who are adolescent or older, few would oppose sterilization, as such persons cannot care for themselves or any children they might produce. Mildly retarded individuals usually should not be sterilized until they have a couple of children. They may manage a small family satisfactorily but usually welcome sterilization to avoid being overwhelmed by more than they can handle.

Women who are seriously psychiatrically ill on a chronic or recurrent basis may be candidates for sterilization, particularly if they are multiparous. Sterilization is preventive in that it reduces the number of children at risk and minimizes the deterioration of environment which larger numbers may produce. Since most women with psychiatric problems do not want large families, their voluntary sterilization does not deny essential human rights; in actual fact, it often extends their right of choice.

Medical, Gynecologic, and Obstetric Indications. Indications for therapeutic abortion in various medical conditions given in Chapter 22 are, with few exceptions, indications for sterilization as well. In most cases serious enough to require therapeutic abortion, sterilization is mandatory regardless of the parity. How and when it is accomplished will vary with the type of termination procedure and condition of the patient. Sterilization may be done with propriety more liberally than therapeutic abortion. Multiparous women with chronic hypertensive vascular disease, heart disease, chronic renal or pulmonary disease, diabetes, etc., not severe enough to demand abortion may often be well advised not to invite additional risks of future pregnancies.

Gynecologic plastic operations for extensive relaxations, prolapse, and the like are most often done in women of considerable parity when the family is complete, and sterilization is usually indicated to protect the repair. This indication is decreasing because of the wider use of vaginal hysterectomy in such situations.

The major obstetric indication is the presence of cesarean section scars. The danger of scar rupture is small (0.5 to 2.0%, depending on the type of scar) but is ever present. Repeated sections have additive risks of anesthesia and laparotomy as well. It is our practice to offer sterilization with the 3rd section and strongly recommend it with the 4th; in a woman of parity over 4 who requires primary cesarean section, it is justifiable to accompany it with sterilization if the patient desires to avoid risks.

Great multiparity has been widely considered an indication for sterilization, as supported by Eastman's demonstration in 1940 that the maternal mortality was 3 times as high in women of parity over 8 as in women of lesser parity. In 1955 he pointed out that improved obstetric management had reduced maternal mortality so that the risk of pregnancy did not significantly exceed the operative risk for

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TUSKEGEE STUDY TALKING POINTS

During two days of confirmation hearings, Dr. Foster effectively refuted unfounded charges that he was aware of the infamous Tuskegee Study prior to 1972, when the study became public. He showed the nation that he is a man of compassion deeply committed to providing medical services to underserved areas, and that in keeping with his character, Dr. Foster upon learning of the Study in 1972, immediately called a meeting of the medical society to identify and treat the men.

Efforts to link Dr. Foster to the Study have failed utterly.

- Dr. Foster did not attend the May 19, 1969 meeting of the Macon County Medical Society and PHS officials connected with the Study. State medical records show that he delivered a baby that evening, and the statement of the baby's mother convincingly places Dr. Foster in the midst of complex surgery throughout the meeting.
- Dr. Ira Myers did not testify in a 1974 deposition that he had spoken with Dr. Foster about the Study before 1972. The testimony at that time was unclear, and Dr. Myers has rejected the efforts to twist his testimony. Dr. Myers publicly has supported Dr. Foster's recollection that their meeting took place in 1972.
- The PHS officials never told the Society the details of the study. All investigations agree that nothing was said at the meeting about the lack of treatment or the lack of consent. Nor was any evidence at all found that any Society member at the meeting ever discussed it afterwards with Dr. Foster or any other person. Even Dr. McRae indicates that the PHS presentation was so unremarkable that he never mentioned it to anyone.
- The Study was not widely known in Tuskegee. The Study had ceased to be active locally long before Dr. Foster came to Tuskegee in 1965. It always had been run out of the research laboratories of the Public Health Service in Atlanta, not by doctors in Tuskegee. Local citizens and medical professionals never were fully informed of the study and did not knowingly participate in it.
- Tuskegee Institute was not involved in the Study. Even those providing services to PHS, such as X-rays, knew nothing: theirs was simply a business relationship with a federal agency with no explanation of the Study. Study leaders had taken steps to hide the Study form the Institute as early as the 1940s.

Ultimately, the effort to place the onus of the Study on black institutions or black individuals must be seen not only as misguided and completely incredible, but deeply offensive.

The Tuskegee Study

In 1932, the Public Health Service (PHS) began a study of 600 black men in Macon County, Alabama, some 400 of whom had syphilis. The disease was not infectious in the 400 men, but held real health dangers for them. PHS assured the State that it would treat the men, but did not, even when penicillin became available. The men were not informed of the study by PHS, but thought that they were being treated. From roughly 1935 to 1945, PHS actively interfered with treatment of the men.

By the time Dr. Foster came to Tuskegee in 1965, the Study was far different than in 1935-1945. Barriers to treatment had crumbled, and by 1965 all but one of the men had received treatment from some local doctor or other source outside the Study. PHS obscured the Study, with misleading information as to treatment and consent in medical journals and locally. Even those providing services to PHS, such as X-rays, knew nothing.

PHS re-examined the study in February 1969, and arranged to meet with the local Medical Society on May 19, 1969. The PHS officials were acutely aware of the racial aspect of the Study, and the strong evidence is that they did not tell the black Tuskegee physicians that they were withholding treatment from black men without the mens' knowledge or consent, or ask the black doctors to endorse such practices. Indeed, the evidence is that PHS told them that all of the men had received effective treatment, and gave a report of procedures for their "continued" care. Indeed, PHS finally did begin to provide medical information about the men to their local physicians in 1970.

Of the six or more doctors present, only one, Dr. Luther McRae, has stated that Dr. Foster attended the May 19, 1969 meeting. No other person supports this recollection, and no document places Dr. Foster at the meeting. Official state medical records provide strong evidence that at the time of the May 19, 1969 meeting, Dr. Foster was delivering a baby. These records are far more reliable than the memory of Dr. McRae, whose license to practice medicine was revoked in 1985 for the improper distribution of controlled substances. Nor is there any evidence at all that any Society member at the meeting ever discussed it afterwards with Dr. Foster or any other person. Even Dr. McRae indicates that the PHS presentation was so unremarkable that he never mentioned it to anyone. When the full story of black men misled and untreated came to light in 1972, the shock of Dr. Foster and the other Macon County doctors was entirely genuine.

The other source of information about the Study was medical articles in specialty journals unlikely to be read by Dr. Foster. The articles are at times misleading, and in themselves did not alert even those national newspapers provided with copies in 1969 to the nature of the Study. To condemn Dr. Foster on the strength of these articles would be to condemn every member of the medical profession who practiced prior to 1972.

TALKING POINTS -- SENATOR ASHCROFT LETTER
May 22, 1995

Dr. Foster: Making every effort to provide the facts

- Dr. Foster has bent over backwards to clear up the confusion and misinformation that those opposed to his nomination has spread. It is a final irony, and a final unfairness, that his efforts to provide the facts are now being twisted. It seems that is all that his opponents have left.

- Dr. Foster testified before the Committee for two full days, fielding detailed and often hostile questions. He impressed the American people with clear fitness to be Surgeon General, and with his determination to "set the record straight." He was open, honest and forthright.

Clarifying technical terminology

- Dr. Foster was at pains to clarify points during the hearing, especially where the questions confused scientific and medical meanings with lay meanings. Dr. Foster paused to clarify an earlier exchange with Sen. Ashcroft with a scientific point.

- In going over the 350-plus pages of transcript, Dr, Foster noted an instance of possible confusion: A question had been asked by Senator Ashcroft in everyday language, and Dr. Foster instinctively had heard it in the language of a scientist. Sen. Ashcroft asked about "evaluations" of the I Have a Future program. To a researcher, I Have a Future had a single evaluation, with more than one reporting point, as Dr. Foster explained in detailed but scientific terms (T1, T2, T3, etc.). When Dr. Foster saw that Sen. Ashcroft **may have been** seeking information about each reporting point, he moved immediately to provide it and clarify any **possible** misunderstanding. Dr. Foster had no reason to hide this information. It actually was somewhat more positive than the analysis about which he was questioned during the hearing.

Dear Colleague:

You recently received a letter from Senator Coats concerning Dr. Henry Foster's nomination to be Surgeon General. You all saw or heard of Dr. Foster's testimony before the Labor and Human Resources Committee. He is a distinguished educator, a scholar, and a warm and caring physician, one whom I feel is eminently qualified to serve as Surgeon General.

Others oppose Dr. Foster, and we all agree to disagree at times. In dealing with a nomination, we each must make a choice. In one way the choice ultimately is one posed by Senator Coats himself recently in the Washington Post, recalling the hearings on Judge Bork: "Do we try to get even or do we say that's not the way we do business?"

I am concerned about Senator Coats' letter. It involves the infamous Tuskegee Study of Untreated Syphilis, a study commenced in 1932 without the informed consent of the men, who were left untreated while the course of their disease was studied by scientists in Atlanta with the Public Health Service. The study was not formally ended until 1972. Dr. Foster resided in Tuskegee from 1965 until 1973, and the men who were unwitting participants in the study lived in surrounding Macon County.

Tuskegee especially then was the cultural and medical center, and Dr. Foster was at the heart of medical servces for a multi-county area. He testified about his incredible workload. Indeed, at the time, 14 percent of all black children delivered in hospitals in the entire State of Alabama were delivered at his hospital, where he was the only obstetrician. Many of these deliveries were high-risk because of the widespread poverty and lack of prenatal care. Dr. Foster brought a program of prenatal care to the region, and patched together innovative techniques to bring service to an underserved area. His testimony at the hearing tells a truly remarkable story, and I invite each of you to read it.

When the study came to light in 1972, Dr. Foster as president of the local medical society called a special meeting and initiated efforts to locate and treat the men. Some eight months later, on the eve of hearings which I had scheduled, Secretary Weinberger committed HEW to provide full medical treatment for the study subjects for all conditions for the rest of their lives.

We know a great deal about the Tuskegee Study because a claim was raised that the local medical society was informed of the study by the Public Health Service at a May 19, 1969 meeting. One person, a Dr. Luther McRae, claimed that Dr. Foster attended that meeting. Chairman Kassebaum and I jointly requested that

the White House have the FBI conduct an investigation to determine:

1. Is there any evidence placing Dr. Foster at the 1969 meeting between the PHS officials and the Macon County Medical Society? If so, what is it?

2. Is there any evidence of the scope and details of the presentation by the PHS officials to the Medical Society in the 1969 meeting?

3. If Dr. Foster did not attend the 1969 briefing, is there any evidence indicating that he knew of the study prior to 1972? If so, what is it?

The White House cooperated fully and the FBI report was made available for all members of the Committee to study personally. I studied the report. At least four of my colleagues on the majority side of the Committee studied the report. Senator Coats did not. If he had, he would not have written the letter.

A complete and objective study of the voluminous documents obtained by the Committee investigators, either independently or with the close cooperation of the White House, shows that the study had ceased to be active locally long before Dr. Foster came to Tuskegee. The study always had been run out of the research laboratories of the Public Health Service in Atlanta, not by doctors in Tuskegee. Local citizens and medical professionals never were fully informed of the study, even when it began in 1932, and did not knowingly participate in it. By 1965, the study existed only vestigially, and in 1969 PHS was seeking to exit a deeply embarrassing situation.

The presentation of materials in Senator Coats' letter is highly selective, and in the ultimate analysis, genuinely unfair, not only to Dr. Foster but to Tuskegee University and all of Macon County. The letter culls a few documents from the mass of materials provided by the White House or obtained through the Committee's own investigation and presents them in a misleading fashion. To give a few examples, it cites selectively from a letter by a Dr. Myers to Dr. Brown, a study leader, which lists Dr. Foster as a Macon County Medical Society officer and underlines a portion regarding planned contacts "with local officers," implying that Dr. Foster was contacted. It fails to quote the handwritten notation that the conversation was had not with Dr. Foster but with Dr. Luther McRae (whom Dr. Brown noted as "white") and also fails to quote the portion of the letter which states of the local public health officer that "She feels that [the study] is not generally known or publicized. She doubts if the medical society is aware of its existence." Another letter is quoted in which Dr. Brown claims to have told the society of the study and to have given a list of the men to each society member. The same letter also states his view that publication of the study data "should await a more favorable

national climate." Cited portions of other documents omit the clear concern with the racial impact of the study and the trepidation of the study leaders in approaching what now was a predominantly black group of local physicians.

Their trepidation is entirely understandable. They were involved in a study commenced by others at a time when attitudes toward black Alabamians were, to say the least, not advanced. Tuskegee itself was a hotbed of civil rights activity, in the midst of breaking ground with the first black sheriff and state legislators in Alabama in the century. We all recall the mood in college towns such as Tuskegee in 1969, and the PHS officials were painfully aware of the local mood. Each of you can judge the likelihood that these nervous officials went before a group of black doctors in Tuskegee and asked them to join in denying needed medical treatment to black men without the mens' knowledge or consent. Each of you can judge the likelihood that each of these doctors -- and Tuskegee Institute and Macon County, as implied in the letter -- heard this or knew it and did nothing. In fact, all participants in the meeting agree that this did not happen. It is clear that nothing was said at the meeting to alert the doctors to the lack of treatment for the men or the failure to obtain their informed consent.

Senator Coats notes that "it approaches the inconceivable that the members of such a small society, following a visit from federal officials regarding a controversial, racially explosive study of local patients with syphilis, would not in two years have discussed the meeting." That is precisely the point. It would indeed be inconceivable -- if the federal officials did in fact did tell the doctors the full truth. The simple fact is that they did not. All participants agree that nothing was said about consent or treatment. All agree that no one ever discussed the meeting again. A portion (not quoted by Senator Coats) of Dr. David Sencer's deposition states that the reaction of the society to the presentation was a "total lack of interest."

There have been and I suppose are scientists, isolated in laboratories and focused entirely on their research, who are heedless of the sufferers of disease as individual human beings, who can hear of untreated illness and not be moved. Each of you can judge whether Dr. Foster is such a person. Each of you can judge whether Tuskegee and Macon County are communities filled with such people.

We all can understand that the scientists who ran the study might be anxious to minimize their culpability when the morality of the actions of their predecessors was thrust upon them, and we can understand them being less than forthright, and trying to shift responsibility elsewhere. That was the case here. They had misrepresented the study in print before it became public. A 1955 article states that the study began with "a group of Negro men over 25 years of age who **volunteered** for the examination. ... It is the practice of the Public Health Service officers to refer

men who develop syphilitic or nonsyphilitic conditions requiring therapy to the proper sources of treatment." 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). They continued to misrepresent the study when it came to light. The July 27, 1972 Background Paper cited in part by Senator Coats also claims that "persons in the study were informed they had syphilis, [and] were informed that they could request and receive syphilis treatment at any time." The men on whom Senator Coats' theory relies simply were not telling the truth to anyone. They did not inform or involve the local community. The doctors, educators, students and residents of Tuskegee did not sit idly by knowing of this study. To suggest that they did is to insult the integrity and humanity of each of them, black or white.

The letter makes other charges. Without support or explanation, it claims that the "statement by the woman whose baby Dr. Foster delivered that evening (May 19, 1969) is not inconsistent with Dr. Foster's having attended the meeting." In fact, the mother's statement and the official state records place Dr. Foster in the midst of a surgical procedures to deliver a child after a difficult, high-risk pregnancy from the time the meeting started until after it concluded.

[One other charge deserves comment. The letter claims that "the public record shows that victims received no treatment for an additional seven to eight months." That is not accurate. It did take nearly eight months for HEW to take full responsibility for the lifetime medical care for all of the men. This is not to say, however, that the local doctors themselves did nothing in the meantime. Indeed, HEW's agreement to pay retroactively for medical care suggests that the local doctors were active before HEW. In any event it is hardly fair to blame Dr. Foster because he, as a very busy physician in a small town, was unable to make a huge federal agency spring into action faster than it did. The record is clear that Dr. Foster did everything he reasonably could be expected to do for these men.]

I believe that Dr. Foster has shown his deep commitment to serving people and the vision and ability to provide real leadership in important areas such as preventing teen pregnancy. He has shown himself a fair man and a consensus-builder. While others may take issue with his position on a woman's right to choose to terminate a pregnancy and see that, inappropriately I believe, as a disqualification for a public official, I hope that we all can agree to disagree in a straightforward manner. That is how we should do business.

Sincerely,

Edward M. Kennedy
United States Senator

Statement of Minnie Capleton Jamison

My name is Minnie Capleton Jamison, and I am a resident of Tuskegee, Macon County, Alabama. I reside at 1307 Gregory Street in Tuskegee.

On the evening of May 19, 1969, I gave birth to my son, Steven Darryl Jamison. Dr. Henry W. Foster was my obstetrician and guided me along the entire course of my pregnancy and delivered the baby. It had been a difficult pregnancy. I was confined to bed for seven of the nine months, and during the fourth month it was necessary for Dr. Foster to perform a surgical procedure to prevent a miscarriage. I had had two miscarriages before this.

I went into labor on May 18, 1969. I was admitted to John A. Andrew Memorial Hospital in Tuskegee that evening, and I was given medicine to slow labor. My baby was delivered by Dr. Foster on the next evening, May 19, 1969. The delivery was by Caesarean section.

I remember the evening well, but I do not remember all of the specific details. I know that Dr. Foster looked in on me from time to time, but I do not recall exactly what time he looked in or exactly how often he checked on me. I remember that the delivery took place at night, and that I was in surgery for approximately two hours. I recall specifically that part of the procedure was at 7:00. I recall that I was very nervous and I was hyperventilating. I was doing breathing exercises and I tried to focus on a clock at 7:00 p.m. I remember that the anesthesiologist was trying to calm me at the time, and that Dr. Foster joined and helped to calm me. I recall that all of this was before Dr. Foster started to operate, but I do not recall more specifically at what point this was in the procedure. I understand that the medical record indicates that the delivery took place at 9:17 p.m., and I do not dispute that record.

I also remember well what fine care Dr. Foster gave to me and my son. I remember that throughout a difficult time for me Dr. Foster was warm and attentive. I had been told by another obstetrician that I could never have a child. Dr. Foster told me that he would work with me and do everything humanly possible to make sure I could have a child, and he did. He was a very busy man with many patients, but he always took time and was always there to help. He was always very human and very professional. He is a fine man and will make a fine Surgeon General.

SIGNED: Minnie Capleton Jamison

Minnie Capleton Jamison

DATE: 4/28/95

STATE OF ALABAMA
DEPARTMENT OF PUBLIC HEALTH
DONALD E. WILLIAMSON, M.D. • STATE HEALTH OFFICER
CENTER FOR HEALTH STATISTICS
DOROTHY S. HARSHBARGER • DIRECTOR

March 4, 1995

Ms. Beth Nolan
Associate Counsel to the President
The White House
Washington, D.C. 20500

Dear Ms. Nolan:

At the request of Henry W. Foster, M.D., I have examined birth certificates filed in the Center for Health Statistics in the Alabama Department of Public Health for births that occurred in Macon County, Alabama on May 18, 19, and 20, 1969. While information on the individuals whose births occurred on those days is confidential, information on the attendant at birth can be released upon the request of that attendant.

In examining the paper certificates for the births, I found several documents that had what appeared to be the time of birth typed in the margin outside of the standard form. For the dates requested, the following birth certificates were found that had a stamped signature of Henry W. Foster, M.D., as the attendant at birth:

One birth on May 18 showing the time as 12:38PM

Two births on May 19 showing the times as 3:33AM and 9:17PM

Two births on May 20 showing the times as 1:32AM and 3:18PM

All of the births giving Henry W. Foster, M.D., as the attending physician occurred at Tuskegee Institute in John A. Andrew Hospital.

In addition, there was another birth occurring on May 19, 1969, at Tuskegee Institute, but the original certificate of birth for this event has been replaced by a new certificate of birth after a legal action to the record. The new certificate gives an

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abstract of the information, and does not show the attendant at birth. The original certificate of birth has been placed in a sealed file that can only be opened by an order from a court of competent jurisdiction. While the attendant at birth will probably be shown on the original certificate, the time will most likely not be shown since the margins were usually cut off when the paper records were replaced in the files. I would need a court order to open and look at that record to determine who attended the birth.

If you have questions or need additional information, please call me at (334)613-5426.

Sincerely,

Dorothy S. Harshbarger

Dorothy S. Harshbarger
State Registrar and Director

1974 Deposition of Dr. Ira Myers

During two days of confirmation hearings, Dr. Foster effectively refuted unfounded charges that he was aware of the infamous Tuskegee Study of Untreatred Syphilis prior to 1972, when the study became public. He let the nation know that he is a man of compassion deeply commited to providing medica services to a badly underserved area, and that in keeping with his character, he in fact had immediately led efforts to locate and treat the men.

The facts also have defeated recent attempts to link not only Dr. Foster, but also Tuskegee University and all of Macon County to knowledge of and participation in the Study. Dr. Ira Myers, then Alabama State Health Officer, testified in a 1974 deposition that he had discussed the Tuskegee Syphilis Study with Dr. Foster. Specifically, Dr. Myers testified, "I had discussed this matter with him (Dr. Foster) on a subsequent time in connection with a comprehensive health planning meeting, as I recall now; and he (Dr. Foster) says, 'Well, we think we ought to treat them.'" Dr. Myers has rejected the strained efforts to use this deposition to link Dr. Foster to the Study.

As Dr. Foster testified, in July, 1972, when the story of the Tuskegee Study first came to light, he was at a meeting of the Alabama Advisory Council for Comprehensive Health Planning, of which he was then a member. Dr. Foster was called out of the meeting by the press to comment on the Study. This was the first time that Dr. Foster had heard of the Study, and he remembers the meeting clearly because he was so shocked and amazed by the revelation. At the time he expressed his determination to see that the men were treated, just as Dr. Myers testified in his 1974 deposition.

Dr. Myers testified that he spoke to Dr. Foster concerning the Study at only one such meeting, and at the time he had difficulty identifying the specific time of that meeting. Dr. Myers has since rejected the attempt by some to twist the testimony to place the date of the meeting before 1972, and has gone on the record to support Dr. Foster's recollection.

Dr. Foster's and Dr. Myers' recollections are confirmed by contemporaneous press accounts. The Atlanta Constitution (UPI) and Montgomery Advertiser both reported on the following Sunday, July 30, 1972, that the Macon County Medical Society already had met and had voted to attempt to locate the men and provide them with treatment forthwith.

1974 Deposition of Dr. Ira Myers

Dr. Ira Myers, former Alabama State Health Officer, was deposed on October 15, 1974, in Pollard v. United States (M.D. Ala.), an action for damages filed on behalf of the subjects of the Tuskegee Study. Dr. Myers was a named defendant in the lawsuit. In his deposition, Dr. Myers stated that he had discussed the Tuskegee Study with Dr. Foster while they were at a state health planning meeting. Specifically, Dr. Myers testified that "I had discussed this matter with him (Dr. Foster) on a subsequent time in connection with a comprehensive health planning meeting, as I recall now; and he (Dr. Foster) says, 'Well, we think we ought to treat them.'"

This is correct. Dr. Foster remembers first learning of the Tuskegee Study when he was called out of a health planning meeting by the press to comment on it. At the time he expressed his shock upon learning of the Study and his determination to see that the men were treated. He promptly called a special meeting of the Macon County Medical Society to set treatment in motion. The Atlanta Constitution (UPI) and Montgomery Advertiser both reported on July 30, 1972, that the Macon County Medical Society had met and voted to attempt to locate the men and provide them with treatment forthwith.

The deposition continues and becomes somewhat confused as to the persons with whom Dr. Myers spoke at various times, and there appears to be some confusion of Dr. Foster and Dr. McRae. McRae was the previous Medical Society president, and it is established by contemporaneous documents that Dr. Myers and Dr. McRae spoke concerning the Tuskegee Study in 1969. The lawyers' questioning was focused on other issues, and did not dispel the uncertainty clearly felt by Dr. Myers; indeed, certain facts (e.g., that Dr. Foster had become president of the Society at the time of the conversation) are further confused and misstated by the attorneys. As they left the subject, however, Dr. Myers clearly stated his association of the conversation with Dr. Foster as linked to the planning group's meeting. Dr. Foster has a clear recollection of speaking with Dr. Myers at the health planning meeting at which he first learned of the Study, as the shocking nature of the information about the Study made that particular meeting especially memorable. Dr. Myers speaks of only one conversation with Dr. Foster, and there certainly was no discussion between the men which involved the implications of the Study prior to that time.

The planning group in question was the Alabama Advisory Council for Comprehensive Health Planning. The Council had responsibility for general state health issues. The Council had no connection with the Tuskegee Study.

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UPJOHN STUDY

Q: ***Aren't you really responsible for many more abortions? You have claimed responsibility for the Upjohn study which caused at least 55 abortions.***

- Let me tell you a little about the Upjohn study, Senator. As a major health sciences center with a fully accredited ob/gyn residency program, Meharry Medical College has three functions: education, patient care, and research. It is that last function that pertains to the Upjohn Study: it was our obligation to give our residents research experience.

- As Chairman of the Department of Obstetrics and Gynecology, I applied for a grant from the Upjohn Company to conduct the trial. I was the principal investigator, or grant administrator, at Meharry Medical College for an FDA-approved clinical trial -- conducted in many medical centers throughout the country -- that took place over several years. It's purpose was to test the efficacy and safety of an abortifacient suppository. The trial was a research project conducted in an academic medical center, all medical procedures were performed in the hospital, and all patients were volunteers.

- I had responsibility for administering the grant. That meant that I administered the funds, assured that procedures were proper, and published results. The actual procedures were performed by residents. I wrote about preliminary results of the study covering 55 patients.

Q: ***Dr. Foster, did you ever personally perform one of these abortions [insert a suppository into a woman]?***

- My role was to oversee and administer the project. We are a teaching hospital. The procedures were done by residents. In fact, I was only present on very few occasions and then it was in capacity of instructing the residents as the supervising faculty member.

Q: *Did you ever perform the procedure?*

A: No.

Q: So what you're saying is that we should add 55 to the 39?

- No, Senator, that's not what I'm saying. I've been trying to give you as good an idea of my medical practice over 38 years as possible. I've told you about Meharry, I've told you about the Upjohn study, and I've told you about Tuskegee. Ultimately, you need to make your own judgment about my record

Q: But the question remains, shouldn't we add 39 to the 55?

- I honestly don't see how you could, sir. I didn't perform those procedures. I've told you all the facts. I will let you make your own determination.

Q: What do you mean by "preliminary results". Were there additional patients?

- Yes, there were.

Q: How many additional patients?

- The study took place over a couple of years. I honestly don't know the exact number as I did not write about them.

Q: But, as chief investigator, aren't you responsible for every one of those 55 [or more] abortions?

- Senator, in one sense, as Head of the Ob/Gyn Department, I am responsible for every procedure performed by every medical practitioner in that department. But I was not even present at most of the Upjohn cases; there were times I was not even in the country.

- About the time I published the report of that 55, I was asked by the Robert Wood Johnson project to head a national multi-million dollar grant process. The grant was to provide health services for high risk youth around the country and my job was to publicize it, review all proposals, make the grant awards, and monitor over 20 projects in 18 cities around the nation. It really took all my remaining time.

Q: ***Why did you say on <u>Nightline</u> that you had to do it for accreditation? This has since been widely disputed.***

- My work as the principal investigator for the Meharry site was consistent with my responsibilities as Department Head to allow opportunities for research into methods for improving legal, medically accepted procedures. Such research projects also are consistent with the standards for accreditation of medical schools. Guidelines published by the Accreditation Council for Graduate Medical Education state:

  > *The quality of the educational experience within a department of obstetrics and gynecology is enhanced by an active research environment. It is highly desirable that every program encourage each resident to be involved in a research project.*

Q: ***Why did you do the study?***

- I believe that when abortions are done, they should be performed in the safest manner possible. Therefore, as an expert in the field of maternal health, I support research into safer methods.

Q: ***Do you support testing the "Morning After" Pill?***

- I think abortions should be safe, legal, and rare. That pill is currently being tested. I support research that will make any medical procedure -- not just abortion --safer. As I understand it, the FDA is responsible for making the final determination in this case.

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Divider Title: _____

VETTING ISSUES

•First spoke with Phil Lee on the telephone regarding the possibility of being nominated for Surgeon General. Later had a more extended telephone call with Lee.

•Met with various HHS officials on January 13.

•Went to White House to meet President Clinton in mid-January.

•At some point, was asked by HHS officials about abortions. Dr. Foster described the one he remembers most vividly, but did not provide a specific number of abortions performed.

•In late January, spoke with White House Counsel staff regarding forms and writings and positions. Discussed abortion but did not get into numbers of abortions performed.

•Thurs. Feb. 2: Announcement at the White House

•Fri. Feb. 3: Issued statement based on his recollection of number of abortions performed (estimating fewer than a dozen) without consulting medical records.

•Shortly thereafter, requested Meharry Medical College to search his records to determine number of abortions.

•Feb. 6: Meharry Medical College gave Dr. Foster preliminary estimate of 39 abortions performed during his tenure there.

•Feb. 8: Appeared on Nightline.