

JOHN PODESTA - STAFF SECRETARY

Dr. Henry W. Foster, Jr.

Box 1

- Newspaper Clips regarding Henry Foster
- Cases in which Henry Foster. Meharry Medical College or Hubbard Hospital were parties
- Memorandum regarding Kwanzaa Celebration
- Prep Questions
- Two speeches by Henry Foster with a one page summary on each
- Additional Writings by Henry Foster
- Testimony Submitted to the Senate Labor and Human Resources Committee
- Testimony Submitted by the Family Research Council to the Senate Labor and Human Resources Committee
- Edited Transcript of Dr. Henry Foster's hearing for Surgeon General [May 2 and May 3, 1995]
- Distributed Information
- Research

w/ 4 boxes of binders and folders on Dr. Foster

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ENCLOSURES FILED OVERSIZE ATTACHMENTS

5 boxes read and filed 7/3/95

**Dr. Henry W.
Foster, Jr.**

BOOK I

The Nomination of Dr. Henry W.Foster, Jr.

Book I

- A. Abortion
- B. Accreditation
- C. Anti-Foster
- D. Commissioned Corps
- E. Confirmation Hearing
- F. Correspondence
- G. Credibility
- H. DPC Senate Packet
- I. Ed Board Packet

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Clinton Presidential Records Digital Records Marker

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A

Divider Title: _____

DRAFT

TALKING POINTS ON NUMBERS OF ABORTIONS

•At some point prior to the announcement at the White House, HHS officials asked Dr. Foster about abortions. Dr. Foster described the one he remembers most vividly, but did not provide an estimate of the number of abortions he performed in his entire career.

•The day after the announcement, the Administration issued a statement based on Dr. Foster's recollection of number of abortions he had performed (estimating fewer than a dozen) without any consultation of medical records.

•Dr. Foster has admitted that he made a mistake by guessing the number of abortions he performed without first consulting the medical records.

•Shortly thereafter the statement was released, Dr. Foster requested Meharry Medical College to search his records to determine number of abortions he had performed.

•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 (the entire post-Roe v. Wade era.)

•These records also indicate that for approximately three-quarters of these 39 patients, another physician or resident participated in or performed the abortion procedure.

•Dr. Foster cannot remember the comments he may have made at the HEW Advisory Board hearing in 1978 (where the transcript states that he said that he had performed over 700 amniocentesis procedures). From the context of the remarks, he believes in retrospect that he intended to say "they" (not "I") and refer to the procedures undertaken by Drew Hospital.

PHOTOCOPY
PRESERVATION

180

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

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

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

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

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

1 MR. LAZARUS: Right.

2 FATHER MCCORMICK: Then it says, "and the
3 importance of the knowledge to be gained as to warrant
4 such modification and waiver." There are two conditions
5 there, by the word "and," unless I am misreading this. It
6 has got to be of some benefit to the subject, and the
7 importance of the knowledge to be gained. In other words,
8 the supposition of that is that the procedure, experimental
9 or investigative, is going to be of some benefit to the
10 subject.

11 DR. HAMBURG: I wouldn't interpret it that way.
12 It says the sum of benefits. It may be zero plus ten, but
13 it still comes out to ten.

14 FATHER MCCORMICK: Therefore it should be "or?"

15 DR. HAMBURG: No.

16 FATHER MCCORMICK: No, wait a minute. What I
17 have in mind is this. If the only consideration --

18 MR. GAITHER: Dick, hold on.

19 THE REPORTER: I don't know what happened,
20 because everybody talked at once. You will have to watch
21 that.

22 MR. GAITHER: Okay, I am sorry.

23 Father McCormick?

24 FATHER MCCORMICK: The point I was making is
25 this: If a fetus about to be aborted, and that is what we

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1 And this was the discussion, that limit, that
2 was talked about in the very early period by the gentleman
3 from San Diego Medical School and by a couple of other
4 scientists. You can draw some rational point beyond which
5 you don't stretch. You let the natural course of events
6 occur, which is death. It seems to me if you --

7 DR. SPELLMAN: I thought you were going to say
8 implantation.

9 MR. CONWAY: Oh, the implantation that takes
10 place, that is the purpose.

11 DR. SPELLMAN: That would be the end point of
12 this experiment.

13 MR. CONWAY: Oh, sure. And you perfect the
14 therapy methodology and --

15 SPEAKER: How about the other purpose?

16 MR. CONWAY: What is the other purpose? That's
17 just an effort --

18 SPEAKER: To find a good contraceptive.

19 THE REPORTER: Too many people are speaking at
20 once. We are not getting anything on the record.

21 DR. SPELLMAN: To follow the other argument, it
22 seems to me to give scientific validity to this, which
23 after all is an experiment. You are going to then have to
24 use the pregnancy as the period of the clinical trial. You
25 will have to depend on amniocentesis and you will have to do

Need platform
infraction rule
the sick
unstable
disabilities group
the sick person
Almond
Loe v. Wade
CH

MEMORANDUM

This memo reflects the critical issues in Dr. Foster's writing and experience. It does not review his full work, the vast proportion of which puts him among the truly respected members of his profession and of his sub-specialty within that profession.

informed consent
minority

I. Abortion

A. Approximately 15 years ago, as Meharry's Chief of OB/GYN services, Dr. Foster was responsible for an abortifacient study sponsored by the Upjohn Company. He supervised a test of a pharmaceutical product administered to 60 patients, aged 15-31, seeking voluntary abortions. The women were given a vaginal suppository to induce pregnancy termination. No patients died or suffered serious side effects of the procedure, nor is there any report of fetal survival with injury.

B. In an article exploring contraceptive methods for persons suffering from sickle cell disease, the nominee wrote:

"Contraceptive methods can be grouped into the following six broad categories: ...[steroids, IUDs, barrier methods, timing, sterilization] and abortion."

"...therapeutic abortion is an option that must be made available to patients who fail with [an alternative] contraceptive approach."

C. Counseling before abortions is addressed as follows in one writing:

"The purpose of this counseling...includes acquainting patients with the procedure, providing options to abortion, allowing questions to be asked, and providing informed consent. The overall objective is to decrease patients' fears and anxieties."

Summary on Abortion: Dr. Foster has been responsible for an abortifacient drug test. He recalls, additionally, over the thirty-year span of his practice, doing under one dozen abortions. He has written sporadically about abortion and supports choice for abortions that are safe, legal and rare.

II. Hysterectomy

A. In a 1976 publication, Dr. Foster described hysterectomies he performed over a ten year period during which he removed - and wrote a justification for so doing - 82 uteri that were normal. He noted that doctors must "guard vigilantly against the injudicious and indiscriminate removal of the normal

4

uterus."

Context
The article stated that sterilization and mental retardation were among the indicators for hysterectomy. Dr. Foster says that this is no longer his view nor is it the view generally of OB/GYNs. He and his profession have learned more about and become much more sensitive to the overutilization of hysterectomy. He similarly no longer would espouse the statement, in the same 1976 article, that hysterectomy in patients with severe mental retardation may be done for sterilization or for the patient's hygiene.

B. In another article, Dr. Foster reported on a hysterectomy performed on a woman ill with Meigs' syndrome, a possible malignancy, experiencing breathing difficulty, bloating, and very early pregnancy. In the article, Dr. Foster wrote:

" [The patient was] a 35-year-old unmarried black woman....[H]er social history revealed that she was the head of a two-room household composed of one adult, that being herself, and four children ranging in age from three to 16 years. She was unemployed and received no welfare assistance."

Dr. Foster described the patient's illness, indicating the appropriateness of hysterectomy in the situation, and then added:

"The dismal social history made this decision just a bit less difficult."

Summary on Hysterectomy: Dr. Foster, following the professional practice in past decades, performed hysterectomies more frequently than he now would and for reasons other than those he would now deem adequate. He deeply regrets the sentence about the "social history" of the patient just referenced and believes it was wrong when he wrote it and is wrong now.

III. Additional Concerns

A. The second example [II.B.] under "Hysterectomies" and references in a number of Dr. Foster's documents to special problems of the severely mentally retarded may bring forth charges of social engineering. His concern for the mentally disabled and others is keen, though statements such as the above-quoted will require contextualization.

B. There are references in the writings to the "black life style." Dr. Foster has written that there are "differences in life styles between blacks and whites", usually meaning to describe socio-economic differences disproportionately disadvantaging black Americans. He has suggested that for some socially and economically deprived persons, "the procreative

processes often become the only fulfilling life experience available."

Dr. Foster describes his "life style" references in the following context, for example, as requiring that in work with inner city teens, outreach personnel communicate well -- from a base of shared experience -- with the teens in the programs.

C. Dr. Foster has cautioned against family planning in black communities unless (i) comprehensive health care is a viable component of the program, (ii) family planning is voluntary and not coercive and (iii) black persons are included at all meaningful policy-making and administrative levels of the program. Dr. Foster has characterized as "genocide" family planning programs that did not have those three characteristics since reducing births in a population with high infant mortality will ultimately lead to the decline of that population. Dr. Foster said over twenty years ago that "[t]he majority of this Country's health providers have never even in the vaguest way planned a program of genocide for black people." He cautions that well-designed family planning will dispel any contrary impression.

D. Some comments about rural, Southern, African-American experience appear in the writing as in the following from a 1967 article:

"At present, however, most of the patients seen on our obstetric service are from the lowest socio-economic strata in this country and, on occasion, rival some of the most primitive of cultures."

Dr. Foster has described some folkways he has observed in the rural South he returned to after his training in Massachusetts. His remarks are benign and reflect only on the superstitions and unsophisticated practices of isolated, rural peoples' treatment of medical problems.

E. A description of Dr. Foster's community-based teen pregnancy programs notes progress toward teen pregnancy reduction where education is linked to self-esteem enhancement and to direct access to contraceptives. He appears to support school-based teen pregnancy reduction programs and surveys of youngsters to measure attitudes and values about contraception, sexuality, etc.

F. Dr. Foster believes that a woman should have counseling and the choice to abort a pregnancy where testing reflects that the child will be born with Downs syndrome, Tay-Sachs disease, sickle cell disease or similar conditions. With regard to the choice, he believes his role should be limited to non-directive counseling.

coalition
swed (X)
(X)

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DRAFT

January 26, 1995

Abdominal Pregnancy
August 1967

States that for condition of abdominal pregnancy prompt termination of the pregnancy is proper course, but he recognized there were exceptions to this general principle. However, also states that three of twelve pregnancies observed carried living fetuses to 39+ ~~months~~ ^{weeks}. Two of these were completely normal and survived.

Review of "Twin Pregnancy: A Three-Year Report"
Journal of the National Medical Association
March 1970

DRAFT

By Kurt Kuhn

This piece is a self-proclaimed "elementary review" of the findings for a three year study into twinning. It concludes that twin pregnancy is a abnormal condition which contributes directly to increased maternal morbidity and perinatal mortality. (page 141).

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Review of "Meigs' Syndrome Complicated by Pregnancy"
Journal of the National Medical Association
September 1971

DRAFT

By Kurt Kuhn

At first glance, this appears to be a noncontroversial review of a case involving a rare type of tumor on a pregnant patient's ovary. However, Foster goes on to explain that his patient's social history -- the patient was a 35 year-old unmarried black woman -- revealed that she was the head of a two-room, four child household, unemployed, and not on welfare assistance. Upon explaining that the patient's pelvic organs had to be totally extirpated due to the strong possibility of malignancy -- and apparently some deficiencies in the hospital's testing capabilities -- Foster adds, "The dismal social history made this decision just a bit less difficult."

Summary of Articles by Dr. Henry W. Foster, Jr.
Stacy Reynolds

DRAFT

Staff Conference: Meharry Medical College Endometrial Stromal Sarcoma
August 1974

Dr. Foster took part in an exercise with one or medical students in which they attempted to diagnose a patient based on a specific fact pattern and questions for further details. The article is not controversial and does not raise any questions of social policy.

Family Planning and the Black Community

DRAFT

Presented to Howard University Hospital
May 22, 1975

Page 1: HP and GL: In order for a woman to be able to recognize and exercise her right to maintain control over her own fertility, "there is the need to conduct a massive educational effort: (a) to have health personnel include family planning as a part of the comprehensive health services they provide; (b) to educate the public (the patient) to appreciate good health and how to maintain it." (Emphasis provided.)

Page 1: VERY HP and GL: Basic principles for structuring family planning services:

"1. Voluntary family planning is a significant health measure. Family planning information must be provided in such a way whereby anonymity is maintained."

HP: Question: Anonymity when the patient is under 18?

"2. Family planning services must be delivered humanly and in physical surroundings that are adequate."

"3. Male participation in family planning must be sought."

VERY GL: Especially excellent language in light of the fact that Dr. Foster was espousing this currently hot point of view twenty years ago.

"4. Family planning settings can provide many noncontraceptive services for patients."

HP: Noncontraceptive services: Does this mean abortions or cancer check-ups?

"5. Population concerns are inappropriate for family planning programs."

"6. Abortions are safer when performed in early pregnancy." (Emphasis provided.)

"Any family planning services which do not embrace all of these principles are deficient and potentially harmful especially for the ghetto populace."

Page 1: HP and GL: "In addition to the achievement of optimal family size by those obtaining voluntary family planning services, there will follow the other expected benefit of family planning -- the improvement of health." (Emphasis supplied.)

Pages 1 and 2: GL: "There obviously is a need to lower infant mortality and decrease maternal mortality and morbidity. This need can be addressed by better spacing of wanted pregnancies and the avoidance of unwanted pregnancies." (Emphasis supplied.)

Dr. Foster's focus is avoiding unwanted pregnancies (through the use of contraception) not terminating unwanted pregnancies.

Page 2: VERY GL: "FURTHERMORE, A VERY LARGE PROPORTION OF WOMEN SEEKING ABORTION ARE NOT USING BIRTH CONTROL MEASURES."
(Capitalization supplied.)

Dr. Foster is clearly advocating using birth control measures in order to avoid abortions.

Page 2: HP: "Ghetto life is in general characterized by a relatively unsophisticated culture which has resulted in great part from the economic and political isolation that has characterized this group. Because of isolation, there is a strong orientation towards fatalism which helps explain resistance to any alteration in reproduction and the reproductive process."

Page 2: HP and GL: "Organizational barriers confronting the motivated ghetto patient seeking family planning services are often overwhelming. . . . In this regard, poverty constitutes an awesome barrier and is inseparable from all others. Additional organizational barriers are maldistribution of health personnel, problems of transportation, communications and deficient physical facilities."

Pages 2 and 3: VERY HP: "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. THESE APPREHENSIONS ARE QUITE UNDERSTANDABLE AND ON OCCASION ARE WELL FOUNDED." (Capitalization supplied.)

Page 3: HP: "[I]t is my firm conviction that the majority of this country's health providers have never in a conscious manner planned a program of genocide for Black people and indeed are motivated by a sincere desire to be beneficial. What has occurred, however, is that many well-intentioned family planners and family planning programs have been set up for large segments of the Black population, without due consideration of many significant factors to which they can relate."

Does this mean that Dr. Foster advocates designing family planning programs based on race? Will this be viewed as divisive?

Page 3: HP and VERY GL:

"1. All family planning programs must be completely voluntary and that no coercive family planning programs be allowed to become part of a national or local legislative policy."
(Emphasis supplied.)

"2. Comprehensive health care must be a viable component of any family planning program including the capability of infertility diagnosis and therapy."
(Emphasis supplied.)

DRAFT

"3. All family planning programs for Blacks must include effective Blacks at every substantive policy making and administrative level."

I don't think that Dr. Foster is saying that only African-Americans can design and implement family planning programs for African-Americans but that they must be included. However, others may misinterpret this quote as saying the former.

Pages 3 and 4: VERY HP: "Far more frightening than this [referring to patients being belittled or berated if they refuse services or show reluctance], however, is the legalization of coercive sterilization practices. SOCIAL WELFARE LEGISLATION IN THIS FORM REMOVES THE RIGHT OF A WOMAN RECEIVING WELFARE BENEFITS TO HAVE CHILDREN." (Capitalization supplied.)

Of course, given the current mood for welfare reform, Dr. Foster may well be questioned as to whether the government can impose certain requirements on individuals who voluntarily seek its assistance in exchange for that aid.

Page 4: Following questions posed: "Is it wise to attempt to approach a national zero population growth in a group where the infant deaths are twice that of the national average? Might not a higher birth rate in such a group at some time serve as a necessary protective mechanism in that group where the life expectancy is significantly less than that of the national average.?"

This is a dangerous hypothetical. What if the shorter life expectancy is due to the higher birth rate? E.g., Individual resources are insufficient because they are spread too thin, but with a lower birth rate the resources are sufficient.

Page 4: HP: "Most family planning programs are predicated and structured on the erroneous assumption of a common national life style."

Page 4: VERY HP: "To those who are deprived socially and economically the procreative processes often become the only fulfilling life experience available. To curtail or remove this avenue of expression is often tantamount to taking away the only need for existence itself."

Equating procreation with an avenue of expression?

January 26, 1995

"Removal of the Normal Uterus"
Southern Medical Journal, January 1976

STEV 176
DRAFT

Discusses removal of uterus which I guess is sometimes controversial. The only thing that struck me was his statement:

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 severely handicapped individuals.

(p. 14)

January 26, 1995

DRAFT

Notes of Bill Kysella

"Clinical Management: Sickle Cell State and Pregnancy"
Urban Health, March 1977

Technical. Explains procedures followed in his unit:

After taking a complete history and conducting a physical examination, the patient is evaluated and advised of the availability of pregnancy termination. If after intense counseling, she chooses this option, . . . The majority of our patients, however, do not choose the option of abortion. (p. 20, col. 3)

[. . . therapeutic abortion must clearly must be an option made available to the patient who fails at contraception. (p. 52, col.3)

abortion
as contraception

top col.3 - We offer sterilization - SOL. by.

DRAFT

in Ambulatory Obstetrics and
Gynecology 1980

Ed. Dr. George Ryan

Review of Ambulatory Gynecologic Surgery
Publication Date Unknown (1978 at Earliest)

By Kurt Kuhn

This chapter deals with the option of selective out-patient surgery as a means for lowering national health care costs. As with most policy articles there are several ways in which this piece might be controversial.

The primary reason that this article could be controversial is that, as Foster outlines, several powerful forces (e.g. insurance companies, hospitals, and physicians) have been opposed to a move toward out-patient surgery. This piece, however, may be particularly inflammatory since it partially attributes their opposition to less than altruistic concerns of these forces.

Foster states, "there has been an active resistance to the expansion of ambulatory surgery. This resistance is created by a financial reimbursement system which promotes hospitalization of patients who might otherwise be cared for in the ambulatory setting." (page 401). First, Foster points to the practice by insurance companies to completely or partially refuse reimbursement for out-patient surgery. (Id.). This same practice was followed by Medicare, Medicaid, and CHAMPUS until recently. (Id.) Foster also points to "reluctance" by insurance companies to provide professional liability insurance to practitioners for such procedures (Id.). Foster tempers this criticism by pointing out that this practice has recently begun to change due to the need for cost containment, (page 403), and that the reservations these companies had were "probable justified until recently" due to concerns about malpractice judgments and the lack of care standards, (page 408).

Foster also contributes opposition for out-patient services to hospital administrators. He writes:

Hospital administrators often pressure surgeons to "utilize" hospital beds. Such a practice, of course, increases occupancy rates and subsequently hospital income. Further, it helps amortize expensive hospital programs and equipment, some of which have been installed at the behest of operating surgeons. (page 401)

Foster carries this logic over to physicians. Pointing out that in many areas hospitals are physician owned and operated, he goes on to conclude that these situations are marked by "little or no incentive" for physicians to utilized out-patient care. (Id.).

The piece could also be controversial when it deals with the handling of out-patient procedures. Specifically, some may be

alarmed by his discussion of abortion. He writes that in light of the "psychosocial dynamics" of abortion "special counseling is an absolute prerequisite to this procedure." (page 414). This counseling is designed to acquaint patients with the procedure, provide options to abortion, allow for questions, provide conformed consent, and to decrease the patient's fears and anxieties. (page 414).

DRAFT

January 27, 1995

BK

Clinical Practice Survey
OB World, March 1979

Technical discussion of how to treat a particular hypothetical patient. Nothing too striking. Dr. Foster believed that "screening for sickle cell hoemoglobin is essential in all patients of African and Mediterranean descent."

Another author of the article stated, " As stressed by Dr. Foster, concerns about the pregnant ppatient must also be extended to the fetus." Dr. Foster suggested a need for genetic counseling in some instances.

Summary of Articles by Dr. Henry W. Foster, Jr.
Stacy Reynolds

DRAFT

Transfusion Therapy in Pregnant Patients with Sickle-Cell Disease: A National Institutes of Health Consensus Development Conference
91 Annals of Internal Medicine 122-123 (1979)

In this article Dr. Foster and a co-author set out the recommendations of the consensus development group about whether further research on transfusion therapy was needed and how that research should be conducted. Overall, the article is non-controversial and merely concludes that further research is necessary, a national approach is necessary to get accurate results in a reasonable amount of time, research subjects should be randomly assigned to "transfusion" and "no-transfusion" groups (however, transfusions would be available to the "no-transfusion" group "for specifically defined indications"), and psychological factors relating to receiving transfusion therapy when interpreting the results.

It should be noted that using a "no-transfusion" group varies from Dr. Foster's opinion expressed in our interview. In connection to a reference in another article where he suggested placebos should not be used, Dr. Foster explained that he was thinking about the transfusion therapy when he asked that question because he was not sure it would be ethical to withhold a beneficial treatment, such as transfusion therapy, from a research subject.

In the final paragraph, the article states, "The presence of hemoglobin SS, SC, or sickle thalassemia, which constitute sickle-cell disease, should not be the sole justification for either abortion or sterilization. The procedures should be done on the basis of medical indications or patient desire, or both." This statement does not seem to relate to anything else in the article and does not explain the connection between abortion and the proposed transfusion therapy study in any way.

January 26, 1995

Notes of Bill Kysella

DRAFT

"Reproductive Performance in Women with Sex Chromosome Mosaicism"
Obstetrics & Gynecology Vol. 55, No. 5, May 1980

Discusses abortion exclusively in the context of couples with a history of spontaneous abortions. These are non-controversial "natural" abortions. However, the final sentence states that subsequent pregnancies of such couples should "be monitored by amniocentesis in such case so that abortion can be available for genetically abnormal fetuses when found."

A
DRAFT

Review of "Managing Sickle Cell Anemia in Pregnant Patients,"
Contemporary OB/GYN, Dec. 1980
Kurt Kuhn
January 26, 1995

This article for the most part is noncontroversial. It deals with the procedures for handling pregnancy and contraception in women with sickle cell anemia. However, there are two references to abortion which deserve mention.

Foster points out that the decision to risk pregnancy is a viable option for women with sickle cell anemia since those that receive exemplary care face only a 3% mortality rate. He goes on to state, "For patients who choose not to take this risk, the option of elective abortion must be available." (page 27). Later in the piece, Foster explains that he prefers his patients to use barrier contraceptives and have the option of "therapeutic abortion when contraception fails." (page 32).

Both of these mentions appear noncontroversial since they occur in the context of risks to the mother's health.

OBSTETRICS & Gynecology Annual

Review of Sickle Cell Disease in Pregnancy: An Update
Publication Date Unknown (1981 at Earliest)

By Kurt Kuhn

This piece seems to simply be an overview of sickle cell anemia and its affects on pregnancy. It covers the history of the disease, the medical specifics of it, its affects on pregnancy, and the possibility of further funding for programs designed to combat it.

Two points of the article are worth individual notation here. First, previous harassment associated with misconceptions of the disease causes Foster to advocate the encouragement and fostering of voluntary mass screening for people of African descent through structured provider and consumer education programs. (page 153). Second, Foster states that the choice to risk maternal mortality (the risk is probably 1 to 2 percent) is justifiable because, "There are probably few life experience more rewarding than reproducing one's own kind." (page 155).

DRAFT

Review of Thalassemia, co-authored by Robert Lownes
Publication Date Unknown (1984 at Earliest)

By Kurt Kuhn

This chapter deals with the detection and prevention of thalassemias, 'a genetically-determined group of disorders characterized by absent or reduced production of one or more alpha or beta goblin chains." (page 137). The chapter seems entirely noncontroversial.

✓
DRAFT

Review of "Study of Lipids in Human Amnion and Chorion"
American Journal of Obstetrics and Gynecology
July 15, 1964

By Kurt Kuhn

This article is an explanation and review of a study conducted on the membranes which surround the fetus during development. The membranes were "obtained at the time of spontaneous vaginal delivery of eight patients with uncomplicated gestations." (page 670). In light of the simple investigatory nature of the piece and the manner in which the material was collected, this piece seems in no way controversial.

Legislative Forum Statement on Teenage Pregnancy

Presented on behalf of the National Medical Assn to a House Committee on July 20, 1984

Dr. Foster addressed the committee on the problems of teenage pregnancy and advocated action by Congress to help address the problem. The following are selected quotes and his recommendations.

Dr. Foster recognized that the causes of teenage pregnancy are multiple and complex and stated, "For so many youngsters, teenage childbearing is a societal symptom and emanates primarily from deprivation. This deprivation is characterized by racism, urban decay, family dissolution, welfare policies, illiteracy and a variety of other factors. The problem of teenage childbearing will not go away until we begin to effectively address these quality of life issues."

In addressing prevention of teenage pregnancy, he suggested, "Prevention can be viewed from three (3) perspectives--programs that enhance knowledge, programs that provide access to contraception and interventions that improve marketable skills."

Dr. Foster, as the representative for the National Medical Association, attended a meeting held by the National Urban League and the NAACP in which his group developed the following eight recommendations:

1. 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.
2. Structuring skills development programs in prime relevant jobs with the promise of upward mobility.
3. Provision of sexuality education provided by trained peers, trained adults, trained clergy; to occur at home, at school and at church with equal emphasis on each sector.
4. Communicating the values of deferred gratification through development of ceremonies of "rites of passage" in order that our youth can learn there are rewards at all developmental levels.
5. Sponsoring positivity focus youth groups by churches, schools, sororities, fraternities and other black institutions and other organizations.
6. Pooling funds and sharing resources to counter act negative group persuasion through programs described as frank and personal integrity, family loyalty, and personal pride.

DRAFT

7. Addressing the mass media by local and national organizations, demanding positive portrayal of ethnic and racial images. Demand public service programs and announcements designed to improve the images of blacks and their families.

8. Emphasis on restructuring the labor market and directing government funding priorities away from defense and towards job training and full employment to mitigate (?) against the possibility that generations of black youths might never (sentence not completed)

To implement the above, "and other appropriate" recommendations, Dr. Foster suggested that Congress increase funding to "federal entitlement programs that promote reproductive knowledge and provide contraceptive access." He also advocated appropriate legislation to "enhance job and academic opportunities particularly for black teenagers, thus leading to better marketable skills."

ef

Maternal Death Associated With Sickle Cell Trait

DRAFT

American Journal of Obstetrics and Gynecology
October 1, 1985

Letter to the editor commenting on findings in an article on a maternal death in a sickle cell trait patient.

Nothing remarkable.

Review of "Sickle Cell Anemia Not a Risk For PTL"
Ask the Perinatologist Newsletter
Fall 1991

DRAFT

By Kurt Kuhn

This article merely contains a short answer by Foster to a few questions about the affects of sickle cell anemia on pregnancy. It is a reiteration of many of the points he has made in other articles. It seems completely noncontroversial, however, he does mention that the ability to ascertain fetal hemoglobin status allows for genetic counseling and thus the option of termination. (page 1).

January 25, 1995

BK

ENACT

What Does Health Care Reform Portend for Undergraduate Medical Education?

Date: Submitted 7/12/93

Analysis: Nothing controversial or exciting, however, it does mention that a Canadian Dr. will speak at the annual (1994) meeting of CREOG/APGO, providing "insights as to how this issue is being addressed in Canada."

January 25, 1995

BK

7-1-95

"Health Care Reform and its Impact on the Medical Profession"

Presented June 19, 1993

Non-controversial history of Meharry Medical College.

Mentions potential negative impact of health care reform on all med schools, but particularly those, like Meharry, which accept students from poor backgrounds.

Specifically supports partnership between some VA hospitals and rural communities. Apparently, a previous attempt to do just that never got off the ground. (p.7)

Specifically supports strengthening legislation:

re: Historically Black grad schools (Title III of the Higher Education Act, Section 326).

re: Reauthorization of NIH (biomedical and behavioral research facility construction).

Review of "Minority Academic Health Centers of the Future."
Presented at the Annual Meeting of the Association of Minority
Health Professions Schools; Feb. 10-12, 1994
Kurt H. Kuhn

H.L., page 1: "The need for health care reform in this country
is long overdue and is inevitable."

H.L., page 1: "health care reform overall promises to benefit
most those of lesser resources -- patients cared for in
disproportionate numbers by minority academic health centers."

H.T., page 2: Claims that figure of 35 million Americans
uninsured is deceptive because number is merely for a given time.
If you include those who gain and loss coverage during a year
with gain or loss of employment then number is close to 55
million.

H.T., page 2: current form of Health Security Act under funds
academic health centers -- minority and otherwise.

H.T., page 2: Repeats 3 points on needs for health care reform
highlighted above.

H.T., page 3: Addresses perceived shortcomings in Health
Security Act. These include: no provision to address shortfall of
funding for undergraduate medical education, transition to
generalist and ambulatory training, and overall medical school
infrastructure, and also, that reducing IME from 7.7% to 3% can
not be justified.

H.L., page 4: "Increasing the number of primary care physicians
is an idea whose time has come."

H.L., page 5: "Let there be no mistake, basic research is
essential and must be maintained. If I have a quarrel, it
relates only to the distribution of these limited dollars. There
must occur increased funding for behavioral and epidemiological
research."

H.L., page 6: "What is needed to lower the infant mortality rate
is education and access and utilization of preconceptional,
prenatal, intrapartum, and postpartum care. These are not high-
tech interventions. They have to do with access and the
distribution of systems and providers."

H.L., page 7: "if we, the members of AMHPS, fail to infiltrate
and influence public policy makers, all of the sensible funding
and intervention solutions will go wanting."

DRAFT

Review of "Will Health Care Reform Affect Undergraduate Medical Education?" Presented at the Fifth Annual W.F. Bernell James Obstetrics and Gynecology Symposium; Feb. 11-13, 1994
Kurt H. Kuhn

Hot Topic, page 2: cites "despair expressed" by individuals at meeting to provide input to Ira Magaziner on Health Security Act in Fall 1993. Admits he was "in concurrence with most of the tenets of our discussion." Points out three "clear and distinct unambiguous needs." These needs are (1) the continuation of education for health care professional in this country; (2) the cost of health care education; (3) funding sources for health care education.

Hot Language, page 2: Speaking to fellow doctors on the push for health care reform he states, "I suggest it behooves us all, to the extent that we can, to become proactive rather than waiting until health care reform is fully upon us and being forced only to react." Could sound like a call for physicians to protect their own interests in the health care debate.

H.T., page 4: Claims that it is logical to expect "managed competition" to decrease income from medical practice and limit funding to medical education positions.

H.T., page 5: Predicts a "Harvard plan" to create a 50-50 split between primary care physicians and specialists. Hospitals are paid for trainees on a 1.1 and .7 basis respectively.

H.L., page 6: Say shift to primary care physicians will lead to "lower income, lower salaries, and the possibility for faculty attrition." Cites as "the ripple effect."

H.L., page 8: "Health care reform is an idea whose time has come. Change is not the enemy; it is simply a fact. Change has always been inevitable; it is when we fail to anticipate and to function proactively that the effects of change become threatening."

H.L., page 8: "any problem for the whole of undergraduate medical education is compounded when addressed in the context of underrepresented minorities and historically black colleges and universities."

DRAFT

Review of Introduction: U.S. Congressman Harold Ford at Meharry
Medical College Commencement, May 22, 1994; & Recognition of
Meharry's Golden Achievers, Id.
Kurt H. Kuhn

Nothing controversial.

DRAFT

How Can We Provide Good Health Care For Everyone?

Presented to the Lonnie S. Burnett Vanderbilt OB/GYN Society
June 18, 1994

Page 2: HP: Dr. Foster questioned when health care reform will occur and slightly slurred the President. "For those who listened carefully to President Clinton's 1994 State of the Union message, while asserting in unequivocal terms that universal access must and will be a part of any health security act, very adroitly he avoided the issue of the time frame in which this will occur." (Emphasis provided.)

Page 3: HP: Universal coverage ultimately will evolve and this coverage will include pre-existing conditions and catastrophic illnesses. However, I cannot see how universal coverage can be successful without having employer-mandate as a component." (Emphasis supplied.)

Page 4: HP: Dr. Foster discusses a two tier system of health care, using the following example: The "new health care paradigm may cover kidney transplants to the age of 62 1/2 years. . . . The bad news is, if you are over 62 1/2, need a kidney transplant and you have inadequate resources to purchase supplemental coverage, you are in dire straits." (Emphasis supplied.)

Dr. Foster notes that there already is a stratification of care in the Medicare population. "For those patients with adequate resources, many purchase additional coverage through the private health care system to supplement their Medicare coverage. And, in a free market economy, this is as it should be." (Emphasis supplied.)

Reaching Parity for Minority Medical Students: A Possibility of a Pipe Dream?

Presented to the 105th Annual Meeting of the Association of American Medical Colleges
November 1, 1994

Page 1: HP: "Reaching parity for underrepresented minorities in our medical schools is an essential requirement if significant improvement in health care outcome in this nation is to occur."

Page 2: HP: "The current disparity of underrepresented minority medical students will be virtually interminable unless new measures are taken to improve their educational preparedness."

Pages 2-3: GL: Rationale for increasing the number of underrepresented minorities who enter medical schools: 1. Altruism — "nation has a moral obligation to effect equal access to educational opportunities for all of its citizens. This concept is the embodiment of democracy; it constitutes the very underpinings for a free society." 2. Pragmatism — "ethnic construct of this nation is changing dramatically."

Page 3: GL: [P]hysicians who are most likely to practice in underserved areas are those individuals who themselves come from these areas." "Three out of four physicians graduating from Meharry Medical College chose to practice in inner city or in rural settings. For majority graduates across the nation, only one in four chose such practice sites."

Page 3: GL: While addressing the decrease of life expectancy for African-American males, Dr. Foster stated, "[O]ne of the means of increasing life expectancy is by reducing infant mortality, since life expectancy is set at the time of birth."

Page 4: HP: Addressing rate of academic progression and the higher percentage of underrepresented minorities to fail to graduate with their class: "This deficit in performance by underrepresented minorities emanates primarily from being inadequately prepared educationally for the rigor of the premedical curriculum, usually starting in kindergarten and progressing through college."

Page 5: HP: "'What are the mechanisms for reaching parity?' What is needed will not likely occur and that is a domestic 'Marshall Plan.' The best teacher-pupil ratios should exist in the inner city rather than the reverse. The welfare system which now exists should be scuttled forthwith. Failing to see these sweeping changes occur however, does not render it impossible for our goal to be achieved."

Page 5: GL: Presented strategies for increasing number of underrepresented minorities into medical school: (1) "Intensified the recruitment of underrepresented minority students already in college. . . . [E]xpanding cooperation between medical schools and undergraduate colleges." (2) Identifying groups of college students who pass the MCAT with scores

qualify them for admission to medical school but do not apply and students who are admitted to medical schools but do not matriculate. Targeted students "are referred immediately to medical school recruitment and financial officers." (3) "[I]dentification or creation of magnet health sciences high schools with high minority enrollments. These high schools then seek partnerships with colleges and medical schools to create an integrated educational pathway." (4) Development of health sciences high school programs in existing schools with medical schools having input, including input into curriculum planning.

DRAFT

- Q: Isn't it true that Dr. Foster believes we should not bother with informed consent because it is impossible for the doctor to determine what is and what is not "reasonable disclosure?"
- Q: Explain his comments that: "I cannot determine what constitutes reasonable disclosure, and quite frankly the courts have not helped."
- Q: Doesn't this article demonstrate that Dr. Foster supports not telling the patient about all the risks involved and options available to a pregnant women?
- A: In the article Dr. Foster: (1) describes the history of informed consent; (2) argues for "increasing our knowledge and understanding of the issues," despite the ambiguity in the courts as to what constitutes "adequate disclosure"; and (3) closes the article with the conclusion that we must bother with informed consent, especially in the context of those who perform abortions and/or provide contraceptive services to minors.

Article: "Effect of Mercury Compounds on Cholineacetyl Transferase,"
Research Communications in Chemical Pathology and Pharmacology, Vol. 30, No. 2, November 1980, pp. 381-384.

- Q: Isn't it true that Dr. Foster supports the inhumane treatment of male albino rats in medical research?
- A: No, at the appropriate time they are decapitated.

Article: "Resident Scheduling: Night Float Programs,"
Obstetrics & Gynecology, Vol. 77, 1991, pp. 940-943.

- Q: Isn't it true that Dr. Foster is anti-resident, supporting long hours and rigid schedules for residency programs in obstetrics and gynecology which lead to higher resident stress?

- A: No. In this article, the authors conclude that:

the night float system is perceived as a potentially important innovation in improving resident education and patient care in obstetrics and gynecology; however, the system is more likely to be considered successful when flexibility is permitted."

Furthermore, the article stresses that obstetrics and gynecology residents should be allowed to learn and work in a humane environment conducive to professional and personal growth.

~~Privileged and Confidential~~
February 8, 1995

**MEMORANDUM FOR BETH NOLAN
ASSOCIATE COUNSEL TO THE PRESIDENT**

FROM: Jana L. Blair
Office of Counsel to the President

SUBJECT: Discussion of Paper Presented by Howard W. Ory
by Henry W. Foster, Jr. / No date--appears to be late '70's

1. Page 122, Foster stated shared concern for improving the quality of contraceptive methods are indebted to Family Planning Evaluation Division of the Center for Disease Control (CDC) for its role in the virtual elimination of deaths from spontaneous abortions related to intrauterine devices (IUD's).

This statement shows Foster's concern for improvement of the quality contraceptive methods.

2. Page 122, Dr. Foster stated that since the Division seeks to eliminate the mortality and to control the morbidity that are associated with contraception by epidemiology, he [Foster] must ask "What is the limit beyond which we can expect to enhance safety given limitations imposed by our inadequate understanding of human behavior?" Foster also raised the issue of the role or relationship behavioral scientists play in meeting the objectives of the division.

This comment shows Foster's concern with human behavior in the safe and effective use of contraceptives.

3. Page 122-123 Dr. Foster discusses the author's table which lists the methods of contraceptives used by women and notes that the author failed to list hysterectomy. In noting this, Dr. Foster stated that, "[he does] appreciate the difficulty in determining whether or not the procedure is performed solely for the purpose of sterilization or ostensibly for some medical indication." He goes on to state that in some centers "hysterectomies are performed expressly for the purpose of contraception."

Foster introduces the idea of a hysterectomy as a means of contraception.

4. Page 124, Dr. Foster discusses tables presented by Dr. Ory, in reviewing the tables he states that septic spontaneous abortion is one of the harmful effects of and IUD.

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Sec. 3.2(C) Initials: JB Date: 5/31/18

DRAFT

5. Page 129, Without commentary, Dr. Foster reemphasizes points made by the author concerning abortion. He reviewed the author's various tables and noted that the tables depict increasing mortality and morbidity with advancing pregnancy, decreased morbidity and mortality associated with suction procedures, and increased problems associated with surgical procedures.

At this point Foster only restates what the author wrote.

6. Page 130, Dr. Foster stated "Legalized abortion is rather new to the American scene. Consequently, some long-term complications are unresolved." He stated "[he] will close, therefore, by simply listing these long-term complications, which are associated with legalized abortion, and offering ...a challenge to help us formulate a better understanding of these entities which are sterility, prematurity, spontaneous abortion, ectopic pregnancy, Rh isoimmunization, specific effects on teenagers, and psychological sequelae."

Here Foster stresses the need to resolve long-term complications caused by legalized abortion. While he recognizes the problems of legalized abortion, I read his statements to indicate he advocated improvement or perfection of abortion techniques.

~~Privileged and Confidential~~

February 8, 1995

DRAFT

MEMORANDUM FOR BETH NOLAN
ASSOCIATE COUNSEL TO THE PRESIDENT

FROM: Jana L. Blair
Office of Counsel to the President

SUBJECT: Study by Foster: Phospholipase A2 Activity in Human Amniotic Fluid

In this study Dr. Foster obtained amniotic fluid from pregnant women 16-18 weeks pregnant and during term pregnancies to determine the presence of A2 which is an enzyme which regulates certain prostoglandins responsible for the initiation of labor. This was strictly scientific results.

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1987

January 26, 1995

Notes of Bill Kysella

DRAFT

"Thalassemia"

Chapter in Hematologic Problems in Pregnancy

No date.

Technical report on genetic disorder which states, "the couple must be provided with genetic counseling and offered antenatal diagnosis, with the option of pregnancy termination." (p. 133) It appears that parents can find out if their fetus has the disorder and may then be presented with the option to terminate. Given the fact that a certain form of thalassemia "uniformally leads to . . . in utero fetal death," (p. 134) the abortion option does not seem like a particularly harsh measure.

January 25, 1995

BK

DRAFT

Gender Shift in the Physician Work Force: Implications for Health Care Reform.

Current Sabbatical Topic.

Assessment of what the dramatic change in the increase in the number of women entering the medical profession implies for health care reform.

Critical of the Congress in his proposal:

Irrespective of the recent inaction of the 103d Congress, health care reform is occurring and will continue to do so at an accelerating rate. legislation is just one of several very powerful forces driving this changing paradigm in health care delivery. Market place forces responding to high costs and rising costs, although the two are different, are both contributing to this reform. In sum, despite lawmakers' failure to act decisively in 1994 on health care reform, a clear public dissatisfaction with healthcare in this country persists.

Footnotes omitted.

Purpose of his study:

. . . to determine from a national sampling what might be the differences in attitudes between genders and varying age groups towards health care reform. And if differences are found, what is likely to be the magnitude of their effect on health care reform.

January 25, 1995

Summaries of Selected Writings/Speeches of Dr. Henry Foster

Speeches

"Reaching Parity for Minority Medical Students: A Possibility or a Pipe Dream?"

Presented to the 105th Meeting of the Association of American Medical Colleges on November 1, 1994.

This speech was basically about the problem of lack of parity for underrepresented minorities in medical school, why the problem exists and how to change it. In the speech, Dr. Foster seems to promote affirmative action in present admissions and other long term strategies which would help increase the pool of qualified minorities. Dr. Foster concluded with his optimism that parity can be achieved.

The speech begins with a history of discrimination in education dating back to the days of slavery and tracing it to present problems of de facto inequalities, concluding that the problem of disparity is created by the educational deficit. Dr. Foster then turns to the reasons why the number of underrepresented minorities should be increased and states, "This nation has a moral obligation to effect equal access to educational opportunities for all of its citizens." He also gives pragmatic reasons for increasing the numbers such as changes in the ethnic structure of America and the evidence that the physicians who are most likely to serve underserved areas are those people who came from those areas. Dr. Foster acknowledges that there have been improvements in the numbers of underrepresented minorities in medical school but argues that the improvement is not enough and is moving too slow. He also argues that part of the problem is not just the number of minorities starting medical school, it is also the attrition of minorities in medical school. One of the problems Dr. Foster identifies as effecting the attrition is dismissal for inadequate academic performance. Dr. Foster blames this on the inadequate preparation for the rigor of premedical curriculum that begins in kindergarten and progress through college.

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

"Presidential Address" Presented to the Association of Professor of Gynecology and Obstetrics, March 4, 1994

Generally a defense to attacks by some people who were advocating taking Ob/Gyn out of the required clerkships. In the speech, Dr. Foster said:

Obstetrics has, in my view, always been undervalued in our country. Look at the labor laws and practices--they single out and often punish expectant mothers. I have read that, during World War II in Great Britain, pregnant women received double food rations--I wonder if this logical and humane thought ever occurred to policy makers in this country.

This seemed to be a digression and he did not elaborate on the problems with labor laws but it appears to condemn the equal treatment of pregnant women in the workforce.

"Minority Academic Health Centers of the Future" Presented to the Annual Meeting of the Association of Minority Health Professions Schools, February 10-12, 1994

Argued in favor of minority medical schools and criticized the Health Security Act for not providing enough funding for medical education, graduate and undergraduate.

"How Can We Provide Good Health Care for Everyone?" Presented to the Lonnie S. Burnett Vanderbilt Ob/Gyn Society, June 18, 1994

Generally hits on points relating to improving health care and access to health care. In the speech, Dr. Foster stated, "I cannot see how universal coverage can be successful without having employer-mandate as a component."

Seems to support a British-type healthcare reform in which adequate health care is available to all but the wealthier could opt for additional coverage from a private-fee-for-service sector. He said, "I believe that adequate housing should be available to everyone in this country, but to have a Beverly Hills type home can only accrue through maximizing the free enterprise system."

January 25, 1995

Summaries of Selected Writings/Speeches of Dr. Henry Foster

Articles

"Children and the Institutionalized Mentally Infirm"

Using a hypothetical research project, this article criticized the methods of obtaining informed consent from children and institutionalized mentally ill. Dr. Frost suggested that a moratorium be placed on research on people in a "captive state," in which he included "the functionally illiterate, the senile, those who do not command the English language and certainly the mentally incompetent." He would permit biomedical research on children with the informed consent of their parents but, "because of the differences in life styles between blacks and whites, quite possibly adulthood as a practical matter begins earlier for the former group and accordingly, a more workable definition of childhood may be appropriate."

Dr. Frost also suggested that the relationship between biomedical research and the financing of medical education because there is pressure to lure the research dollar that may be detrimental to biomedical research subjects.

Finally, he pointed out some problem areas using the hypothetical case. Most of the points he made were not controversial. However, in talking about the use of a placebo for a portion of those patients in a study, he asked, "Even when patients receive prior advice [that a placebo may be administered], is it just or fair to knowingly deny a potentially beneficial agent to one group and provide it for another - even if on a chance basis?"

"Biomedical Research Subjects: Who Should Be Exempt?" Editorial in 50 Journal of Medical Education, (Nov. 1975)

Expands on the group Dr. Foster advocates for exemption from serving as research subjects explaining that he would exempt captive individuals such as the fetus, the child, the military/prisoner, and the poor. He would further include those non-captive people where there appears to be "a deficiency or absence of those biosocial defense mechanisms essential for coping with a very complex society." In this category, he included, as above, "the functionally illiterate, the senile, those who do not command the language, and the mentally incompetent."

HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE
Friday, Feb. 3, 1995

Contact: Avis LaVelle
(202) 690-7850

Statement by Dr. Henry Foster, Nominee for U.S. Surgeon General

My specialty in the practice of medicine is obstetrics/gynecology. I have personally delivered more than 10,000 babies in nearly 30 years of practice including my service in the military.

In that period of almost three decades as a private practicing physician, I believed that I performed fewer than a dozen pregnancy terminations. None were in out-patient settings; all were in hospitals and were primarily to save the lives of the women or because the women had been the victims of rape or incest.

I was also Chief of Service at two major teaching institutions where many physicians held hospital privileges. A wide variety of medical procedures and research was performed at both. To my knowledge, all were in accordance with the law and educational requirements.

I have dedicated my life's work to improving access to medical care and improving quality of life for women and children, a passion rooted in my early years of practice in the rural South. I have placed particular emphasis on prevention, especially in such areas as teen pregnancy, drug abuse and smoking cessation in children. In my work with teenagers, abstinence has always been stressed as my first priority.

Through my long affiliation with Planned Parenthood Federation of America, my personal goal has always been to provide education, counseling, preventive health care and contraceptive access to patients needing such services. If abortion is provided, my wish is that it be safe, legal and rare.

I am proud of my affiliation with Planned Parenthood just as I am of my affiliation with many other prestigious organizations such as the March of Dimes Foundation, the American Cancer Society, the Y.W.C.A. and my church.

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DRAFT

In 1984, Dr. Foster was the principal investigator for an FDA-approved clinical trial to test the efficacy and safety of suppositories that would interrupt early pregnancies (no more than eight weeks term). The trial was conducted as a research project at the Meharry teaching hospital and was part of a multi-center study. All sixty patients were volunteers who provided informed written consent. All procedures were performed in accordance with all Tennessee laws. The trial found the suppositories, which were produced by Upjohn, efficacious and safe, but Upjohn never sought final approval of the treatment.

Dr. Foster published an article in the 1985 Obstetrics and Gynecology outlining his findings. [Of the 60 patients enrolled in the study, 55 had pregnancies terminated after the suppository was given. 4 patients required follow up surgery to complete the pregnancy termination that had been initiated with the insertion of the suppository. These four patients received dilatation and curettage and all recovered completely. One patient withdrew from the study and carried her pregnancy to term.]

"Who knows how many lives?": The hidden truth about Dr. Henry Foster

(word count 877)

By Don Boekelheide

This is the story of a baby boy who might never have been born, a young mother's difficult pregnancy, and a dedicated doctor who worked tirelessly to help bring a new life into the world.

Over two decades after the birth of her son, Jeannette Hight of Charlotte, North Carolina, remains deeply grateful. "Except for God and my doctor," She says, "Christopher would not be alive today".

Who was the doctor? Dr. Henry Foster Jr., the obstetrician-gynecologist who has been nominated for the post of Surgeon-General of the United States.

Hight is director of the Plaza Presbyterian Weekday School, a highly regarded preschool in Charlotte, where she has worked since 1976. Her husband, Charles C. Hight, is Dean of the College of Architecture at the University of North Carolina, Charlotte. Christopher now lives in Texas.

Unfortunately, Dr. Foster's long career dedicated to bringing babies into the world is not making the headlines these days. Instead, since his nomination, the doctor's life has been strip mined by President Clinton's political foes, intent on dredging up as much negativity as they can from Foster's long and distinguished career.

Hight is outraged by criticism of the doctor who saved her son's life.

Surrounded by boxes of toys and piles of books on child development in her office at the preschool, she tells how Dr. Foster helped her have a baby.

The Hights first met Foster in 1965 at the Tuskegee Institute, the famed Alabama school founded by Booker T. Washington.

Jeannette and Charles were newlyweds, who had just moved to Tuskegee from Baltimore. Charles, a young civil engineer turned architect, had been hired to help establish a school of architecture at the traditionally black college. Jeannette began teaching at the university's laboratory nursery school.

At the nursery, Jeannette taught Foster's children. Charles, who had a private architecture practice in addition to his university position, helped Foster to design and build a home. When the young couple decided to start a family, they asked Foster to be their obstetrician.

From the beginning, Hight's pregnancy was difficult. At 3 1/2 months, she almost lost the baby. She remembers Foster rushing to her bedside at the hospital in the middle of the night, still wearing his bedroom slippers.

Again at 6 months, the child was endangered when Jeannette went into early labor, and once again Foster nursed her through the crisis. After nine long months of careful medical supervision, Dr. Foster delivered the Hight's healthy baby boy.

"Dr. Foster was very attentive and caring," Hight remembers. "He did everything he could to help me carry this child through to delivery. Not every doctor would have cared as much, and helped me get through the pregnancy. Some might have said 'Oh, she can have have another child.' Not Dr. Foster."

Hight does not believe her experience with Foster was exceptional. "It was not just me," She explains. "He did the same thing for other women who had trouble during pregnancy. Who knows how many lives there are out there who would not be here except for Dr. Foster?"

Based on her experience, Hight thinks Foster would make an excellent surgeon general. He would be responsible and concerned, Hight says, and would take the job seriously. He is known for bringing up-to-date knowledge and wide experience to his work, and for studying hard when he needs more information.

Foster has publically stated that he personally "abhors" abortion. Abortion obviously played a minor role in his practice, with reliable records showing a total equivalent to about one abortion per year over a career spanning nearly four decades. These factors may help explain why Foster first underestimated the number of abortions he had performed.

A strident chorus of Foster's detractors have seized on his misstep, however, as an excuse to deliberately distort the doctor's record. Not only

have they accused Foster of lying, and of performing hundreds of abortions. He has even been assailed for following a recommended medical practice of the time, performing hysterectomies on severely retarded women during the 1970s. This charge is based on a quote taken out of context from an article Foster wrote arguing in favor of reducing the number of hysterectomies. Foster has long since stopped performing the operation for severely retarded patients.

Hight's support for her former doctor goes deeper than simply pointing out that he never broke the law, or suggesting that painful decisions made between doctor and patient should remain private, not volatile fuel for public, and highly political, witch burnings.

"I know from my experience with him," Hight emphasizes. "He is interested in saving lives. He is not an 'abortion doctor'. All the abortions were no doubt done for a good reason, most likely to save the life of the mother. He never been associated with an abortion clinic. That is just not the way he is."

The Hights now hope that the thousands of other mothers and fathers, and daughters and sons, who have been helped by Henry Foster will join them in supporting this good and gentle doctor. Instead of condemnation, Jeannette Hight believes that Dr. Foster deserves praise for the many lives he has saved, and for all the healthy babies, like Christopher, he has helped bring into the world.

Contact: Don Boekelheide 704-599-9435

7117 Leaves Lane

Charlotte, NC 28213

Note: This piece was originally written for the op-ed page of the Charlotte, North Carolina, *Observer*. A news story ran instead, an interview of Jeannette Hight in the paper's local section, on February 14, 1995. Since the *Observer* did not publish it, you are free to run it if you so choose.

D.B.

5TH STORY of Level 1 printed in FULL format.

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February 6, 1995, Monday

SECTION: Washington Dateline

DISTRIBUTION: TO NATIONAL AND HEALTH/MEDICAL EDITORS

LENGTH: 213 words

HEADLINE: AMERICA TO FOSTER HOW MANY WAS IT? FRC'S BAUER REPORTS
NEW INFORMATION CONNECTS FOSTER TO POSSIBLY 700 ABORTIONS;
'Americans don't want an Abortionist Activist General,' Bauer says;
Foster, 1978: 'I have done a lot of amniocentesis and therapeutic abortions,
probably near 700.'

DATELINE: WASHINGTON, Feb. 6

BODY:

Family Research Council President Gary Bauer called again on Monday for the President to withdraw his nomination of Dr. Henry Foster as the nation's next surgeon general -- after newly discovered information linked him to many more than the "fewer than a dozen" abortions he admitted performing as a "private practicing" physician, according to a statement he released last week.

"First Dr. Foster told Senator Kassebaum he had done one abortion, then he told the American people he had done 'possibly' 12 abortions ... Today the number is 700," Bauer said. "If Dr. Foster isn't sure about his own medical record as an abortionist, how can pro-family Americans be comfortable with his appointment to the nation's highest medical position?"

Bauer was referring to a transcript from the Department of Health, Education and Welfare office of the Secretary, Ethics Advisory Board Meeting on Friday, Nov. 10, 1978, in Seattle, Washington. (Quotes from Pages 180.)

"Once again, pro-family Americans are reminded of the Clinton Administration's total commitment to the failed social policies of the last 30 years," Bauer said. CONTACT: Kristi S. Hamrick or Kristin Hansen (radio) of the Family Research Council, 202-393-2100

LANGUAGE: ENGLISH

LOAD-DATE-MDC: February 7, 1995

*Copy
John Tanner*

6TH STORY of Level 1 printed in FULL format.

Copyright 1995 PR Newswire Association, Inc.
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February 2, 1995, Thursday

SECTION: Washington Dateline

DISTRIBUTION: TO NATIONAL EDITOR

LENGTH: 343 words

HEADLINE: CLINTON TO NAME SURGEON GENERAL; FAMILY RESEARCH COUNCIL PRESIDENT
BAUER SAYS PRO-FAMILY AMERICANS WILL LOOK TO CONGRESS TO DEFEND THEIR CHILDREN;
'Dr. Foster appears to be Elders-Lite'

DATeline: WASHINGTON, Feb. 2

BODY:

Family Research Council President Gary Bauer said today that the musical chairs in the U.S. Surgeon General's office will not change opposition to the same old song in the Clinton Administration's social policies. Bauer noted that President Clinton is said to be ready to announce Dr. Henry W. Foster, Jr. of Nashville, Tennessee, as his new surgeon general.

"Dr. Foster appears to be Elders-Lite. He may not have her methods, but he has supported the same failed policies," Bauer said.

According to Family Research Council, Dr. Foster has long been a supporter of contraceptive-based sex education and distribution programs, and of school based clinics. His abortion activism includes serving as a board member of Planned Parenthood and working on a Planned Parenthood committee dedicated solely to furthering abortion. (Note: a fact sheet is available.)

"Clearly, Dr. Foster has shown his support for the failed sexual politics of the last 30 years," Bauer said. "But the Clinton Administration is not the only branch of government to have a say on this possible nomination. We will count on the new U.S. Congress that was elected with the votes of millions of pro-family Americans not to repeat the mistake that was made when Dr. Joycelyn Elders was inflicted on our children. FRC will call on the new Congress to fight this possible nomination.

"President Clinton has shown himself as the most pro-condom, pro-abortion president in U.S. history. From executive orders during his first days in office, to his proposed big-government takeover of health care, Bill Clinton has supported taxpayer funding for ultra-liberal policies on life issues. Family Research Council will continue to fight the failed social policies that have marked the Clinton Administration no matter who its spokesman is."

For more information or interviews, call the FRC media office. CONTACT:
Kristi S. Hamrick or Kristin Hansen (for radio) of Family Research Council,
202-393-2100 or fax, 202-393-2134

LANGUAGE: ENGLISH

4TH STORY of Level 1 printed in FULL format.

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February 8, 1995, Wednesday

SECTION: Washington Dateline

DISTRIBUTION: TO NATIONAL AND HEALTH/MEDICAL EDITORS

LENGTH: 608 words

HEADLINE: 'WHO BELIEVES HENRY FOSTER?' ASKS FAMILY RESEARCH COUNCIL

DATELINE: WASHINGTON, Feb. 8

BODY:

Consider the following:

- * "I believed that I performed fewer than a dozen pregnancy terminations ... primarily to save the lives of the women or because the women had been the victims of rape or incest." -- Dr. Henry Foster, 2/3/95
- * "If what he has done is what he has said he has done, I don't think that would disqualify him ... If the facts are no different than I understand them to be, I don't understand why he'd be in trouble," Pres. Clinton, 2/6/95
- * "I have done a lot of amniocentesis and therapeutic abortions, probably near 700." Dr. Henry Foster, 11/10/78
- * "I talked to Dr. Foster about this. He flatly and totally insists that he has not done 700 of these procedures. He says the entire statement is untrue." -- Avis Lavelle, HHS, 2/6/95
- * "Administration officials said the transcript could be mistaken, released out of context, or doctored." -- Wash. Post
- * Pharmaceutical Corp. funds research on a 'do it yourself' abortion drug involving 59 abortions -- NC News, 1981
- * "Frankly, the number of abortions that Dr. Foster performed is irrelevant." -- Rep. Nita Lowey, 2/7/95

On Wednesday, Family Research Council President Gary Bauer called again on the Clinton White House to withdraw the controversial nomination of Dr. Henry Foster to the nation's highest health office -- U.S. Surgeon General.

"One of the first criteria for a national health leader should be credibility," said Bauer. "And frankly, reports on Dr. Foster's record, released over the last few days, raise serious questions about his ability to be trusted by Americans concerned for their families' health."

"The defenders of Dr. Foster's nomination have fallen back to the position of saying that the number of abortions he has performed is 'irrelevant.' But Foster himself has made this a defining issue by attempting to hide and then minimize his radically pro-abortion record."

Bauer noted media reports that when the Foster nomination was first announced, the subject of abortion was avoided. Senator Nancy Sebaum, chairman of the Labor and Human Resources Committee, was led to believe that Dr. Foster had committed one abortion. Then, as evidence began to emerge, a formal, public statement from Dr. Foster claims the number was "fewer than a dozen."

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Next, the transcript of a 1978 meeting appears to reveal Dr. Foster claiming to have performed "probably near 700" abortions. He flatly denies making a statement that is on the record. Then, a 1985 medical journal article by Dr. Foster and four co-authors describes a medical experiment involving 59 abortions.

"After all this, Rep. Lowey says the number is 'irrelevant.' But is the credibility and even the veracity of the nominee 'irrelevant'?" Bauer asked. "Did Dr. Foster lie to Senator Kassebaum? Did he lie to President Clinton? Did he lie to the public?"

Bauer continued, "Based on his record, Dr. Foster seems to be no different from former Surgeon General Joycelyn Elders when it comes to supporting abortion, promoting condom distribution to youths, favoring the establishment of school-based clinics, and recommending masturbation to children. There is one difference, however. Americans always knew where Elders stood."

CONTACT: Kristi S. Hamrick or Kristin Hansen (for radio) of the Family Research Council, 202-393-2100

LANGUAGE: ENGLISH

LOAD-DATE-MDC: February 9, 1995

3RD STORY of Level 1 printed in FULL format.

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February 9, 1995, Thursday

SECTION: Washington Dateline

DISTRIBUTION: TO NATIONAL AND HEALTH/MEDICAL EDITORS

LENGTH: 1762 words

HEADLINE: MORE QUESTIONS RAISED ABSTINENCE ABSENT IN FOSTER'S
'FUTURE'; ANTI-ABORTION RECORD -- MISSING IN ACTION, SAYS FRC

DATELINE: WASHINGTON, Feb. 9

BODY:

Family Research Council President Gary Bauer called again on Thursday for President Clinton to withdraw Dr. Henry Foster's nomination for the nation's highest health office.

"Dr. Foster's performance on Nightline on Wednesday not only didn't set the record straight, he presented an entirely new record -- as an abortion foe and a champion of chastity. Unfortunately, his paper trail leads in the opposite direction. Dr. Foster's abortion total changes faster than the lottery number. This candidate has no credibility on either his policy positions or his record."

RHETORIC VERSUS RECORD:

* FOSTER'S RHETORIC: He opposes abortion, despite his pro-abortion activism.

-- On Nightline, Foster: "I abhor abortions. I abhor war. To me, abortion is failure. I don't like failure."

FOSTER'S RECORD: Dr. Foster has been a radical abortion activist. His record includes:

- serving as a board member of Planned Parenthood Federation of America for 7 years beginning in 1975;
- working on the National Leadership Committee of Planned Parenthood's campaign to Keep Abortion Safe and Legal with the purpose of fighting any abortion restrictions such as parental consent;
- acting as a public policy advocate for Planned Parenthood which made him a spokesman for abortion and its related issues;
- performing abortions ... at least 39.

* QUESTION: Can the White House produce any documentation for this pro-life position -- with the exception of its first bio which left out Foster's abortion history? Why didn't Dr. Foster take advantage of the conscience clause to personally avoid doing abortions?

* FOSTER'S RHETORIC: The real abortion head count is 39 ... Not 1 or 12 or 55 or 700 and counting.

-- On Nightline, Foster: "Washington is a fast town. I've got -- I'm becoming a fast study. I should have refused, Mr. Koppel, to answer that question until I knew the exact number."

Koppel: "Well, you did better than that. You issued a statement."

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Foster: "Yes."

Koppel: "A written statement, and that's the one I was referring to moment ago, when I referred to fewer than a dozen."

Foster: "Right."

(a few statements later)

Koppel: "But if you said, Dr. Foster, 'I have done scores, I have done dozens, I have done hundreds. I cannot give you the number,' the problem is you were quite specific. Fewer than a dozen is not just a vague number, it's a fairly precise number."

Foster: "Yes, but it was a guess."

FOSTER'S RECORD: From the beginning of his nomination process, Foster's math has been shaky, beginning with statements made to Sen. Kassebaum about one abortion. On Feb. 3, he wrote, "I believed I performed fewer than a dozen pregnancy terminations ... primarily to save the lives of the women or because the women had been victims of rape or incest." But that statement directly contradicted news paper reports on an abortion study and testimony he gave in 1978. A transcript shows Foster testifying, "I have done a lot of amniocentesis and therapeutic abortions, probably 700."

* QUESTIONS: What else in Foster's White House record is a guess? How can we have any confidence in what this nominee proposes for the nation? Were the 39 abortions also for rape, incest and life of the mother reasons? Under what circumstances does Dr. Foster believe it is acceptable to guess at medical statistics?

* FOSTER'S RHETORIC: Some abortions don't count.

-- On Nightline, Foster: "My study is -- once this -- the literature will be my ally, This was published in the 'Journal of Obstetrics and Gynecology,' called the 'Green Journal.' There were 60 patients in the study."

Koppel: "And how many of those resulted in successful terminations of pregnancy?"

Foster: "Fifty-Five"

Koppel: "And so you're not counting those when you speak of 39 abortions?"

Foster: "No, no."

FOSTER'S RECORD: The doctor's professional record includes, in addition to the 55, 700 procedures named in testimony from 1978. His record of abortion involvement is clear. He actually acknowledges 39 abortions. What is unclear is what constitutes a "real" abortion for his statistics.

QUESTIONS: Why is Dr. Foster so unclear about his personal record? Given the apparent irrelevancy of some abortions, will Dr. Foster use his office to push the idea of abortion without taking responsibility for the acts of abortion?

* FOSTER'S RHETORIC: They made me do it -- for the money and accreditation.

FOR THE MONEY:

On Nightline, Foster: "To keep for my veracity. We are in a medical setting. We had a research grant. We have to do that to train

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our residents. We were in a multi-center study with the Upjohn Company, and we tested a product, a suppository, not a mechanical procedure, to train residents. ...

Foster: "We have to train our residents, all residents, how they manage the complications of abortion. That's a part of keeping our program accredited, and at that time, and like now, 20 percent of all universities survive on grant funds. That was a grant. The study was subsequently terminated because of (crosstalk)."

FOSTER'S RECORD: Medical school programs are not forced to participate in any particular experiments or drug tests. In fact, programs bid to win such grant projects and can choose not to bid. Dr. Foster, however, seemed to have an interest in abortion-related testing even before bidding on the Upjohn project. In the 1978 transcript, Foster favored approving testing on unborn children who were scheduled for abortion -- specifically, he approved pre-natal testing for sickle cell anemia for the purpose of aborting infected children earlier in the pregnancy.

FOR THE ACCREDITATION:

On Nightline, Koppel: "Dr. Foster, you said earlier on in this conversation, I'm not sure if I'm using precisely the term, but you said you abhor abortion, correct? Why would you participate, not only participate in a study, but indeed, lead a study in behalf of a chemical company, the sole purpose of which was early abortion?"

Foster: "Right, as I explained earlier, we have a responsibility in training residents to maintain our accreditation. Very difficult job. We maintained an accredited residence program for 17 years. We have a responsibility to teach all residents how to manage the complications of abortion."

Koppel: "But that doesn't suggest that you're going to create a number of abortions specifically so that they can handle complications from them, doesn't it?"

Foster: "No, but there are going to be some of their own. No we don't make them, but you cannot have a situation where you can predict who will or who will not have complications."

Koppel: "I guess the only thing I'm asking is, in this particular case, where we're talking about these vaginal suppositories, they are useful only during the first, I think, seven weeks of pregnancy, wasn't that correct?"

Foster: "You're absolutely right, 42 days."

Koppel: "So that we would not be talking here about women who were having abortions for reasons of incest or rape or danger to the mother, but more likely than not, women who had just discovered that they were pregnant and wanted to terminate their pregnancy."

Foster: "Yes ..."

THE RECORD: Abortion training is not required for accreditation. In fact, it is not even mentioned in the Accreditation Council for Graduate Medical Education "Special Requirements for Residency Training in Obstetrics and Gynecology." Any hospital can choose not to do abortion training. In fact, currently the American College of Obstetricians and Gynecologist is attempting to force abortion training as an accreditation issue, because so few hospitals have chosen to do abortion training for their residents. And even though ACOG is trying

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to force the abortion accreditation issue on hospitals, all programs would have to include a conscience clause so that individuals could refuse to take part in abortion training. And those abstaining doctors, once graduated, would still be certified as being fully trained.

QUESTIONS: Is Dr. Foster's position that "abhorrent" abortions are acceptable when done for grant money? Will Dr. Foster use his bully pulpit in the Surgeon General's office to fight against "abhorrent" abortion training being done in medical schools? Why didn't the conscience clause protect him?

FOSTER'S RHETORIC: He's an abstinence man. Not interested on widespread contraceptive distribution.

On Nightline, Koppel: "But with the involvement of parents, you do favor the widespread distribution of condoms?"

Foster: "No."

Koppel: "No?"

Foster: "I favor abstinence. Abstinence, that's what I favor. That's the bedrock of our program."

FOSTER'S RECORD: The "I Have a Future" program, which has been cited as Dr. Foster's major accomplishment has an 8-page brochure as well as some fact sheets describing its activities. It has been the subject of newspaper feature articles. Yet in none of this material in print is the word abstinence mentioned. The distribution of contraceptives to teenagers is specifically listed as one of the program's five objectives.

Dr. Foster's support for abstinence would also seem to be in conflict with the attitude of his Planned Parenthood colleagues. Planned Parenthood has joined in lawsuits to get abstinence programs removed from schools. The organization has published pamphlets claiming that abstinence programs are harmful.

QUESTIONS: Why is Dr. Foster affiliated with an organization (Planned Parenthood) that has opposed his favored abstinence approach? Why doesn't the "I Have a Future" literature even mention abstinence -- while it does promote contraceptive availability?

CONTACT: Kristi S. Hamrick or Kristin Hansen (for radio) of the Family Research Council, 202-393-2100

LANGUAGE: ENGLISH

LOAD-DATE-MDC: February 10, 1995

18TH STORY of Level 1 printed in FULL format.

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February 22, 1995, Wednesday

SECTION: Washington Dateline

DISTRIBUTION: TO NATIONAL EDITOR

LENGTH: 618 words

HEADLINE: FOSTER 'FABLE' MEHARRY 'MAINTAINED' WELL;
FOSTER FACT: MEHARRY RANKED LOWEST IN THE NATION TWICE, HAD \$\$ PROBLEMS DURING
FOSTER'S SERVICE

DATELINE: WASHINGTON, Feb. 22

BODY:

Family Research Council Gary Bauer on Wednesday called again on President Clinton to withdraw his nomination for U.S. Surgeon General because of the continuing revelations regarding Dr. Foster's record. According to newspaper accounts, Meharry Medical College was ranked last in two national reports during Foster's service from 1973 to 1994. This follows reports that the school lost its accreditation in 1991.

Foster officially headed the school of medicine beginning in 1990, following his chairmanship of the ob/gyn department beginning in 1973. However, in his 8/95 Nightline interview, Foster said, "I maintained an accredited residence program for 17 years."

"Pro-family Americans are looking for a surgeon general who can rally the nation to a higher standard of good health," Bauer said. "But despite his earlier claims, Dr. Foster has not shown Americans, in his leadership at Meharry, a record worthy of repeating. And despite the Clinton Administration's blindness to this point, Foster's pro-abortion activism makes most Americans uneasy about what he will do in office."

FOSTER FACTS:

* "Nashville's troubled Meharry Medical College has been ranked last in the nation in a National Science Foundation-funded survey of the country's 94 medical schools." Nashville Banner, 1/19/78

* "According to Private Practice, Ten Worst (Medical Schools) are: (in last place) 98: Meharry Medical College." Nashville Tennessean, 3/10/80, and Nashville Banner, 3/10/80

* "Serious problems in the financial mismanagement of Meharry Medical College have contributed to the college's 'precarious' financial condition, federal auditors have found ... Meharry's management problems, outlined in a federal audit report obtained by the Nashville Banner under the Freedom of Information Act, include:

- * The use of federal funds for non-federal projects.
- * Poor collection procedures on student loans.
- * Failure to reconcile the general fund bank accounts for more than a year.
- * Weak controls on expenditures, accounting for about 25 percent of Meharry's annual deficit.

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Insufficient accounting staff.

'Incomplete and inaccurate records' and an 'inadequate accounting system.' The records for fiscal 1978 were in such bad shape they couldn't be completely audited, the auditors said." Nashville Banner, 4/17/79

* "Meharry Medical College, which for years has been the beneficiary millions of dollars in federal subsidies, is learning to cope with a different experience -- paying Uncle Sam. The U.S. Department of Health and Human Services has required the school to repay between \$2.7 and .8 million -- the total amount is still in dispute -- in federal funds at the federal officials said were used for unauthorized purposes." Nashville Banner, 3/3/81

"I feel the president is totally committed to my nomination, based what I define as what characterizes me at the beginning, at the top of this program, what I've done through the years in maternal and child health, health delivery, reducing teen pregnancy, improving the lives of these young people." Foster, Nightline, Feb. 8, 1995.

"Based on his record, and the accuracy problems Dr. Foster has had in describing his own history, Family Research Council calls again on Bill Clinton to withdraw this nominee," Bauer said.

CONTACT: Kristi S. Hamrick or Kristin Hansen (for radio) of the Family Research Council, 202-393-2100

LANGUAGE: ENGLISH

DATE-MDC: February 23, 1995

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April, 1989

SECTION: Vol. 21 ; No. 3 ; Pg. 28; ISSN: 0043-0633

LENGTH: 9169 words

HEADLINE: Beyond the legal right; why liberals and feminists don't like to talk about the morality of abortion.

BYLINE: DeParle, Jason

BODY:

Why liberals and feminists don't like to talk about the morality of abortion

We going to watch a child being torn apart. . ." promises Dr. Bernardson, "by the unfeeling steel instruments of the abortionist." But the promise isn't really kept. What we see in *The Silent Scream*, Nathanson's famous anti-abortion film, isn't red dismemberment but flickering gray chaos. I stopped the video tape three times to examine the fuzzy image that Nathanson calls a child's mouth emitting its silent scream. But what I saw looked more like a satellite photo of a Manitoba blizzard, an undifferentiated swirl.

Several years ago as the film's influence spread-Ronald Reagan showed it at the White House-Planned Parenthood released a handsome brochure of rebuttal, entitled "The Facts Speak Louder." Whereas *The Silent Scream* claimed the fetal head was too big for a suction tube and had to be crushed first with forceps, the brochure said the doctor could have used a larger tube. Whereas *The Silent Scream* said the invasion of the uterus raised the fetal heart throb from 140 beats per minute to 200, the brochure said a rate of 200 is normal. The lines of inquiry remained the same on the "CBS Morning News," where dueling experts speculated on whether a 12-week-old fetus possesses enough cortex to feel pain, and what, in fact, we mean by pain something understood or merely reflexive? "We know that the fetus spends lots of time with its mouth open," said one Yale physician, so what looked like a scream might have been "a chance random finding"

While these facts may, as Planned Parenthood says, speak loudly, it's unlikely that they say what the prochoice groups hope, since they put the fetus, even a televised facsimile, on center stage, precisely where prochoice groups don't want it. Assume the film is wrong and the Planned Parenthood brochure is right. Assume that was a fetal yawn and not a scream. None of the experts contested that it was a fetal mouth, and that it was part of a fetal head, attached to a fetal spine, and that it had arms and legs, fingers and eyes. Nathanson was certainly wrong to suggest that the 12-week-old fetus was "indistinguishable in every way from any of us"; a rather important difference, one would think, is that the rest of us aren't enveloped in the living flesh of another human being with needs and rights of her own. But if the film's scientific and rhetorical claims are extravagant, it nonetheless succeeded in directing all eyes toward-take your pick-the "fetus" or "unborn child."

Writing in *Ms. magazine*, Barbara Ehrenreich argued that the film's failure to mention the woman having the abortion, "not even as a sinner or a murderer," was the "eerie thing" about it. "Abortions, after all, have to take place somewhere," she wrote, "i.e., in the uterus of an actual human being." Ehrenreich's point is well-taken: much of the right-to-life movement does act as if abortions took place in an abstract neutral setting, rather than within a woman whose life may begin to unravel with an unwanted pregnancy. But I don't think I'd call that the "eerie thing" about *The Silent Scream*; as eeriness goes, the image, clear in mind if fuzzy on screen, of tiny bits of head, shoulders, ribs, and thighs being fed to a suction tube is formidable.

It's hard to hold these two images-the dismembered body of the fetus and the enveloping body of the mother,

each begging the allegiance of our conscience-in mind at the same time. One of the biggest problems with the abortion debate is how rarely we do it, at least in public discourse. While contentious issues naturally produce one dimensional positions, the remarkable thing about abortion is that many otherwise sensitive, nuanced thinkers hold them. To one side, visions only of women in crisis, terrified and imperilled by an invasive growth; to the other, only legions of innocent children, chased by the steely needle.

The inhumanity that issues from baronies within the right-to-life movement is well known: the craziness of a crusade against birth control; the view of women as second-class citizens; even the descent into bomb-throwing madness. The insistence that an unborn child must always be saved, no matter the cost, isn't compassion but a compassionate mask, and it obscures a face of cruelty.

But what ought to be equally if not more disturbing to feminists, liberals, and others on the Left is the extent to which prominent prochoice intellectuals mirror that dishonesty and denial. One-and-a-half million abortions each year is not the moral equivalent of the Holocaust, precisely because of the way in which fetuses are distinguishable: growing inside women, they can wreck the lives of mothers and of others, including her children, who depend upon her. But the fact that three of 10 pregnancies end in abortion poses moral questions that much of the Left, especially abortion's most vocal defenders, refuses to acknowledge. This lowering of intellectual standards offers a useful way of looking at the reflexes of liberals in general, and also reveals much about the passions-many of them just-that underpin contemporary feminism.

What the suction machine sucks

The declaration of a legal right to an abortion doesn't end the discussion of what our attitude toward it should be, it merely begins it. Ehrenreich, like many of the prochoice movement's writers and intellectuals, would have us believe that the early fetus (and 90 percent of abortions take place in the first three months) is nothing more than a dewy piece of tissue, to be excised without regret. To speak of abortion as a moral dilemma, she has written, is to us "a mealy-mouthed vocabulary of evasion," to be compromised by a "strange and cabalistic question "

Yet everything we know-not just from science and religion but from experience, intuition, and compassion-suggests otherwise. A pregnant woman, even talking to her doctor, doesn't call the growth inside her an embryo or fetus. She calls it a baby. And she is admonished, by fellow feminists among others, to hold it in trust: Don't drink. Don't smoke. Eat well, counsels the feminist manual, *Our Bodies, Ourselves*"think of it as eating for three-you, your baby, and the placenta. . ." Is it protoplasm that she's feeding? Or is it protoplasm only if she's feeding it to the forceps?

Grant for a moment that it is; agree that what the suction machine sucks is nothing more than tissue. Why then the feminist fuss over abortions for purposes of sex selection? If a couple wants a boy and nature hands them the makings of a girl, why not abort and start again? All that matters-no?-is "choice."

It wasn't sex selection but nuclear power that got a feminist named Juli Loesch rethinking her own contradictory views of fetuses. As an organizer attempting to stop the construction of Three Mile Island, she had schooled herself on what leaked radiation can do to prenatal development. At a meeting one day, she says, a group of women issued an unexpected challenge: "if you're so concerned about what Plutonium 239 might do to the child's arm bud you should go see what a suction machine does to his whole body."

In fact, we need neither *The Silent Scream* nor a degree in fetal physiology to tell us what we already know: that abortion is the eradication of human life and should be avoided whenever possible. Should it be legal? Yes, since the alternatives are worse. Is it moral? Perhaps, depending on what's at stake. Fetal life exists along a continuum; our obligations to it grow as it grows, but they must be weighed against other demands.

The number of liberals, feminists, and other defenders of abortion eager to simplify the moral questions is, at the very least, deeply ironic. One of the animating spirits of liberalism and others factions on the Left, and proudly so, is the concern for the most vulnerable. But what could be more vulnerable than the unborn? And

how can liberalism hope to regain the glory of standing for humanity and morality while finding nothing inhumane or immoral in the extermination of so much life?

The problem with much prochoice thinking is suggested by the movement's chief slogan, "a woman's right to control her body," which fails to acknowledge that the great moral and biological conundrum is precisely that another body is involved. Slogans are slogans, not dissertations; but this one is revealing in that it mirrors so much of the prochoice tendency to ignore the conflict in an unwanted pregnancy between two competing interests, mother and embryo, and insist that only one is worthy of consideration. Daniel Callahan, a moral philosopher, has written of the need, upon securing the right to a legal abortion, to preserve the "moral tension" implicit in an unwanted pregnancy. This is something that too few members of the prochoice movement is willing to do.

One fine example of preserving the moral tension appeared several years ago in a Harper's piece by Sallie Tisdale, an abortion clinic nurse with a grudging acceptance of her work. First the mothers: "A twenty-one-year-old woman, unemployed, uneducated, without family, in the fifth month of her fifth pregnancy. A forty-two-year-old mother of teenagers, shocked by her condition, refusing to tell her husband. A twenty-three-year-old mother of two having her seventh abortion, and many women in their thirties having their first. . . . Oh, the ignorance . . . Some swear they have not had sex, many do not know what a uterus is, how sperm and egg meet, how sex makes babies. . . . They come so young, snapping gum, sockless and sneakered, and their shakily applied eyeliner smears when they cry. . . . I cannot imagine them as mothers."

Then the "I am speaking in a matter-of-fact voice about 'the tissue' and 'the contents' when the woman suddenly catches my eye and asks, 'How big is the baby now?'. . . . I gauge, and sometimes lie a little, weaseling around its infantile features until its clinging power slackens. But when I look in the basin, among the curdlike blood clots, I see an elfin thorax, attenuated, its pencilline ribs all in parallel rows with tiny knobs of spine rounding upwards. A translucent arm and hand swim beside. . . . I have fetus dreams, we all do here: dreams of abortions one after the other; of buckets of blood splashed on the walls; trees full of crawling fetuses. . . ."

It's not surprising that the defenders of abortion don't like pictures of fetuses; General Westmoreland didn't like the cameras in Vietnam either. Fetuses aren't babies, and the photos don't end the discussion. But they make it a more sober one, as it should be. Fetuses aren't just their image but our image too, anyone's image who is going to confront abortion.

If the prochoice movement doesn't like the way *The Silent Scream* depicts the fetus, turn to an early edition of *Our Bodies, Ourselves*. Describing an abortion at 16 weeks by means of saline injection, the feminist handbook explains: "Contractions will start some hours later. Generally they will be as strong as those of a full-term pregnancy. . . . The longest and most difficult part will be the labor. The breathing techniques taught in the childbirth section of this book might help make the contractions more bearable. After eight to fifteen hours of labor, the fetus is expelled in a bedpan in the patient's bed."

Heil Mary

When Suzannah Lessard wrote about abortion in *The Washington Monthly* in 1972 ('Aborting a Fetus: the Legal Right, the Personal Choice'), a year before *Roe v. Wade*, she described what she called a "reaction formation along ideological lines. . . of the new feminist movement" as it related to abortion. This was a time when Gloria Steinem was insisting that a fetus was nothing more than "mass of dependent protoplasm" and aborting it the moral equivalent of a tonsillectomy "I think a lot of women need to go fanatically ideological for a while because they can't in any other way overthrow the insidious sense of themselves as inferior," Lessard "nor otherwise live with the rage that comes to the surface when they realize how they have been psychically mauled." This is an observation about the psychology of oppression that could be applied to any number of righteous rebellions; the path to autonomy tends to pass, by necessity perhaps, through stages of angry defiance. "But I don't think that state of mind—hopefully temporary—is the strength of the movement," Lessard wrote. "It has very little to do with working out a new, undamaging way of living as women."

But to judge by much contemporary prochoice writing, the mere-protoplasm camp still thrives. Certainly, there are exceptions, Mario Cuomo's 1984 speech at Notre Dame perhaps being the most famous: "A fetus is different from an appendix or set of tonsils. At the very least. . .the full potential of human life is indisputably there. That-to my less subtle mind-by itself should demand respect, caution, indeed. . . reverence. . . But I have concluded that the approach of a constitutional amendment is not the best way for us to seek to deal with abortion." And others on the Left have gone even further: Nat Hentoff, who supports a legal ban, has written a number of attacks on abortion in the Village Voice; Mary Meehan, a former antiwar activist, published an article in The Progressive that attacked the magazine's own editorial stance in favor of legal abortion.

But these are the exceptions. Pick up the past 10 years of The Nation, Mother Jones, or Ms. Read liberals and feminists on the op-ed pages of The Washington Post or The New York Times-you're likely to find more concern about the snail darter than the 1.6 million fetuses aborted each year.

Consider:

> Barbara Ehrenreich in a "Hers" column for The New York "I cannot speak for other women, of course, but the one regret I have about my own abortions is that they cost money that might otherwise have been spent on something more pleasurable, like taking the kids to movies and theme parks. . ."

> The Yale University women's center, pledged to be "a place for all women-of every race, ethnicity, age, ability, class, sexual orientation, religion. . ." barred a group called Yale Students for Life. After the prolife group applied for space, the women's center amended its rules to specify that its members support "reproductive freedom." Similar banishment of prolife groups from women's studies centers has occurred on a number of college campuses.

> Mother Jones published a note on Catholic schools that amended the Pledge of Allegiance to read, "with liberty and justice for all, born and unborn." The magazine headlined it, "Heil Mary."

> Linda Gordon, a leading feminist historian, in Harper's: "I'm not sure, by the way, that we should spend our time debating the ethical points of abortion. . . Abstract ethical arguments over when life begins are not very illuminating. They inevitably become moralistic-and they inevitably carry the implication that people who support abortion are less moral than other people.

"When women are able to be self-assertive, that to me is a step toward moral, emotional, and intellectual growth. When I had an abortion, that's what it represented to me."

> Ellen Willis, a senior editor at the Village Voice, in the same issue of Harper's "I think it is a good thing to have an abortion rather than to have a child that you don't want. Women should feel good about it. . . ."

> Katha Pollitt, a poet and critic, writing in The Nation: "When I first heard that an antiabortion demonstrator had stationed himself outside of the building in which The Nation has its offices-a building that houses, among other businesses and concerns, a gynecological clinic that performs abortions-I had an immediate image of what he would look like. He would be pale and rawboned and strained, a hungry fanatic in a cheap suit, like a street-corner preacher in a Flannery O'Connor story. . .

"I was wrong about the details. The demonstrator-perhaps harasser is a better word for what he does-wears his hair in a long ponytail and, in his blue jeans and parka, looks like a pudgy hippie. . . .I was right about the main thing though: he is a religious fanatic. . . ."

"There was a certain elation, I admit, at having my beliefs about the antiabortion movement so neatly confirmed in a single person: that it is a reactionary religious crusade, opposed to nonprocreative sex and contraception, indifferent to the health and individual circumstances of women, bone ignorant. . . ."

> Katha Pollitt again, this time in a "Hers" column for The New York Times: "Moralists, including some who are prochoice, like to say that abortion isn't or shouldn't be a method of birth control. But that's just what abortion is-a bloody, clumsy method of birth control."

> Ms. in 1989, naming Anne Archer, an actress and prochoice activist, Woman of the Year: "Cut to a scene at last summer's Republican National Convention. We're in that part of Schlaflyland where reproductive reactionaries who feel free to thrust bottled fetuses in your face are assured a place on the party platform. The audience. . . contains some of those elements who wouldn't mind frying Betty Ford at the stake for being a radical feminist. . . ."

Archer says "I don't care about the anti-choice women. They're a minority. They're vocal, but it's not really based on intelligent thinking or caring. . . . Once you take a step back and deny women privacy and choice, you put them back in the kitchen; you put them back in an inferior position. If they cannot control their reproductive systems, they cannot control their personal destiny."

"The anti-choice, anti-privacy forces," Ms. says, "would seem to prefer things that way. . . ."

And when it comes to dissent, even dissent of the mildest sort?

> In 1985 The North Carolina Independent, a biweekly alternative paper with a history of support for left-liberal and feminist causes, put a fetus on the front page, labeled with the blandest caption: "Controversial, magnified images like this one. . . are credited with winning converts to the antiabortion camp."

The phone calls and letters poured in. "The enmity that it aroused was just unbelievable," said Katherine Fulton, the paper's editor. "It was perceived as antifeminist." The graphic seemed like "the other sides image. We didn't couch it enough."

> Fetuses again, this time in The Progressive: In 1985, the magazine ran an advertisement from a group called Feminists for Life. "This Little Girl Needs Protection. . ." it claimed, presenting an embryo at eight weeks.

The Funding Exchange, a New York philanthropy that had supported the magazine, wrote to say it was "greatly offended," was canceling its subscription, and would henceforth find it "difficult for our staff to lobby for funding for your publication."

Michael Ratner of the Center for Constitutional Rights, a civil liberties group, weighed in as well: "Happily I am not a subscriber so I needn't cancel my subscription," he wrote. "I would surely do so after seeing the antiabortion ad. . . ."

Liberal precincts

The list could continue, but the point is clear: questioning abortion-not only the legal right but also the moral choice-is often viewed, even by otherwise sensitive and thoughtful activists, as a betrayal of the highest order. (Except, at times, for Catholics, whose antiabortion views are usually dismissed as a quaint if unfortunate quirk of faith.)

A great irony about this public demonstration of zeal is that there may be more ambivalence on the Left than is usually acknowledged. When the The Progressive published Mary Meehan's prolife piece in 1980, it drew more mail than any article save the famous guide to the workings of the H-bomb. About half were predictable: "your knees buckle at the mere thought of taking a forthright stand for women's rights," "prolife is only a code word representing the neo-fascist absolutist thinking." Etc, etc.

But the others: "I support most of the positions of the women's movement, but I part company with those who insist on abortion as a 'right of women to control their own bodies.' There's a lot more than just one body

that is being controlled here." "I have no religious objection to abortion, but I do oppose it from a humanitarian point of view." "I was awfully glad to see a liberal publication printing an antiabortion article."

Why aren't there more voices like these heard in liberal precincts? The answers come in two general sets, one pertaining to liberal and progressive values generally and the other connected more specifically to the passions of contemporary feminism.

Right or wrong, abortion helps further values that liberals and progressives generally hold in esteem. Among them is public health. Even those with qualms about abortion tend to back the legal right, if for no other reason than to stem the mutilation that a return to back alleys would surely entail. There's also an equity-between-the-classes argument: if abortion is banned all women may experience trouble getting one, but the poor will have the most trouble of all. For others, there are always planes to Sweden.

Beyond questions of abortion's legality, the Left tends to hold values that encourage the acceptance of abortion's morality too. There's the civil liberties perspective, which argues that the state should "stay out of the bedroom." There's a population control argument; without abortion, wrote one Progressive reader, "there will be a more intense scramble for food and all the world's natural resources." There's a help-the-poor strand of thinking; what, liberals constantly ask, about the welfare mother who can't afford another child? And there's a fairness-in-the-marketplace argument, which maintains that without absolute control of their fertility, women cannot compete with men: if two Arnold & Porter associates conceive a child at a Christmas party tryst, bringing it into the world, whether she keeps it or not, will penalize her career much more than his.

These principles—a thirst for fairness between genders and classes, for civil liberties, for economic opportunity—are honorable ones. And they speak well of those who hold them as caring not only for life itself but also for its quality.

Careful, though. Quality-of-life arguments sometimes stop focusing on quality and start frowning on life. Concerns about population control have their place; but whether abortion is a fit means of seeking it raises questions that go well beyond environmental impact studies. One of the most troubling prochoice arguments is the what-kind-of-life-will-the-child-have line. Yes, poverty may appropriately enter the moral calculus if an additional child will truly tumble the family into chaos and despair, and those situations exist. (And there is little cruelty purer than child abuse, which afflicts unwanted children of all classes.) But liberal talk about the quality of life can quickly devolve into a form of cardboard compassion that assumes life for the poor doesn't mean much anyway. That sentiment says to an unborn child of poverty: life is tough, so you should die. Compassionate, that.

Polyester clothes

Abortion's neat fit with other liberal concerns creates a package-politics tug. The right-to-life movement looms as the Great Beast in the mind of the Left: "Schlaflyland." "Reproductive reactionaries." (Do opponents of abortion like Nat Hentoff or the Berrigans live in Schlaflyland? Does Christopher Hitchens?) One is inclined to take Katha Pollitt very much at her word, when she confesses 'to a "a certain elation, I admit, at having all my beliefs about the antiabortion movement so neatly confirmed. . . ." That kind of confirmation lulls us into avoiding the issues right-to-lifers pose.

Let's be clear: much of the right-to-life movement is antipoor and antiwoman. This tends to be particularly true of the movement's political spokesmen, like Jesse Helms. And beneath the debate on the moral status of the unborn, lies a debate on how career, family, sex, birth control, and control in general should shape our lives—all of which are important, but none of which finally answer the question of our obligations to prenatal life. Hunkering down for the great defense of other values, the defenders of abortion tend to miss the ways in which their own concerns can wend back to the womb.

Juli Loesch, the antinuclear activist at Three Mile Island, said a social discomfort with the antiabortion people she knew initially closed her mind to their arguments, "They weren't my set," she said. "They liked

Lawrence Welk; I liked the Rolling Stones. They wore polyester clothes; I wore natural cotton. They were pro-inhibition; I was anti inhibition " But in reconsidering her protests against the Vietnam war, Loesch said she found herself being "inconsistent to the point of incoherence. We were saying that killing was not an acceptable solution to conflict situations, yet when we had our own conflict situation we were willing to go straight to killing as a technical fix."

Another obvious link, made too seldom, concerns abortion and executions. If killing criminals is wrong, then what about fetuses? (At least the criminals have done something wrong.) The issues, of course, aren't synonymous; there are thoughtful arguments to be made to permit abortion and ban capital punishment, and the other way around. But one of the real ironies of contemporary politics is that the Left and Right tend to split that ticket in exactly opposite ways, and each often invokes the word "sanctity."

Perhaps if liberals and progressives weren't so besieged in general, more ambivalence about abortion would bubble to the top. In my talks with Katha Pollitt and Barbara Ehrenreich, they, like others, found it particularly troubling that moral objections to abortion would be raised by someone, who, to use Ehrenreich's phrase, "had been on the right side of the barricades." When I asked why, she said, "that kind of thing always cuts the legitimacy of our legal right; it's the kind of wedge used to threaten us."

The Christmas party tryst

While the values of the Left in general provide one set of explanations for the contours of the abortion debate, the specific passions and experiences of feminists provide another. These concerns don't, finally, answer the question of what our personal, as opposed to legal, obligations toward fetal life need to be. But they do underline the history of injustice that women have inherited.

In rough outline, one persuasive feminist argument for keeping abortion legal-an argument I accept-goes something like this: Without the option of abortion, women cannot be as free as men. Not just socially and economically but psychologically as well. And not just those with unwanted pregnancies. As Ellen Willis of the Voice has put it, "Criminalizing abortion doesn't just harm individual women with unwanted pregnancies, it affects all women's sense of themselves. Without control of our fertility we can never envision ourselves as free, for our biology makes us constantly vulnerable." Vulnerable to failed birth control. To rape or other coercive sex. Or simply to passion. Vulnerable in a way that men are not. And in a society that rightly prizes liberty as much as ours, it's unacceptable for one half of its members to be less free, at an essential level, than the other. Therefore the legal right.

Of course, having the legal right to do something doesn't tell us whether it's a desirable thing to do. Women have the legal right to smoke and drink heavily during pregnancy, but few of us would hesitate to dissuade them from doing so. Why don't more feminists take the same view toward abortion-defending the right, but urging women to incline against it whenever possible? The feminist defenders of abortion I spoke with reacted to that proposal with a litany of past and present injustices against women-economic, social, political, and cultural, all of them quite You can sit around all day talking about what's the morally right thing to do-rights and sacrifices and the sanctity of life and all that-but I don't think it can be divorced from women's lives in this society" Pollitt said.

Leaving aside for a moment the wrenching emotional issues, one obvious burden is economics. Having a child-even one put up for adoption-costs not only trauma but time and money, and takes them from women, not men. The financial burden is one reason why poor women are more likely to have abortions than others.

But the same inequity is true among professional women. To return to the Arnold & Porter Christmas party tryst, what would happen if the female associate does the right thing by prolife standards and decides to have the child? At \$ 65,000 a year, she can certainly afford to do it, and her insurance is probably blue chip. But in the eyes of some senior partners, the luster of her earlier promise begins to fade. They may be reluctant to keep her on certain accounts, for fear of offending the clients. What's more, even if the clients understand, she'll be missing at least six to eight weeks of work-just, as fate would have it, when she's needed in court on an

important case. The long-term penalties may be overestimated-good employees are in short demand in most professions; it's the marginal who will suffer the most-but the fears are nonetheless real. What's more, the burden is unequally shared. Her tryst-ee suffers no such repercussions. The clients love him, he shines in court, and his future seems assured. Unfair? Yes, extremely.

These inequities are one reason why the right-to life movement has the obligation, often shirked, to support measures that would make it easier for women of all incomes to go through pregnancy-health care, maternity leave, parental leave, day care, protections against employment discrimination. But even if all these things were provided-as they should be-it's unlikely that the strength of feminist feeling on abortion would recede. Economic opportunity is an important facet of the abortion debate, but it's not, finally, at its core. Of all the women I spoke with, the one I most expected to forward an economic argument was Barbara Ehrenreich-since she is co-chair of Democratic Socialists of America-but she never mentioned it. When I finally asked her about it she said that no amount of money or servants would change the essential moral equation, which centers, in her mind, on female autonomy. "The moral issue has to do with female personhood," she said.

Cruel choices

What surprised me in my talks with the female defenders of abortion, was how many of them seemed to view the abortion debate as some sort of referendum by which society judged women's deepest levels of self. Words like guilt and sin, punishment and shame kept issuing forth. They did so both about abortion and about sex in general. "The whole debate is more about the value of women's lives and the respect we have for women than it is about the act of abortion itself," said Kate Michelman, the head of the National Abortion Rights Action League.

A few days before my scheduled meeting with Michelman, I got a phone call from her press secretary. "We hear a nasty rumor," she said, "that you're writing something that says abortion is immoral." I mentioned the rumor when I sat down to speak with Michelman, who quickly told me about the very difficult circumstances surrounding her own abortion. Her first husband had walked out on her and her three small children when she was destitute, ill, and pregnant. She had to make a difficult moral judgment, she said, weighing her responsibilities to her family against those to the fetus. Then, this being 1970, she couldn't even make the decision herself but had to obtain the consent of a panel of doctors and then, to further the pain, get her ex-husband's signature. Call me immoral, she seemed to say, in an I-dare-you way.

But it seemed to me that Michelman's decision, like those, certainly, of a great number of women, had involved a thoughtful handling of difficult questions-as she herself was underlining. "Sure the fetus has interests, absolutely," she said, as do other things, like a woman's commitments to her family and her health. It was only when I began asking why those leading the prochoice movement didn't discuss these moral tensions more often that her reasoning turned curious and defensive.

"The ethical questions are being raised," she said. "And if a woman makes a decision to have an abortion then she's made the right decision."

I asked her how she knew. With 1.6 million abortions a year, there seems to be a lot of room for error.

Merely asking the question, she said, implied that women had abortions for frivolous reasons "To even raise the question of when it's immoral," she said, "is to say that women can't make moral decisions."

In considering the way a legacy of injustice fuels the adamance over abortion, it is helpful to consider three generations of women: those who preceded the feminist movement of the late sixties and early seventies; those who soldiered in it; and those who inherited its gains. Each has faced the tyranny of a man's world in a way that primes passions about abortion, but each has done so in a different way.

Women who became sexually active outside of marriage in the days of blanket abortion bans faced a world prepared to hand them the cruelest choice: the life-wrecking stigma of pregnancy out-of-wedlock or the back

alley; a "ruined" life or a potentially lethal trip through a netherworld, Men, meanwhile, made the decisions that crafted that world while escaping the brunt of its cruelty. That was an unjust life, and the triumph over it is among feminism's proudest achievements.

Feeling accused

The following account from a woman identified simply as Kathleen comes from *Back Rooms*, a recent collection of oral histories, and is worth quoting at length. It speaks for a tremendous number of women.

"It was the first and only time I was ever sexually intimate with this man. . . He offered me a ring. . . But I did not want to do that. . . I thought about going to a home for unwed mothers and I thought about how my family would deal with it, how it would affect my college career, my scholarships, my job. . . I couldn't even imagine telling my parents. . . It was just unthinkable. . . I just really couldn't put my family through the shame. . .

"Things at that time in Cleveland were very tight. . . I finally located an abortionist in Youngstown, Ohio. It was going to cost one hundred dollars. . . This so called doctor-this man who called himself a doctor-had two businesses. He was a bookie and he was an abortionist. He was an elderly man in a ramshackle little house in a disreputable, shabby section of Youngstown. . . I don't recall seeing any medical certificates on the walls. I don't think anyone who was a doctor would also be a bookie. I think there was some actual gambling going on while we were waiting. . .

"He had a room with a chair and stirrups set up. I went in and it was all very, very secretive. The money had to be in cash, in certain denominations. . . He checked it very thoroughly to make sure it wasn't marked. . . He explained that he was doing a saline injection and that there should be some cramping and that abortion would happen within 24 hours. . . I don't know how many days passed. . . But I do know that when I finally aborted I was alone in my room in the dormitory at school. I went through at least 12 hours of labor alone in my room. . .

"It was more terrible than I ever imagined. . . I remember noticing that the contractions were getting more frequent and more frequent, five minutes, then four minutes, then three minutes, and then there was a lot of blood and there was a fetus. . . I remember taking this fetus and not knowing what else to do but flush it down the toilet. And I was terrified that it wasn't going to go down, and that it would clog up the system, that somehow, some way, I would be found out, The whole system would be clogged up. They'd have to call a plumber and then there would be this hunt to find out who did this terrible thing in the dorm, and I'd be tracked down and prosecuted. I was really in shock and just terrified."

A second generation of women share the memories of illegal abortion, but their perspective has been honed even finer by roles as activists. For these women-in their late thirties to late forties, which includes Ehrenreich, Pollitt, Gordon, Willis, and Michelman-the fight for other forms of feminist freedoms was linked to abortion not only intellectually but through political experience. "My early involvement in the women's movement was involvement in the health movement," says Ehrenreich. Reproductive rights, including birth control, were at the center of the feminist movement of the late sixties and early seventies, and the battles to win them were hard fought. Such experiences aren't likely to lead to a lot of second-guessing.

Nor, for that matter, is the fact that so many women (of many different ages) have had abortions. According to the Alan Guttmacher Institute, 46 percent of American women will have an abortion before menopause, and more than a third of those will have had more than one. During my telephone conversation with Barbara Ehrenreich I asked her why she thought there wasn't more discussion of whether abortion is an acceptable type of killing. She sounded incredulous. "That's a when-did-you-stop-beating-your-wife question," she said. "I've had two abortions-do you want to call me a murderer?"

In retrospect, I regretted my use of the word "killing." I hadn't meant it as an accusation, though, perhaps understandably, that's the way she heard it. I explained that I had in mind a great difference between the word

"killing," which I regarded as neutral and descriptive, and "murder," a legal term meant to describe killing of a very narrow and wrongful sort. This is a problem that makes all discussion of abortion so difficult. I no more think Barbara Ehrenreich or other women who've had abortions are murderers than I think that of people who support capital punishment-there are people I respect and admire greatly in both groups. It's difficult to raise moral qualms about abortion, perhaps especially for a man, without a great number of women feeling accused of something quite serious, even if accusation is not one's intent at all.

Stallions and diaphragms

Women my age-I'm 28-haven't had to worry about back rooms. To a significant extent, too, they no longer face a life-wrecking stigma from a pregnancy outside of marriage (though this still varies greatly with individual circumstance). They have inherited the gains-more economic opportunity, fewer social barriers-that earlier feminists helped secure, and while this is a very good thing there is at least one sense in which that legacy contains some ambiguity: to some extent women were the losers in the sexual revolution. This is true in at least two ways. For one, much of the culture still remains ambivalent about female sexuality, acknowledging its legitimacy while at the same time distrusting it. Secondly, while the legitimation of sex without commitment was sought by women as well as men, men pursue it more often, and women are more vulnerable to its effects.

I ran this theory past Kate Michelman, and she bought it without a blink: "Men want sex, require sex, they use sex to. . . ." Her thoughts outpaced her "Women are less needful of actual sexual intercourse. Women are more needful of intimacy and closeness, while men drive right in there, you know. They want sex. I don't know how men and women ever get together you know. We're very different. But the ultimate impact really falls on women."

More evidence of the way men's sexual behavior feeds the feminist fervor on abortion comes from a Katha Pollitt piece in Mother Jones. Entitled "Nat Hentoff, Are You Listening?" it answers Hentoff's attacks in the Voice on women who have abortions after deciding that giving birth, in Hentoff's words, would be 'Just plain inconvenient.'

"Rather than fulminate against women, about whose lives he seems to know little," Pollitt wrote, "would it not be more seemly for Hentoff to direct his moral fervor toward his brothers?" To help him along, Pollitt composed a sample speech for Hentoff to take on the road. It's worth listening to in detail, for the list it offers of women's legitimate gripes:

"Men! Abortion is a terrible thing, and it behooves us to ensure that there are as few as possible. . . . That means no more extramarital affairs, no more sleeping with our students, no more one-night stands. Should the marriage fail, let's vow to cheerfully continue to support every child we father until that child is 21-we have a bad record there, what with three-fourths of divorced dads reneging on court-ordered child support. . . .

"Now comes the hard part. . . . It goes without saying that we're mounting a major campaign to make male birth control the chief medical priority of our time. . . . vasectomies for you guys who can't live with the conditions I've outlined above, and, for the rest of us-condoms! They're messy, they diminish pleasure, but so what? How can we blame women for having 'convenience abortions' if we won't put up with a little inconvenience to prevent unwanted pregnancy? In fact, since condoms have been known to break, let's wear two at a time!"

"None of this will amount to anything, though, if we don't change our attitudes about sex as well. Face it men, we give women mixed messages. So from now on, let's never call a woman frigid if she won't sleep with us without commitment, or promiscuous if she takes a diaphragm with her when she goes out for a date. As for men who sleep around, let's think of them not as stallions bursting with vitality but as hit-and-run artists so irresponsible they don't even know how many fetuses they scatter about. . . ."

Accepting female sexuality

One could scarcely ask for a better example of the way the male "stallion" legacy makes feminists angry about abortion. And rightly so. But what's interesting about the observations of male irresponsibility, as it relates to abortion, is that both sides cite it. Pro-life feminists, like Juli Loesch, argue that the acceptance of abortion actually encourages exploitation. The "hit and run" artist can pony up \$ 200, send a woman off to a clinic, and imagine himself to have done the gallant thing. "The idea is that a man can use a woman, vacuum' her out, and she's ready to be used again," Loesch says. "It's like a rent-a-car or something." (In such scenarios, Loesch argues, abortion has the same blame-the-victim effect that the Left is typically quick to condemn, with the victimized mother perpetrating the injustice through violence against the fetus.)

When I asked Katha Pollitt about this, she dismissed it with the argument that men will be just as irresponsible with or without abortion, and that the only difference will be the burden left to women. To some extent she's right: irresponsible sexual behavior-by men and women both-will no doubt continue under any imaginable scenario. Then again, it's not unreasonable to suspect that casual attitudes about abortion, particularly among men, could increase precisely the kind of "stallion" behavior that Pollitt rightly protests. And abortion can become a tool of male coercion in other ways as well. "He said that if I didn't have an abortion, the relationship would be over," a friend recently explained. Many women have experienced the same.

Of course, feminist emotion toward abortion isn't just a reaction to male sexuality but also an assertion that women's own sexual drive is equally legitimate. Feminists argue that antiabortion arguments reflect a larger cultural ambivalence, if not outright hostility, toward female sexuality. This is where words like guilt and shame and punishment continue to arise. I recently sat down with Katha Pollitt for a long conversation about abortion. She cited the many ways in which women (and the children antiabortionist want them to raise) are injured by society: poor health care, poor housing, economic discrimination, male abuse. We talked also about power, politics, religion, and the other forces that play into the abortion debate, like the unflagging responsibilities that come with parenthood. (She is a new, and proud, mother.) But when I asked her which, of the many justifications for abortion, she felt most deeply-what, in her mind, was the real core of the issue-her answer surprised me. "Deep down," she said, "what I believe is that children should not be a punishment for having sex."

Ellen Willis of the Voice advances a similar argument. Opposition to abortion, she's written, is cut of the same cloth as the more general "virginity fetishism, sexual guilt and panic and disgrace" foisted on women by a repressive society. The woman's fight for abortion without qualm, she says, is part of the fight for the "acceptance of the erotic impulse, and one's own erotic impulses, as fundamentally benign and necessary for human happiness."

Pollitt agreed. "The notion of female sexuality being expressed is something people have deeply contradictory feelings about," Pollitt said. And her example to Hentoff of diaphragms and dates-damned if you bring one, damned if you don't-shows she's right.

An unspoken assumption

Pollitt and other leading feminists are right about a lot of things-right to point to the terrible past of stigma and dirty needles; right to complain of sexual exploitation; of double standards; of economic discrimination; of a shortage of birth control; of a society that places them in too many binds. Only one question remains: what about the fetus?

Do we have any moral obligations to it? What are they? What happens after the birth control fails, the egg becomes fertilized and implanted, and human life begins to unfold?

> "Maybe I'm a cold and heartless person," said Pollitt, "but I find it hard to think of it as a moral question, the right to life of this thing the size of a fingernail."

> "Would I feel comfortable getting rid of a fetus in the first few months of its life? Yes, indeed," said Ehrenreich. "And I have done it without qualm."

> "To say, 'I support the legal right but I'm against it morally' is still to deny women's equality," said Willis. "If you have some inherent moral bias in favor of fetuses it becomes a moral bias against the woman. There's no way you can give the fetus a claim, even a relative claim, without denying the woman's selfhood. You make the woman a vessel."

At the risk of taking these women at less than their word, I can't help but wonder if they believe this-if they truly believe the moral questions are as simple as they say.

Katha Pollitt said, "It's hard for me to imagine circumstances in which I'd have an abortion at this time in my life," with this-time-in-her-life meaning at age 39, happily married, professionally established, and prosperous. But "not for moral reasons" she said. And she quickly insisted-twice-that she "would never condemn another woman for having an abortion."

Next, she conjured a hypothetical example. Picture a friend, five months pregnant. The friend's husband, Bob, runs off with a 19-year-old flame. The friend comes to Katha Pollitt for advice.

"I would tell her to go ahead and have it, I'll help you," Pollitt said.

Surprised, I interrupted her to ask why.

"A woman in the fifth month of pregnancy is going to have strong feelings," she said.

Again-why?

She mixed up her words. "The baby . . . the fetus . . ." Then she paused and said she would tell her friend to have the abortion if she had a heart condition and would be bedridden or endangered by the pregnancy.

And if she didn't have a heart condition?

"Just because Bob is leaving-why shouldn't she have the child?" she said. "I'd say, 'Fuck you Bob, I'm going to go ahead and hire a lawyer and take you for everything you're worth.'"

When I asked her about this example a few weeks later-didn't her instinct to tell her friend to have the baby indicate the fetus had some innate worth?-Pollitt said there'd been an unspoken assumption in the scenario: "What I was saying is that if she wanted to have the baby until this rat walked out why should he stop her?" But there seemed to be another unspoken assumption as well, that the fetus had some interests of its own-not enough to overrule, say, the mother's heart condition, but not to be easily ignored either. And why-if abortion is so neutral-would Katha Pollitt herself now find it hard to imagine herself ever having on&

Biology and destiny

What the argument for abortion-without-qualm comes down to is this: the fetus doesn't exist unless we want it to. But the whole crisis over abortion is that we know precisely the opposite to be true. It's there physically, feminists say, but not morally. But how could it be one without the other-there to nurture one day (remember, plenty of fresh vegetables, we're eating for three: you, baby, and placenta), but free to dismember the next? Qualm-less advocates argue that all that finally matters is whether the woman, for whatever reason, desires to bring it into the world. Yet the fetus is already there, no matter what we plan or desire. Forces may conspire against a woman and leave her unable to bring it into the world, or unable to do so without a great deal of harm to herself and others. That is, other moral obligations may overrule. But it is suspicious in the extreme to argue-as the qualmlessness position does-that our moral obligations are nothing more than what we want them to be, a wish-it-away view of the world. Inconveniently fetuses exist, quite outside our fluctuating emotions and desires.

Finally, Ellen Willis's argument that by giving fetuses any moral status at all we reduce women to vessels breaks down because women are vessels. They're not just vessels. They're much more than vessels. But the attempt to reconcile the just desire for full female autonomy with our moral obligations toward fetuses by insisting that we have none attempts to wish away a very real collision; it refuses to acknowledge a (so far) inalterable conflict buried in biology. Willis argues this is precisely the oppressive "biology equals destiny" argument that feminism has fought to overturn. Biology doesn't equal destiny; but it does affect destiny, and it leaves us with the extremely difficult fact that women, for any number of reasons, get burdened with unwanted pregnancies to which there are no easy moral solutions. Something important is lost-female autonomy or fetal life-in either event.

There are two highly imperfect ways of dealing with this conflict. The first is abstinence (since birth control fails). But not much chance of that. The second is adoption-another imperfect solution. The first argument against it is that there aren't enough parents to go around, particularly for minority and handicapped children. Ironically those quickest to point this out tend to be those for whom putting up a child for adoption really is a plausible option-white professionals. George Bush's "adoption not abortion" line brought quick ridicule by Pollitt in *The Nation* and Ehrenreich in *Mother Jones*. He's wrong to suggest it as a panacea-babies would quickly outstrip parents, as Pollitt insists-but right to encourage its wider use. The real challenge for liberals and progressives would be to turn the thought back toward Bush, and demand the governmental support, in health care and other ways, needed to get through pregnancy, and needed to raise a child.

The second argument against adoption focuses not on demand but supply: nine months of illness culminating in a "physiological crisis which is occasionally fatal and almost always excruciatingly painful," as Ehrenreich has written. And other worries follow; think of Lisa Steinberg. "It's almost unimaginable to me to think about giving up the baby," said Ehrenreich. "Talk about misery. Talk about 20 years of grief and ambivalence." The grief is real-particularly for people of conscience, like Ehrenreich. (And people of conscience are the targets of moral suasion in the first place.) But where does that argument lead? That in order to spare a child the risks of an adoptive life, we offer the kindness of a suction machine?

"A very scary time"

A few years ago, I was sharing an apartment with a friend who became pregnant just before breaking up with her fiancé. Like many men-like the hypothetical Bob-he just walked away, dealing with the dilemma through denial. My friend dealt with it with a lot of courage. I called her recently to see how the experience seemed in retrospect, and perhaps she should provide the coda, since her view complicates both Ehrenreich's position and my own. Though she said that putting her child up for adoption was "the right thing," she said she "would never, ever, pressure someone to go through the same thing."

It surprised me to hear her say that abortion "crossed my mind several thousand times," since that was the one option she had seemed to rule out from the start. When she realized she was pregnant, she said, she went riding her bicycle into potholes "trying to jar something loose. It was very, very easy for me to think of the sperm and the egg as having just joined. It was like a piece of mucous to me." She decided against abortion after about a very lonely, very scary time."

"At some point, I realized I was old enough, and mature enough, that I could do it have the baby," she said, but she emphasized that this calculus could have been altered easily by any number of factors-including less support from family and friends, a less understanding employer, or the lack of medical care. She spent months in counseling trying to decide whether to raise the child or put it up for adoption, and the decision to give the baby away "was the most difficult thing I've ever had to do." Since the baby was healthy and white the adoption market was on her side-"I could have dictated that I wanted two Finnish socialists," she said-and her certainty that the new parents would not only love the child but pass on certain shared values was an essential thing to know.

"When I think about her," she said, "Just the miracle of being able to have brought her into this life, even if she's not here with me right now, she's with people who love her. It's a miracle."

"When she left to go to her adoptive parents, it was the most devastating and wonderful thing," she said. "I kept thinking this is my child, and I love her."

"It always kept coming back to that-I love her."

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Abortion

1. Dr. Foster, do you believe that life begins at conception? If not, when do you believe that it begins?
2. In your opinion, Dr. Foster, is abortion the taking of a human life?
3. If abortion is not the taking of a human life, then why do you find abortion "abhorrent" and a "failure".
4. You have said that you believe that abortion should be "safe, legal and rare." Since you have stated that abortion is not the taking of a human life, why do you believe that abortion should be rare?
5. When a woman comes to you when she first discovers that she is pregnant, what are some of the basic pieces of advice that you give her? Do you advise them on their diet? Do you advise them not to drink? Not to smoke?
6. Would you advise your patients any differently depending on the term of the pregnancy? For instance, would you advise a woman not to smoke or drink in first trimester, as well as the second or the third?
7. So it's your opinion that behavior such as smoking or drinking is potentially damaging to the baby, and that it is not advisable during any portion of the pregnancy?
8. Dr. Foster, what then is the difference between an abortion which would end the baby's life, and smoking or drinking, which can be harmful to the baby's health?
9. Dr. Foster, in your opinion, is abortion moral?
10. Dr. Foster, in your 39 year career as a doctor have you ever refused to perform an abortion? Why?
11. Have you ever in your career counseled a patient against abortion? Why?
12. Dr. Foster, do you support efforts to counsel women against abortion?
13. If you do support such counselling, who do you think would be appropriate to provide such counselling?
14. Does the state have an obligation to pass legislation to insure that women get such counselling? Don't you think that all women would be better served if they had all the information before they made such a fateful decision?
15. Dr. Foster, in your view, is abortion just another of an array of services that an obstetrician-gynecologist should provide to women?

16. In your Nightline interview, you stated that you oversaw a study in which some 55 abortions were induced by students that you supervised. You further stated that these abortions were done with a drug in the form of a suppository, and "not a mechanical procedure". Over the years, what are the different mechanical procedures that you have taught to your students?

17. Could you describe each of these procedures?

18. During your teaching career, have you ever supervised a medical student performing an abortion?

19. Did you count these abortions when you gave 55 as the number of abortions you had overseen but not performed? If not, why not?

20. Now as I understand it you said that over your career you have performed 39 abortions, not counting the 55 that you oversaw as part of the study. Which of the "mechanical procedures" did you employ in order to terminate the pregnancies? Could you please describe the different procedures you personally have employed over your career?

21. Were there any complications during any of the different procedures that you used in these abortions? Could you describe them?

22. Of the procedures that you have used over your career, is there any one method that you find preferable over the others? Why?

23. In your opinion, Dr. Foster, is abortion one of the standard medical procedures that should be included in any woman's basic health benefits package?

24. If the Congress should enact a reform of the health care system, should abortion be included in the standard benefit package, if the Congress were to set such minimum standards?

25. Dr. Foster, when you say that abortion should be "safe, legal and rare", do you believe that all women should have access to such safe and legal abortions? Should a state be required to provide for those women who cannot afford to have an abortion? Should it be required even if such a state has decided, either through its legislature or by referendum, that it will not fund such abortions?

26. Aside from counselling, what other methods would you advise in order to insure that abortions are "rare"?

27. Do you believe that counselling or any of these methods should be mandatory? If not, how would you insure that abortions will be "rare"?

28. Do you believe that a minor should be required to receive the consent of her parents in order to have an abortion?

29. Do you favor mandatory counselling for minors who wish to have an abortion? After all, you can't expect a person who society doesn't trust to drink, or vote, or in some cases even drive, to be able to make such an important decision without some adult advice.

30. In your program, if a child has become pregnant and is considering abortion, do you require parental involvement? Do you require parental consent? Do you require any kind of counselling for the young woman?

Abortion, Sex Education and other Questions

1. Dr. Foster, you have been affiliated with Planned Parenthood of America for more than fifteen years, including service on its board from 1975-1981. On what issues do you and that organization differ?
2. Do you believe in abortion on demand?
3. Did you work with the National Leadership Committee of Planned Parenthood's campaign to Keep Abortion Safe and Legal which fought efforts to require parental consent and notification if their minor children were seeking to have an abortion?
4. Do you believe that parents have a right to know if their child is seeking to have an abortion?
5. You have said that you have performed 39 abortions over your career. How many of these abortions were not in cases of rape, incest or to save the life of the mother?
6. How many of these abortions, then, would you say were abortions on demand?
7. Is abortion on demand moral?
8. Dr. Foster, why did you find it necessary to downplay the number of abortions you have performed?
9. Dr. Foster, what is the difference in an OB/GYN who performs fewer than 100 abortions, and one who performs more than 100? In your view, is there a difference?
10. Dr. Foster, you have said that abstinence is "the bedrock of our [I Have a Future] program." Does Planned Parenthood support your position?
11. Were you affiliated with Planned Parenthood while you were designing and creating your program?
12. Isn't it true that Planned Parenthood has joined in lawsuits to have abstinence programs removed from schools?
13. Isn't it true that Planned Parenthood has published pamphlets claiming that abstinence programs are harmful?
14. Dr. Foster, if abstinence is so important to your program, how could you remain affiliated with an organization which was actively campaigning against such a philosophy?
15. Dr. Foster, if abstinence is so important to your program, why is it not mentioned once in the brochure that describes your program?

16. Your brochure, however, does list as one of the six "**program objectives**" as: "To provide greater access to, and increase utilization of, comprehensive adolescent health services and social services, *including contraceptive availability.*" In your Nightline interview, you stated that you did not favor the distribution of condoms, even with the involvement of parents. How do you reconcile this?

17(a). If you do not support a parent's right to know if their child is seeking an abortion, how do you reconcile this with their right to know if their child is seeking contraception? How do you reconcile this with your statement in the Nightline interview where you said: "I think that these issues have to be addressed at the family level. I do not feel schools or the health department can unilaterally do this without the involvement of the parents"?

17(b). If, as you stated, you do not agree with Planned Parenthood's stand against a parent's right to know if their child is seeking an abortion and you do not agree with their active campaign against the philosophy which forms the "bedrock" of your program, why did you remain affiliated with an organization that is diametrically opposed to your views?

18. Dr. Foster, let's next turn to sex education. In your opinion, is sex education an important part of a child's education?

20. In your opinion, Dr. Foster, when is the best time to begin such sex education? In the earliest grades? Or should we wait until these children are more mature, say perhaps middle or high school?

21. One of the "project objectives" in your "I Have a Future" pamphlet states: "To improve knowledge, attitudes and behaviors related to personal health, human sexuality, drug and alcohol abuse and other factors which may place them at risk." What specifically do you mean when you say you wish to "improve knowledge" about "human sexuality"?

22. Dr. Foster, in your opinion, is there such a thing as responsible sex for adolescents?

23(a). Does "responsible" sex include noncoital sex or coitus with a condom?

23(b). If not, then why does your organization distribute condoms?

24. Dr. Foster, are you aware of the New Jersey Network for Family Life Education?

25. Do you agree with their philosophy on sex education?

26. In what ways do you disagree?

27. Could you please give me your comments on this passage on masturbation from Learning About Family Life, a sex education textbook package published by Rutgers University Press: "Grown ups sometime forget to tell children that touching can also give people pleasure, especially when someone you love touches you. And you can give yourself pleasure, too, and that's okay. When you touch your own genitals, it's called masturbating."

28. Is this kind of touching "responsible" sex? Is masturbation "responsible" sex?

29. Susan Wilson, the head of the New Jersey Network for Family Life Education, was quoted in the October, 1994 issue of The Atlantic Monthly as saying that abstinence overlooks the fact that "it is developmentally appropriate for teenagers to learn to give and receive pleasure." Do you agree with this statement?

30. Dr. Foster, let us move to the accreditation issue. In your Nightline interview you said "we have a responsibility in training residents to maintain our accreditation. It's a very difficult job. I maintained an accredited residence program for 17 years. We have a responsibility to teach all residents how to manage the complications of abortion". Dr. Foster, is abortion training required for accreditation?

31. Is abortion training even mentioned in the Accreditation Council for Graduate Medical Education's "Special Requirements for Residency Training in Obstetrics and Gynecology"?

32. Isn't it true that any hospital can choose not to do abortion training and still maintain accreditation?

33. Even if that changes, and hospitals are required to train residents to perform abortions as a general rule to maintain accreditation, wouldn't there still be a "conscience clause" to allow individual doctors to refuse to take part in abortion training? Wouldn't you or your residents be protected by that "conscience clause"?

34. Then if you find abortion so abhorrent, and it is not a requirement to maintain accreditation, why did you find it necessary to teach to your students, and even receive grant money to study abortion procedures?

35. Dr. Foster, you said in your Nightline interview that you "maintained an accredited residence program for 17 years." Isn't it true that Meharry Medical College was ranked last in the nation among medical schools twice in surveys by different organizations during this time?

36. Dr. Foster, isn't it true that there were serious problems in the financial management of Meharry, including: the use of federal funds for non-federal projects; poor collection procedures on student loans; failure to reconcile the general fund bank accounts for more than a year; weak controls on expenditures accounting for 25% of Meharry's annual deficit; incomplete and inaccurate accounting records and an inadequate accounting system?

37. Dr. Foster, is it true that the Department of Health and Human Services has required Meharry to repay between \$2.7 and \$3.8 million -- in federal funds that federal officials said were used for unauthorized purposes?

Additional questions on ABORTION:

- Q: *Do you believe in abortion on demand?*
- Q: *If abhor abortion, why do you perform them?*
- 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?*
- Q: *So you think poor women should be denied the right to choose? [or "But what about abortions for other reasons besides rape, incest or life of mother?"]*
- Q: *Do you support restrictions on abortion like parental consent and notification?*
- Q: *Do you favor mandatory waiting periods?*
- Q: *How many abortions have you performed? Why do the numbers keep changing?*
- Q: *Why did you lie when you were first asked how many abortions you performed?*
- 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?*
- Q: *Did you perform any abortions at Tuskegee?*
- Q: *How do you define abortion?*
- Q: *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)?*
- Q: *Dr. Foster advocates the use of abortion as a means of contraception.*

BACKGROUND: Dr. Foster published an article, "*Contraceptives in Sickle Cell Disease*," which examined the different reproductive options for women with sickle cell anemia. He acknowledged in the article that abortion is viewed as a contraceptive in parts of Europe.

- Q: *Dr. Foster is an abortionist.*

Abortion Questions continued

Q: Dr. Foster has promoted in-home abortions to make them more available as contraceptives.

BACKGROUND: As Chairman of the Department of Obstetrics and Gynecology, Dr. Foster was the principal investigator 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.

Q: Dr. Foster's promotion of abortion is evidence of the liberal mindset that encourages sexual promiscuity among young people and does not require them to take responsibility for their actions.

STERILIZATION

Q: Why did you perform sterilizations on mentally handicapped women in the 1970's? Are there any circumstances under which you would view such sterilizations as acceptable today?

BACKGROUND: Nineteen years ago, in 1976, Dr. Foster wrote an article saying he had recently "*begun to use hysterectomy in patients with severe mental retardation.*" This was done to "*eliminate the menses, which can be of significant hygienic benefit to those severely handicapped individuals.*"

Q: Dr. Foster has routinely encouraged sterilization of patients with sickle cell disease after they have been able to deliver a child.

PRIVILEGED AND ~~CONFIDENTIAL~~

April 12, 1995

MEMORANDUM FOR MARVIN KRISLOV

FROM: KURT H. KUHN

Subject: Tennessee Law on Parental Consent or Notification

1. Since 1971, a Tennessee statute has mandated that the age of majority for consenting to a **medical procedure** is 18. T.C.A. §1-3-113 (copy attached). As discussed below, however, different rules apply for dispensing contraceptives and for abortions.
2. Since 1971, Tennessee law has permitted a physician to provide a minor with **contraceptive supplies or information** if either of the following conditions is present: (a) the minor requests and is in need of contraceptive supplies or information; or (b) the minor is referred to the physician by another physician, a member of the clergy, a family planning clinic, a school or institution of higher learning, or any agency or instrumentality of the state or any subdivision thereof. T.C.A. § 68-34-107 (copy attached). Only if neither of these conditions can be met is parental consent required. See id. We have found no definition of "in need" in the law or any reported cases.
3. Since 1979 (with the possible exception of a few weeks in July 1989), Tennessee law has required **parental notification** (but not consent) before a minor obtains an **abortion**.^{*} Parental notification is required two days before the procedure, unless (a) the minor is emancipated by marriage or (b) the attending physician determines, in his best medical judgment, that the abortion is necessary to preserve the life or health of the woman. T.C.A. § 39-15-202 (copy attached).^{**}

^{*} Because of a peculiar technical issue in a Davidson County case, which includes Nashville, it is possible that even parental notification was not required in Nashville from 1979 to 1989.

^{**} From 1973 to 1979, **parental consent** was presumably required by Tennessee common law, but no reported cases tested this requirement. Tennessee also had a statutory consent requirement in effect for a few weeks in July 1989, before the statute was struck down as unconstitutional. In any event, United States Supreme Court precedent since 1976 has prohibited the states from imposing blanket parental-consent requirements because provisions must be made for mature minors to obtain abortions without parental consent.

TENN. CODE ANN. @ 1-3-113 (1994) printed in FULL format.

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*** THIS SECTION IS CURRENT THROUGH THE 1994 SUPPLEMENT ***
*** (1994 SESSION OF THE GENERAL ASSEMBLY) ***

TITLE 1. CODE AND STATUTES
CHAPTER 3. CONSTRUCTION OF STATUTES

Tenn. Code Ann. @ 1-3-113 (1994)

1-3-113. Eighteen-year-olds -- Legal responsibility -- Alcoholic beverage restrictions on persons under twenty-one

(a) Notwithstanding any laws to the contrary, any person who is eighteen (18) years of age or older shall have the same rights, duties, and responsibilities as a person who is twenty-one (21) years of age, except as provided in subsection (b) relative to the rights to purchase, possess, transport, and consume alcoholic beverages, wine, or beer as those terms are defined in title 57.

(b) Notwithstanding the provisions of subsection (a), it is unlawful for any person under twenty-one (21) years of age to purchase, possess, transport or consume alcoholic beverages, wine, or beer, with the following exceptions:

(1) Any person eighteen (18) years of age or older may transport, possess, sell, or dispense alcoholic beverages, wine, or beer in the course of a person's employment; and

(2) The provisions of @ 39-6-910(1) [repealed], shall not be affected by any provision of this subsection, it being the intent of the general assembly that such provisions remain lawful and in full force and effect. Any such priest or minister may utilize and administer alcohol or wine at a communion service, bar mitzvah, bat mitzvah, or other similar religious service or ceremony, in accordance with the practices of such denomination or sect.

HISTORY: Acts 1971, ch. 162, @ 3; 1979, ch. 413, @ 2; T.C.A., @ 1-313; Acts 1984, ch. 1006, @@ 2, 9, 13-16; 1985, ch. 375, @@ 1-4; 1987, ch. 95, @ 1.

NOTES:

COMPILER'S NOTES. Section 39-6-910(1), referred to in this section, was repealed by Acts 1989, ch. 591.

CROSS-REFERENCES. Age of majority for alcoholic beverage and legal purposes, @ 1-3-105.

Alcoholic beverage definitions, @@ 57-2-101, 57-3-101.

Juvenile alcohol abuse, title 68, ch. 27, part 4.

Minimum age for fire protection sprinkler system certification and licensing, @ 62-32-107.

Removal of disability of minor veterans and spouses for receipt of benefits, @ 58-3-103.

Sale of alcoholic beverages to minors, @@ 57-4-203, 57-5-301.

Support of child over 18 in high school, @ 34-11-102.

Lodging establishments, conduct of guests, title 68, ch. 14, part 6.

(3) Nothing herein shall inhibit a physician from refusing to furnish any contraceptive procedures, supplies or information where such refusal is for medical reasons;

(4) Dissemination of medically acceptable contraceptive information by duly authorized persons in state and county health and welfare departments, in medical facilities at institutions of higher learning, and at other agencies and instrumentalities of this state is consistent with public policy;

(5) No private institution or physician, nor any agent or employee of such institution or physician, shall be prohibited from refusing to provide contraceptive procedures, supplies, and information when such refusal is based upon religious or conscientious objection, and no such institution, employee, agent, or physician shall be held liable for such refusal; and

(6) To the extent that family planning funds are available, each public health agency of this state and each of its political subdivisions shall provide contraceptive procedures, supplies, and information, including voluntary sterilization procedures for male or female persons eligible for free medical service as determined by rules and regulations promulgated by the commissioner. The same service shall be available to all others who are unable to obtain the service privately, at a cost to be determined by rules and regulations promulgated by the commissioner. [Acts 1971, ch. 400, § 1; T.C.A., § 53-4604.]

Section to Section References. This section is referred to in § 68-34-103.

Cited: Cardwell v. Bechtol, 724 S.W.2d 739 (Tenn. 1987).

68-34-105. Disposition of funds — Development of program. —

(a) The department is authorized to receive and disburse such funds as may become available to it for family planning programs to any organization, public or private, engaged in providing contraceptive procedures, supplies and information.

(b) Any family planning program administered by the department may be developed in consultation and coordination with other family planning agencies in this state, including, but not limited to, planned parenthood affiliates. [Acts 1971, ch. 400, § 1; T.C.A., § 53-4605.]

68-34-106. Rules and regulations. — The commissioner is hereby authorized to adopt and promulgate rules and regulations to enable the department to implement the provisions of this chapter. [Acts 1971, ch. 400, § 1; T.C.A., § 53-4606.]

68-34-107. Contraceptives for minors. — Contraceptive supplies and information may be furnished by physicians to any minor who is pregnant, or a parent, or married, or who has the consent of such minor's parent or legal guardian, or who has been referred for such service by another physician, a clergyman, a family planning clinic, a school or institution of higher learning, or any agency or instrumentality of this state or any subdivision thereof, or who requests and is in need of birth control procedures, supplies or information. [Acts 1971, ch. 400, § 1; T.C.A., § 53-4607.]

Cited: Cardwell v. Bechtol, 724 S.W.2d 739 (Tenn. 1987).

68-34-108. Sterilization for minors. — It is lawful for any physician or surgeon licensed in this state, when so requested by any person eighteen (18) years of age or over, or less than eighteen (18) years of age if legally married, to perform upon such person a surgical interruption of the vas deferens or fallopian tubes, as the case may be; provided, that a request in writing is made by such person prior to the performance of such surgical operation; and provided further, that prior to or at the time of such request a full and reasonable medical explanation is given by such physician or surgeon to such person as to the meaning and consequence of such operation. [Acts 1971, ch. 400, § 1; T.C.A., § 53-4608.]

Law Reviews. Courts — Scope of Authority
— Sterilization of Mental Incompetents
(Christina Norton Norris), 44 Tenn. L. Rev. (3)
879.

court to permit sterilization of mentally defective person in absence of specific statutory authority. 74 A.L.R.3d 1210.
Power of parent to have mentally defective child sterilized. 74 A.L.R.3d 1224.

Collateral References. Jurisdiction of

68-34-109. Physician liability for sterilization. — Subject to the rules of law applicable generally to negligence, no physician or surgeon licensed by this state shall be liable civilly or criminally by reason of having performed surgical interruption of vas deferens or fallopian tubes, as the case may be, authorized by the provisions of this chapter upon any person in this state. [Acts 1971, ch. 400, § 1; T.C.A., § 53-4609.]

Cross-References. Insurance contracts for
sterilization operations, § 56-7-1006.

68-34-110. Legislative determination. — The general assembly hereby finds, determines and declares that this chapter is necessary for the immediate preservation of the public peace, health, and safety. [Acts 1971, ch. 400, § 1; T.C.A., § 53-4610.]

68-34-111. Criminal penalties. — It is a Class C misdemeanor to threaten, coerce, intimidate or require any person to submit to any surgical procedure authorized by this chapter. [Acts 1971, ch. 400, § 4; T.C.A., § 53-4611; Acts 1989, ch. 591, § 113.]

Cross-References. Penalty for Class C misdemeanor, § 40-35-111.

CHAPTER 35 RENAL DISEASE

SECTION.

68-35-101. Renal disease program.

68-35-102. Renal disease advisory committee.

SECTION.

68-35-103. Powers and duties of department.

Can to date

Code Commission Notes. For recent United States supreme court decisions concerning abortion laws of other states, see *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983); *Planned Parenthood Association of Kansas City, Missouri, Inc. v. Ashcroft*, 462 U.S. 476 (1983); *Simopoulos v. Virginia*, 462 U.S. 506 (1983).
Sentencing Commission Comments. Sections 39-15-201 — 39-15-209 are identical to prior code ch. 4, part 2 of this title. No substantive changes were made in these sections.

Cross-References. Parental consent for abortion by minor, title 37, ch. 10, part 3. Penalties for Class C and E felonies, § 40-35-111. Penalty for Class A misdemeanor, § 40-35-111.
Section to Section References. This section is referred to in §§ 39-13-107, 39-13-214.
Textbooks. Tennessee Criminal Practice and Procedure (Raybin), § 28.63.
Law Reviews. Legal Rights and Issues Surrounding Conception, Pregnancy and Birth, 39 Vand. L. Rev. 597 (1986).

NOTES TO DECISIONS

DECISIONS UNDER PRIOR LAW

I. Criminal Abortions — Lawful Abortions.

For cases decided prior to the 1973 amendment to the former abortion law, see *Smartt v. State*, 112 Tenn. 539, 80 S.W. 586 (1903); *Austin v. State*, 137 Tenn. 474, 194 S.W. 383

(1916); *Miller v. State*, 189 Tenn. 281, 225 S.W.2d 62, 15 A.L.R.2d 1076 (1949); *Dupuy v. State*, 204 Tenn. 624, 325 S.W.2d 238 (1959); *Williams v. State*, 218 Tenn. 359, 403 S.W.2d 319 (1966); *Webster v. State*, 1 Tenn. Crim. App. 1, 425 S.W.2d 799 (1967).

Collateral References. Availability in state court of defense of entrapment where accused denies committing acts which constitute offense charged. 5 A.L.R.4th 1128.

Entrapment defense in sex offense prosecutions. 12 A.L.R.4th 413.

Evidence of commission of similar crimes, admissibility in prosecution for abortion. 15 A.L.R.2d 1080.

Fetus, necessity that it be living at time of commission of act. 16 A.L.R.2d 949.

Homicide based on killing of unborn child. 40 A.L.R.3d 444.

Pregnancy as element. 46 A.L.R.2d 1394.

Recoverability of compensatory damages for mental anguish or emotional distress for tortiously causing another's birth. 74 A.L.R.4th 798.

Right of action for injury or death of woman who consented to illegal abortion. 36 A.L.R.3d 630.

Woman's right to have abortion without consent of, or against objections of child's father. 62 A.L.R.3d 1097.

Woman upon whom abortion is committed or attempted as accomplice for purposes of rule requiring corroboration of accomplice testimony. 34 A.L.R.3d 858.

39-15-202. Consent of pregnant woman required prior to abortion — Information provided by doctor — Waiting period — Penalty for violation — Notice to parents or guardians — Requirements inapplicable in certain cases. — (a) An abortion otherwise permitted by law shall be performed or induced only with the informed written consent of the pregnant woman, given freely and without coercion. Such consent shall be treated as confidential.

(b) In order to ensure that a consent for an abortion is truly informed consent, an abortion shall be performed or induced upon a pregnant woman only after she has been orally informed by her attending physician of the following facts and has signed a consent form acknowledging that she has been informed as follows:

(1) That according to the best judgment of her attending physician she is pregnant;

(2) The number of weeks elapsed from the probable time of the conception of her unborn child, based upon the information provided by her as to the time of her last menstrual period or after a history, physical examination, and appropriate laboratory tests;

(3) That if more than twenty-four (24) weeks have elapsed from the time of conception, her child may be viable, that is, capable of surviving outside of the womb, and that if such child is prematurely born alive in the course of an abortion her attending physician has a legal obligation to take steps to preserve the life and health of the child;

(4) That abortion in a considerable number of cases constitutes a major surgical procedure;

(5) That numerous public and private agencies and services are available to assist her during her pregnancy and after the birth of her child, if she chooses not to have the abortion, whether she wishes to keep her child or place him for adoption, and that her physician will provide her with a list of such agencies and the services available if she so requests; or

(6) Numerous benefits and risks are attendant either to continued pregnancy and childbirth or to abortion depending upon the circumstances in which the patient might find herself. The physician shall explain these benefits and risks to the best of his ability and knowledge of the circumstances involved.

(c) At the same time the attending physician provides the information required by subsection (b), he shall inform the pregnant woman of the particular risks associated with her pregnancy and childbirth and the abortion or child delivery technique to be employed, including providing her with at least a general description of the medical instructions to be followed subsequent to the abortion or childbirth in order to ensure her safe recovery.

(d)(1) There shall be a two (2) day waiting period after the physician provides the required information, excluding the day on which such information was given. On the third day following the day such information was given, the patient may return to the physician and sign a consent form.

(2) A violation of this subsection by a physician is a Class E felony.

(3) This subsection shall not apply when the attending physician, utilizing his experience, judgment, or professional competence, determines that a two (2) day waiting period or any waiting period would endanger the life of the pregnant woman. Such determination made by the attending physician shall be in writing and shall state his medical reasons upon which he bases his opinion that the waiting period would endanger the life of the pregnant woman. This provision shall not relieve the attending physician of his duty to the pregnant woman to inform her of the facts under subsection (b).

(e) The attending physician performing or inducing the abortion shall provide the pregnant woman with a duplicate copy of the consent form signed by her.

(f)(1) The attending physician or agency performing an abortion upon a minor of less than eighteen (18) years of age shall inform the parents or legal guardians of such minor, or if the whereabouts of the parents cannot be determined and there is no other legal guardian, then the agency or other individual to whom the minor's custody has been transferred, two (2) days prior to

the operation that an abortion is to be performed upon such minor; provided, however, that the provisions of this section shall in no way be construed to mean, provide for, or authorize parental objection to, in any way, prevent or alter the decision of the minor to proceed with the abortion.

(2) Notice shall not be required if:

(A) The minor is emancipated by marriage; or

(B) The attending physician determines that, in his best medical judgment, the abortion is necessary to preserve the life or health of the pregnant woman and must be performed prior to the expiration of the two (2) day notice period.

(g) "The physician" or "the attending physician," as used in this section, means any licensed physician on the service treating the pregnant woman.

(h) The provisions of this section shall not apply in those situations where an abortion is certified by a licensed physician as necessary to preserve the life of the pregnant woman. [Acts 1989, ch. 591, § 1.]

Sentencing Commission Comments. Chapter 15, part 2 of this title is identical to prior code ch. 4, part 2 of this title. No substantive changes were made in these sections.

Cross-References. Parental consent for abortion by minor, title 37, ch. 10, part 3. Penalty for Class E felony, § 40-35-111.

Textbooks. Tennessee Criminal Practice and Procedure (Raybin), § 28.92.

Law Reviews. Right to Privacy — Parental Notice Requirements in Abortion Statutes, 48 Tenn. L. Rev. 974.

Cited: Planned Parenthood Ass'n of Nashville, Inc. v. McWhorter, 923 F.2d 474 (6th Cir. 1991).

39-15-203. Records and reports of abortions — Confidentiality. — A physician performing an abortion shall keep a record of each such operation and shall make a report to the commissioner of health with respect thereto at such time and in such form as the commissioner may reasonably prescribe. Each such record and report shall be confidential in nature and shall be inaccessible to the public. [Acts 1989, ch. 591, § 1.]

Cross-References. Confidential records, § 10-7-504.

Parental consent for abortion by minor, title 37, ch. 10, part 3.

Section to Section References. Sections 39-15-203 — 39-15-205 are referred to in §§ 39-13-107, 39-13-214.

Law Reviews. A Critical Survey of Developments in Tennessee Family Law in 1976-77, IX. Abortion (Neil P. Cohen), 45 Tenn. L. Rev. 498.

39-15-204. Right to refuse to perform abortions. — No physician shall be required to perform an abortion and no person shall be required to participate in the performance of an abortion. No hospital shall be required to permit abortions to be performed therein. [Acts 1989, ch. 591, § 1.]

Law Reviews. A Critical Survey of Developments in Tennessee Family Law in 1976-77, IX. Abortion (Neil P. Cohen), 45 Tenn. L. Rev. 498.

39-15-205. Right of hospitals to refuse to accept abortion patients. — No section of this part shall be construed to force a hospital to accept a patient for an abortion. [Acts 1989, ch. 591, § 1.]

Law Reviews. A Critical Story of Developments in Tennessee Family Law in 1976-77, IX. Abortion (Neil P. Cohen), 45 Tenn. L. Rev. 498.

39-15-206. Rights to medical treatment of infant prematurely born alive during abortion — Penalty for violation — Limitation on wrongful death action. — (a) The rights to medical treatment of an infant prematurely born alive in the course of an abortion are the same as the rights of an infant of similar medical status prematurely born spontaneously. Any person who performs or induces an abortion of such an infant shall exercise that degree of professional skill, care, and diligence in accordance with good medical practice necessary to preserve the life and health of such infant prematurely born alive in the course of an abortion, except that if it can be determined, through amniocentesis or medical observation, that the fetus is severely malformed, the use of extraneous life support measures need not be attempted.

(b) Any person who violates this section is guilty of a Class E felony.

(c) No cause of action for wrongful death shall be brought which arises out of the death of a fetus or infant during the course of a lawful abortion, whether such fetus or infant is quick or not, so long as the abortion is performed in accordance with the provisions of this part; however, once an infant is born alive, any person in attendance thereto shall be civilly responsible for providing all reasonable and necessary care reasonable under the circumstances in the general vicinity in which they practice. [Acts 1989, ch. 591, § 1.]

Cross-References. Penalty for Class E felony, § 40-35-111.

Law Reviews. The Regulation of Embryo

and Fetal Experimentation and Disposal in England and the United States (Nicolas P. Terry), 39 Vand. L. Rev. 419 (1986).

39-15-207. Custody of infant prematurely born alive during abortion. — An infant prematurely born alive in the course of a voluntary abortion is hereby declared abandoned for purposes of custody only, and the department of human services shall care for such infant as provided in § 34-1-105. [Acts 1989, ch. 591, § 1.]

Section to Section References. This section is referred to in §§ 39-13-107, 39-13-214.

Law Reviews. The Regulation of Embryo

and Fetal Experimentation and Disposal in England and the United States (Nicolas P. Terry), 39 Vand. L. Rev. 419 (1986).

39-15-208. Research, photography, sale, and experimentation upon aborted fetuses — Penalty for violation. — (a) It is unlawful for any person, agency, corporation, partnership or association to engage in medical experiments, research, or the taking of photographs upon an aborted fetus without the prior knowledge and consent of the mother.

(b) No person, agency, corporation, partnership or association shall offer money or anything of value for an aborted fetus; nor shall any person, agency, corporation, partnership or association accept any money or anything of value for an aborted fetus.

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ABC NEWS

SHOW: Nightline (ABC 11:30 pm ET)

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BODY:

ANNOUNCER: February 8th, 1995.

Pres. BILL CLINTON: He is a good man who has delivered thousands of babies.

TED KOPPEL: [voice-over] You've heard what the President said about his nominee for surgeon general.

Pres. BILL CLINTON: I believe he should be confirmed, and I believe he will.

TED KOPPEL: [voice-over] And you've heard what his opponents on Capitol Hill are saying.

Sen. TRENT LOTT, Majority Whip: Most senators so far have said, 'Look, I'm troubled about this, I think it is a problem.'

Sen. BARBARA MIKULSKI, (D), Maryland: I would say it would be a 50-50 chance of his nomination surviving.

TED KOPPEL: [voice-over] But until now you haven't heard from the nominee himself. Tonight, Dr. Henry Foster speaking in his own defense.

ANNOUNCER: This is ABC News Nightline. Reporting tonight from the White House, Ted Koppel.

TED KOPPEL: Two months ago, then-Surgeon General Dr. Joycelyn Elders was forced to retire because she had become too much of a political liability. Five days ago, President Clinton introduced his new nominee, Dr. Henry Foster, to the nation. Since Dr. Foster is an obstetrician, it probably should have occurred to someone doing advanced work on the nomination that he had very likely performed a number of what are called therapeutic abortions over the years. Not that there is anything illegal about that, but it is, of course, a politically sensitive issue. What has complicated the matter is the confusion that has arisen over just how many such abortions Dr. Foster and performed, and why the matter wasn't clearly and forthrightly dealt with from the beginning.

That we are here in the Roosevelt Room of the White House with Dr. Foster is a sign of the times. There was a day when a presidential nominee might pay a courtesy call or two to a powerful committee chairman on Capitol Hill, but

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otherwise he or she would say nothing in public until the Senate had voted. Dr. Foster, however, accepted our invitation to appear on Nightline this evening at the urging of the White House. The interview is being conducted here in the Roosevelt Room because this is where the White House wanted it. The Clinton administration is closely associating itself, in other words, with Dr. Foster's fight to save his nomination.

Dr. Foster's battle will be a difficult one. Cokie Roberts has been tracking the situation on Capitol Hill. Cokie?

COKIE ROBERTS, ABC News: Ted, it's a difficult nomination because members of Congress are upset, not just with Dr. Foster's own record, but much more so with the White House. They're talking about another botched nomination, saying that once again the White House did not properly vet the situation, and that they don't even know whether the President sticks behind the nominee. Because of those concerns, the President today was forced to make another statement of support.

Pres. BILL CLINTON: That he is a good man who has delivered thousands of babies and devoted his life to trying to prevent the kind of problems that he's now being criticized for. I believe he should be confirmed, and I believe he will.

COKIE ROBERTS: [voice-over] That statement of support comes after almost a week of questions about how many abortions Dr. Foster has performed and under what circumstances, questions that started almost immediately after the President's announcement. The fact that there's no one answer has provided ammunition to anti-abortion activists.

MAUREEN MALLOY, National Right to Life Committee: First they were claiming that he'd only performed one abortion, then it was 12 last Friday, now we're seeing evidence of his having performed at least 60, and evidence of possibly up to 700. What's the real story?

COKIE ROBERTS: [voice-over] That's a question that's allowed the President's political opponents to steer clear of the sensitive issue of abortion, to focus instead on credibility.

Sen. TRENT LOTT, Majority Whip: It's not just an abortion question, it's how the facts have been presented, or the fact that the facts haven't been presented in some instances.

COKIE ROBERTS: [voice-over] Facts about questions the administration should have anticipated.

STEPHEN HESS, Brookings Institution: If you're going to appoint an obstetrician, you know what's going to happen, and you'd better have all your facts lined up. And, you know, we're into the third year of this administration. It's too late for amateur night at the White House.

LEON PANETTA, White House Chief of Staff: I have to tell you that the staff, in this situation, probably did not serve the President well, in terms of actually going in to the full background here.

Sen. BARBARA MIKULSKI, (D), Maryland: There's no doubt that they didn't do the

process as well as that they should, but the fact is that even if they bungled the process, this is an outstanding nominee.

COKIE ROBERTS: [voice-over] There's a strong sense among Democrats that the President cannot back away from this nominee, that Henry Foster should either take himself out of the process, or get his hearing before the Senate, unlike some previous nominees.

Sen. CAROL MOSELEY-BRAUN, (D), Illinois: Just as Lani Guinier was waylaid before she got to the hill, before her nomination ever came to us and there was a hearing involved, it was waylaid at that point, and that's what's going on here again.

COKIE ROBERTS: [voice-over] The specter of Lani Guinier, Clinton's nominee for assistant attorney general, and the criticism the President came under for abandoning her, hangs over this nomination. So does the controversy surrounding the last surgeon general, Joycelyn Elders, which begs the question, why name anyone who creates a political firestorm? Why not pick someone like a cancer or heart specialist?

LEON PANETTA: We looked for the person that we thought was the best qualified to become surgeon general and deal with what we think is the principal problem in the country, the President thinks is the principal problem, is trying to prevent teenage pregnancy.

COKIE ROBERTS: [voice-over] Dr. Foster's teen pregnancy program was singled out for praise by then-President George Bush. That's something you hear over and over from Foster's supporters, who are now gearing up a campaign for his confirmation.

FOSTER SUPPORTER: It's very important that you call your senators and let them know how urgent the situation is, and that you support Dr. Foster's nomination.

COKIE ROBERTS: [voice-over] But for now, at least, the noise is coming from Foster's well-organized opponents.

RADIO TALK SHOW CALLER: And I don't think that they really want a surgeon general that's really a Dr. Kevorkian, who has the blood of potentially, you know, 700 babies on his hands.

COKIE ROBERTS: [voice-over] So, is it possible to salvage this nomination? Can Henry Foster be confirmed?

Sen. TRENT LOTT: I'd say his chances are certainly no better than 50-50 at this chance [sic], this moment.

COKIE ROBERTS: Fifty-fifty is what members are saying publicly into cameras, Ted. Privately, they're giving more pessimistic views. They don't know if there's more information to come out that can make things harder for the nominee. They don't know how much the President is going to stick with him, particularly if it distracts from other issues like welfare reform, which has to go to the same committee. And they don't know if Dr. Foster understands how really tough this can get, how nasty and poisonous this process can become, Ted.

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TED KOPPEL: How solid is the- is the Democratic support, Cokie? And I suppose the other half of that question is, how solid is Republican opposition?

COKIE ROBERTS: Neither one is firmly solid yet, but they are- they are hardening up, but the Democrats are a lot softer than the Republicans at this point. And as we said, the Republicans have the excuse of saying they have a credibility problem so they can pull away from the abortion question, and the Democrats are just angry that they're being forced to go through this, that they- that they can't just have a nice, simple surgeon general nomination in the middle of a lot of other fights that they're having to have at the Capitol, and they thought the White House was getting its act together, and now they're wondering.

TED KOPPEL: Cokie, thanks very much.

As I mentioned before, I'm in the Roosevelt Room at the White House with Dr. Foster. Before we begin our interview in depth, Dr. Foster, I know you have some things you want to say about where you stand, at the moment, and indeed, that was the question that Cokie Roberts was raising that apparently a lot of people on Capitol Hill want to know. How committed are you to this fight?

Dr. HENRY FOSTER, U.S. Surgeon General Nominee: Well, thank you. First of all, I understand today's your birthday, I wish to wish you a happy birthday.

TED KOPPEL: Thank you, sir.

Dr. HENRY FOSTER: And thank you for having me on your show. What I'd like for you to do, Mr. Koppel, to indulge me for just a few moments. It seems that everyone in this country has been defining Henry Foster except Henry Foster. I'm an obstetrician-gynecologist. I have devoted my entire professional life to improving the lives of mothers, babies and their families. Mr. Koppel, I have done thousands of surgical procedures. I have delivered thousands and thousands of babies, all with the single goal to bring healthy babies and healthy mothers through this process.

I was very fortunate, I had excellent training with the University of Arkansas, marvelous school. My OB chairman was president of the American College. I had training in Boston. I had training in Detroit, at Wayne State. But it was at Tuskegee, Alabama, when I was a resident, rotating, that I think my life was galvanized, in terms of what I wanted to do with it. My mentor, Dr. John Daniel Thompson, who was chairman of Emory University, he and his staff alternated every weekend, drove over 300 miles round-trip to come to Tuskegee to shepherd our training and to provide care for those poor women. He was a white Southerner. When I completed my training, I sat down with my family and said, 'I must go there. That is where the worst problems are.'

But it was a springboard. Shortly after I got there, Tuskegee Institute was successful in getting an MNI [sp?] grant, maternity grant. It was a regionalized program. It was recognized in Washington as a forerunner to regionalized care. It got me elected to the National Academy of Sciences, then the youngest person ever admitted, in 1972. Then the Robert Wood Johnson Foundation recognized this concept of regionalized care, so they invited me onto their national advisory committee. That is now the standard for perinatal care.

TED KOPPEL: Dr. Foster, I don't want to prevent you from defining yourself,

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but as I told you before we began the program, we have a total of 11 minutes to talk to you tonight.

Dr. HENRY FOSTER: Yes. Good. Very good.

TED KOPPEL: So if you would wrap this part up, we'll take a break and get to the questions.

Dr. HENRY FOSTER: I will. I will. After Tuskegee, I went to Meharry, and I was fortunate there, when the Robert Wood Johnson Foundation said, 'Run this national program for us,' and from that I developed the program, 'I Have a Future.' It has been recognized by the AMA as a model program in teen sexuality and it was subsequently recognized and awarded by President Bush as a daily point of light. That's the context of my life, building. I abhor abortions. I abhor war. To me, abortion is failure. I don't like failure.

TED KOPPEL: All right, Doctor. Thank you very much. We're going to take a short break. When we come back, some questions, and in fact, I'll be repeating the one I asked you a moment ago, how much of a fight are you going to put up? We'll be back in a moment.

[Commercial break]

TED KOPPEL: And we're back once again in the Roosevelt Room at the White House with Dr. Henry Foster.

Dr. Foster, you defined yourself by your own terms. Now let me ask you to define yourself by mine. There is some question about your honesty, sir, or at least whether you were disingenuous when you spoke about the number of abortions that you have performed over the years. Initially, someone, in your name, said one. You were then quoted as saying you think it was less than a dozen. How many?

Dr. HENRY FOSTER: I'll tell you how many, but let me give you the scenario. The day before the President announced his intention to nominate, I was asked by someone in the administration had I done abortions, and I said yes, and the one I remembered most was a woman who had AIDS, and that was essentially the end of that conversation. Shortly thereafter, someone said 'Have you done more than one abortion?' I casually said 'Yes, most physicians have done more- obstetricians have done more than one abortion.' And they said, 'How many have you done?' Washington is a fast town. I've got- but I'm becoming a quick study. I should have refused, Mr. Koppel, to answer that question until I knew the exact number.

TED KOPPEL: Well, you did better than that. You issued a statement.

Dr. HENRY FOSTER: Yes.

TED KOPPEL: A written statement, and that's the one I was referring to a moment ago, when I referred to the fewer than a dozen.

Dr. HENRY FOSTER: Right.

TED KOPPEL: Is that correct?

Dr. HENRY FOSTER: Yes. Let me show-

TED KOPPEL: Fewer than a dozen?

Dr. HENRY FOSTER: That's what I said. That's what I was asked how many had I done. I said, 'I really don't know.' They said, 'Was it a hundred?' I said, 'No, I don't think so.' So, as, again, I wish I had refused to say then. But they said 'A dozen?' I said, 'Yes, perhaps a dozen, maybe less than a dozen.' Then there's this furor. Now my credibility is at stake and I have to do something about it, the veracity of my statements.

This was all from memory. Mr. Koppel, I finished medical school 20- in 1958, 37 years ago I finished.

TED KOPPEL: Thirty-five, 36, 37 years ago.

Dr. HENRY FOSTER: And I started doing procedures from the time I went into my internship. I was depending on memory. I shouldn't have done that. I wish- I wish I hadn't, but I was so-

TED KOPPEL: But if you had said, Dr. Foster, 'I have done scores, I have done dozens, I have done hundreds, I cannot give you the number,' the problem is, you were quite specific. Fewer than a dozen is not just a vague number, it's a fairly precise number.

Dr. HENRY FOSTER: Yes, but it was a guess and I should not have made it, no.

TED KOPPEL: Let me- let me- I mean, you've had ample time to think about it now.

Dr. HENRY FOSTER: Okay.

TED KOPPEL: And you've had ample time to consult with your advisers here at the White House.

Dr. HENRY FOSTER: Right.

TED KOPPEL: Do you have a number now?

Dr. HENRY FOSTER: Yes, I do have a number now. For the last three days, I have worked furiously at the George W. Hubbard Hospital of Meharry Medical College, all of my patient records, and all of the operative logs from the time I went to Meharry in 1973 until tonight have revealed that I was listed as the physician of record on 39 of those cases in 38 years in practice and 22 years at Meharry. Further, I must add one other point.

TED KOPPEL: Please.

Dr. HENRY FOSTER: To keep for my veracity. We are in a medical setting. We had a research grant. We have to do that to train our residents. We were in a multi-center study with the Upjohn Company, and we tested a product, a suppository, not a mechanical procedure, to train residents.

TED KOPPEL: Right. A vaginal suppository.

Dr. HENRY FOSTER: A vaginal suppository.

TED KOPPEL: Which could induce-

Dr. HENRY FOSTER: Early abortion.

TED KOPPEL: Early abortion.

Dr. HENRY FOSTER: That's correct. Legal- early legal abortion. And read by- we have to train our residents, all residents, how they manage the complications of abortion. That's a part of keeping our program accredited, and at that time, and like now, 20 percent of all universities survive on grant funds. That was a grant. The study was subsequently terminated because of [crosstalk].

TED KOPPEL: Before- before that study was terminated, Dr. Foster - and I was just reading up on that particular study - you were in charge of the research on that study.

Dr. HENRY FOSTER: Because I was chairman of the service.

TED KOPPEL: My recollection is that during the first year, there were some 80 women who used that suppository, and you are quoted as saying that 75 of those resulted in termination of pregnancy.

Dr. HENRY FOSTER: That's incorrect. My study is- once this- the literature will be my ally. This was published in the Journal of Obstetrics and Gynecology, called the 'Green Journal.' There were 60 patients in the study.

TED KOPPEL: And how many of those resulted in successful terminations of pregnancy?

Dr. HENRY FOSTER: Fifty-five.

TED KOPPEL: And so you're not counting those when you speak of 39 abortions.

Dr. HENRY FOSTER: No, no.

TED KOPPEL: You don't consider those abortions.

Dr. HENRY FOSTER: Yes, but many times I was not even in the country when they were done. This was a research program. All the doctors on staff received, were assigned patients when patients presented themselves. These were not patients I knew, they weren't my private patients, and the residents were the doctors who we were teaching to insert the suppositories.

TED KOPPEL: All right. We have to take a short break, Dr. Foster. We'll be back in just a moment.

[Commercial break]

TED KOPPEL: And we're back once again with Dr. Henry Foster at the Roosevelt Room inside the White House.

Dr. Foster, you said earlier on in this conversation, I'm not sure if I'm using precisely the term, but you said you abhor abortion, corrected? Why would you

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participate, not only participate in a study, but indeed, lead a study in behalf of a chemical company, the sole purpose of which was early abortion?

Dr. HENRY FOSTER: Right. As I explained earlier, we have a responsibility in training residents to maintain our accreditation. Very difficult job. I maintained an accredited residence program for 17 years. We have a responsibility to teach all residents how to manage the complications of abortion-

TED KOPPEL: But that doesn't suggest that you're going to create a number of abortions specifically so that they can handle the complications from them, doesn't it?

Dr. HENRY FOSTER: No. But there are going to be some of their own. No, we don't make them, but you cannot have a situation where you can predict who will or who will not have complications.

TED KOPPEL: I guess the only thing I'm asking is, in this particular case, where we're talking about these vaginal suppositories, they are useful only during the first, I think, seven weeks of pregnancy, wasn't that correct?

Dr. HENRY FOSTER: You're absolutely right, 42 days.

TED KOPPEL: So that we would not be talking here about women who were having abortions for reasons of incest or rape or danger to the mother, but more likely than not women who had just discovered that they were pregnant and wanted to terminate their pregnancy.

Dr. HENRY FOSTER: Yes. And the purpose of the study was to determine the safety, the efficacy, and the patient acceptability of this modality, so patients might be able to avoid having mechanical procedures when they were done for medical reasons or any other reasons. But I must emphasize that these were procedures done in a research institution. There were studies across the country, it was a multi-center-

TED KOPPEL: We are down to our last three minutes or so. There are a number of other issues I want to touch with you quickly. The question that I asked you initially, you heard Cokie Roberts report, even on the record, senators and congresspeople are saying they think you stand about a 50-50 chance. Off the record, they are not quite that optimistic. How much of a fighter are you?

Dr. HENRY FOSTER: I'm a big fighter. I'm looking forward to being touted around the Hill to get my message across. I'm going to go with the process all the way, primarily because this is an opportunity for me to improve the care of the people in this nation.

TED KOPPEL: And how committed do you feel that the President is? I mean, the fact that we are doing this interview here, as I said earlier, in the White House, suggests that for the moment, at least, the White House is certainly committed to your nomination. What conversations have you had with the President and his advisers that lead you to feel, that lead you to have any confidence, that they'll stick with you?

Dr. HENRY FOSTER: You answered the question for me. This is an example. I feel

the President is totally committed to my nomination, based on what I define as what characterizes me at the beginning, at the top of this program, what I've done through the years in maternal and child health, health delivery, reducing teenage pregnancy, improving the lives of these young people. This is a program that can be replicated across the country.

TED KOPPEL: Your predecessor, as you know, ultimately was forced to resign because she simply became politically too controversial. Do you take great issue with anything that Joycelyn Elders did, as distinguished from what she said?

Dr. HENRY FOSTER: Process-wise, yes. But the goals were improving the quality of life, which I think, incidentally, is the goal of virtually most of the people watching this show. It's a matter of process, how do we get there.

TED KOPPEL: So that when we talk about teaching children sex education, when we talk about the distribution of condoms, for example, any- any difference between you and Dr. Elders?

Dr. HENRY FOSTER: I think so.

TED KOPPEL: Where?

Dr. HENRY FOSTER: I think that these issues have to be addressed at the family level. I do not feel schools or the health department can unilaterally do this without the involvement of parents.

TED KOPPEL: But with the involvement of parents, you do favor the widespread distribution of condoms?

Dr. HENRY FOSTER: No.

TED KOPPEL: No?

Dr. HENRY FOSTER: I favor abstinence. Abstinence, that's what I favor. That's the bedrock of our program. That's why we have 18 kids out, 16 kids out of 23 out of the inner city housing project that are going to college now, nine African-American males. We teach people abstinence. That's our first route.

TED KOPPEL: What's the- what's the main lesson that you have been taught here in your- in your five rather intense days in the Washington cauldron?

Dr. HENRY FOSTER: To make up my own mind about what I want to do. I will not be pushed again to do something or give numbers or depend on my memory. I will be much more factual, or I will refuse to respond.

TED KOPPEL: Dr. Foster, thank you very much. I appreciate your joining us on the program tonight.

Dr. HENRY FOSTER: Thank you so much for having me.

TED KOPPEL: I'll be back in a moment with a late-breaking news story.

[Commercial break]

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TED KOPPEL: ABC News reported earlier this evening, and the White House has now confirmed, that Ramzi Ahmed Yousef, the alleged mastermind of the bombing of the World Trade Center, has been arrested in Pakistan. He has now been brought to New York's Metropolitan Correction Center, under indictment for his role in the bombing that killed six people and injured more than a thousand. Yousef had been on the FBI's most wanted list for nearly two years. In a statement released tonight, the President called the capture a major step forward in the fight against terrorism. Yousef is scheduled to appear in federal court for arraignment tomorrow.

That's our program for tonight. I'm Ted Koppel at the White House. For all of us here at ABC News, good night.

The preceding text has been professionally transcribed. However, although the text has been checked against an audio track, in order to meet rigid distribution and transmission deadlines, it has not yet been proofread against videotape.

LANGUAGE: ENGLISH

LOAD-DATE-MDC: February 9, 1995

February 17, 1995

MEMORANDUM

TO: Beth Nolan
Office of White House Counsel

FROM: Anna L. Durand *AL Durand*
Deputy General Counsel
Department of Health and Human Services

SUBJECT: Enclosed Materials

Enclosed for your use are the following:

- 1) A summary of abortion law in Tennessee and Alabama during Dr. Foster's years of practice in those two states. (This item is listed under "Prostaglandin Follow-Up" on the 2/14 "To Do" List.)
- 2) A draft of the statement of Louis Rabb, the hospital administrator at John Andrew Hospital while Dr. Foster was Chief, Obstetrics and Gynecology, there. (This item is listed under "Abortions" on the 2/14 "To Do" List.) This draft reflects my last conversation with Mr. Rabb. Let me know when you want me to contact him again.
- 3) A summary of Alabama and federal sterilization law during the relevant period. (This item is listed under "Sterilizations" on the 2/14 "To Do" List.)

Two PHS readers have read the Ethics Advisory Board transcript for November 10, 1978. At John Podesta's request, a copy of the transcript was sent to Senator Specter's administrative assistant, with the language regarding amniocentesis and therapeutic abortion, along with places where the transcriber indicated difficulty following the conversation, flagged. We will forward to you today a copy of the transcript with flags on the other portions the PHS readers thought deserved attention. (This item is listed under "Ethics Advisory Board Transcript" on the 2/14 "To Do" List.)

The Medline search on "Henry Foster," was sent to your office on February 13, 1995. (This item is listed under "Writings and Speeches" on the 2/14 "To Do" List.)

The following is a list of the outstanding HHS items on the 2/14 "To Do" List, in roughly the order you can expect to receive

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them:

- 1) A summary of the Meharry accreditation issue.
- 2) A summary of federal regulations regarding patient consent to experimental procedures.
- 3) A summary of Tennessee law regarding consents needed to sterilize mentally retarded persons.
- 4) A summary of HHS data on the "I Have a Future" program or other programs with which Dr. Foster was associated.
- 5) A precis of Dr. Foster's writings and speeches on health care reform.

Please do not hesitate to call if you should have questions about any of the enclosed materials.

cc: John Podesta

2/17/95

Relevant Abortion Law

TennesseePre-1973

Abortion and induced miscarriage were criminal violations unless the procedure was necessary to preserve the life of the woman.
Tenn. Code Ann. §§ 39-301, 39-302.

1973 Amendments

Laws Amended: § 39-301 was amended to exempt from criminal liability abortions performed under certain conditions.
§ 39-302 (relating to criminality of induced miscarriages) was repealed.
§ 39-302 was added to provide for post-performance reports of abortions to Tennessee Commissioner of Public Health.
• The effective date of these amendments is not clear.

Consent

Requirement: The pregnant woman's consent is required; the law does not specify the form of the consent.

Waiting

Period: None.

Other

Restrictions: • The abortion must be performed by a licensed physician pursuant to the physician's medical judgment.
• The woman must provide the physician proof of her Tennessee residence and the physician must keep a record of such proof.
• The physician must provide a post-performance report of the procedure to the Tennessee Commissioner of Public Health.

If the abortion is to be performed during the second trimester, all of the above restrictions apply, and in addition

- the abortion must be performed in a hospital.

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If the abortion is to be performed during the third trimester, all of the above restrictions apply, and in addition

- the physician, after consultation with other physicians, must certify that the abortion is necessary to preserve the life or health of the woman.

Restrictions
on Minors:

None specified.

1978/1979 Amendments

Laws Amended: § 39-302 was added to require informed consent, a waiting period, and parental notification before an abortion performed on a minor.

- The new law became effective on July 1, 1978, but was amended twice shortly after enactment.

Consent
Requirement:

Informed, written consent must follow oral disclosure to a woman of the following:

- That she is pregnant.
- The number of weeks of gestation.
- If more than 22 weeks have elapsed since gestation, the fetus may be viable.
Note: May 9, 1979 amendment changed "22 weeks" to "24 weeks."
- Abortion is a major surgical procedure.
Note: In 1992, a state court found that this piece of the disclosure requirement violates the state constitution.
- The benefits and risks attendant to continued pregnancy followed by childbirth and abortion.
- A 1983 amendment added two more disclosure requirements:
 - Numerous social service agencies are available to assist the woman who decides to take the pregnancy to term.
 - The particular risks associated with pregnancy followed by childbirth and abortion for the particular patient.

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**Waiting
Period:**

The woman may not consent until two days after receipt of the above information (i.e., the woman may consent on the third day).

Note: May 9, 1979 amendment provided an exemption from the waiting period if the physician determined that the delay would endanger the life of the woman.

Note: In 1992, a state court found that the waiting period violates the state constitution.

Other

Restrictions: Same as noted above under 1973 Amendments.

**Restrictions
on Minors:**

- The provision pertaining to minors was added by an amendment effective July 1, 1979.
- If the patient is under 18 years of age, the physician must notify the parents or legal guardian two days prior to the procedure unless
 - the patient is married, or
 - the physician determines that the procedure is necessary to preserve the life or health of the patient and must be performed prior to the expiration of the two-day period.
- While parental notice is required, the parent or guardian doesn't have the right to object to or prevent the procedure.
- Note: In 1992, a state court interpreted the statute to require notice to one parent and said no notice is required if the psychological, physiological or emotional health of the patient is in jeopardy. In 1994, a state court declared the waiting period unconstitutional.

Alabama

Pre-1973: Abortion was a criminal violation unless it was necessary to preserve the woman's life or health. Ala. Code § 13A-13-7.

2/17/95

Alabama Sterilization Law

Although there is Alabama case law addressing a state statute authorizing sterilization of institutionalized mentally incompetent persons, we have been unable to find an Alabama statute more generally addressing sterilization procedures, the authority to perform them, or any restrictions thereon.

An Alabama statute enacted in 1971, Act No. 2281, provides that no consent is required for a licensed physician to render any legally authorized medical service to a person mentally unable to consent who but for the mental disability would be able to consent and who has no known relatives or legal guardian if two or more licensed physicians indicate in writing that:

- such medical services are necessary in their judgment
- any attempt to secure consent from any court or to locate unknown relatives would result in delay that would increase the risk to life or health

It seems implicit in this law that a parent or legal guardian could consent to a medical procedure for a mentally incompetent person.

However, a 1979 Alabama Supreme Court case, Hudson v. Hudson, 373 So. 2d 310 (Ala. 1979) casts doubt on that interpretation, at least when the procedure in question is sterilization. In Hudson, the parents of a 16-year-old with the estimated intelligence of a 4-year-old sought a court order to allow the sterilization of their daughter because of their concerns about her inability to handle the responsibilities of parenthood. They had reason to believe that their daughter was or might become sexually active. The court noted that there was no contention that the procedure was medically necessary or that failure to authorize the sterilization would endanger the girl's life or health. The court observed that this was a case of first impression. Citing the "profound nature of the constitutional and social issues" and the "irreversible character" of the procedure, as well as the decisions of the "overwhelming majority" of courts in other jurisdictions that had considered the issue, the court refused "to act in this field absent statutory authorization."

A few years earlier, a three-judge panel of the U.S. District Court in Alabama had declared unconstitutional a state statute (Code of Ala., Tit. 45, § 243), which permitted a state institution to sterilize any mentally retarded inmate if "the assistant with the advice and consent of the superintendent" deemed it advisable. Wyatt v. Aderholt, 368 F. Supp. 1382 (M.D. Ala. N.D. 1973). The court stated that such sterilizations could not be left to the "unfettered discretion of any two officials or individuals." The court further noted that the statute contained

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no provision for notice, hearing, or any other procedural safeguard.

In a decision a few days later, Wyatt v. Aderholt, 368 F. Supp. 1383 (M.D. Ala. N.D. 1974), the court noted that "since it appears that sterilization continues to be performed in certain instances by the state health authorities," the court would issue procedural safeguards. With respect to an institutional resident determined by a court of competent jurisdiction to be legally incompetent or whom the director could not certify "without reservation that the resident understands the nature and consequences of the sterilization," those procedural safeguards were:

- the director sets forth reasonable grounds for believing sterilization is in the resident's best interest.
- a 5-person Review Committee, whose membership was to be approved by the court, approved the sterilization after reviewing medical records, interviewing the resident, and interviewing relatives and other concerned parties.
- a court of competent jurisdiction determines that sterilization is in the best interest of the resident.

Federal Sterilization Regulations

NB: These regulations apply to sterilizations performed by a federally funded program or project or funded by Medicaid or Medicare.

Prior to 1973

DHEW funded sterilizations under general authorities for funding of "family planning services." Regulations provided that such sterilizations must be "voluntary" -- though the term was not specifically defined.

July 1973

DHEW placed a moratorium on federal funding of sterilization of persons under 21 or legally incapable of consent.
38 Fed. Reg. 20903 (August 3, 1973).

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February 6, 1974

DHEW issued rules, 39 Fed. Reg. 4730, that permitted the sterilization of minors and other persons legally incapable of giving consent, provided the following procedures were implemented:

- Review by a project-appointed review committee of the proposed sterilization of a person under 18 or legally incapable of giving informed consent.
- Court approval of the proposed sterilization of a person legally incapable of giving informed consent.
- A nontherapeutic sterilization could not be performed less than 72 hours following informed consent.
- Informed consent, which required disclosure of
 - risks and benefits of the procedure
 - alternatives to the procedure
 - physician's obligation to answer the patient's questions
 - the fact that refusal to undergo sterilization would not lead to loss of any other benefits provided by the program
- Documentation of informed consent

March 1974

A United States district court in the District of Columbia held that DHEW's sterilization regulations were invalid insofar as they permitted the provision of sterilization procedures to persons who could not give legally effective consent under state law:

"nor can the consent of a representative, however sufficient under state law, impute voluntariness to the individual actually undergoing irreversible sterilization." NWRO v. Weinberger, No. 74-243 (D.D.C. 1974).

April 18, 1974

In response, to the court decision DHEW issued interim rules, 39 Fed. Reg. 13878, reinstating the moratorium against federal funding of sterilization of any person who was mentally incompetent or under the age of 21.

November 8, 1978

The Department issued revised regulations prohibiting federally funded programs from sterilizing persons under age 21, persons who are mentally incompetent, and persons who

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are institutionalized.

Where federally funded sterilizations are allowed, several restrictions apply:

- Informed consent can be obtained no less than 30 days, but no more than 180 days, prior to the procedure, except in the case of emergency abdominal surgery, where a waiting period of 72 hours is still required.
- Hysterectomies done principally for family planning purposes are prohibited, and persons receiving hysterectomies must sign a written acknowledgement that they have been informed that the operation would make them sterile.
- Records must be kept for at least 3 years.

August 4, 1982

The Department adopted a revision of the 1978 regulations to allow hysterectomies without the required acknowledgments where the woman is already sterile or a life-threatening emergency exists. 43 Fed. Reg. 52165.

STATEMENT OF LOUIS A. RABB

I was the Hospital Administrator at John A. Andrew Memorial Hospital at Tuskegee Institute in Alabama from 1950 to 1974. As Hospital Administrator, I was aware of all aspects of hospital operations, including the areas supervised by Dr. Henry A. Foster, who was Chief, Obstetrics and Gynecology, at John Andrew Hospital from 1965 to 1973.

John Andrew Hospital has closed since the time I left my position there; I believe that it closed within the last five years. [check] I do not know where the records for John Andrew Hospital are currently housed.

I am not aware of any abortion, other than an abortion to preserve the woman's life or health, ever having been performed at John Andrew Hospital during my employment there. It is my general recollection that even abortions to preserve the woman's life or health were rare during the entire time I was Hospital Administrator.

Dr. Foster is a dedicated and highly regarded professional. While he was at John Andrew Hospital, his professional activities met with the highest standards. He is intelligent, a hard worker, and an excellent person both professionally and personally. I was delighted when I heard he was being considered for nomination to the position of U.S. Surgeon General; I think he is an outstanding candidate.

Date: _____

Louis A. Rabb
Tuskegee, Alabama [check]

205--727-0784

February 17, 1995

MEMORANDUM

TO: Beth Nolan
Office of White House Counsel

FROM: Anna L. Durand *AL Durand*
Deputy General Counsel
Department of Health and Human Services

SUBJECT: Enclosed Materials

My earlier memo of this date ended with a list of items you could expect to receive from us. Enclosed are items (2) and (3) from that list:

- 2) A summary of federal regulations regarding patient consent to experimental procedures.
- 3) A summary of Tennessee law regarding consents needed to sterilize mentally retarded persons.

Please do not hesitate to call if you should have questions about any of the enclosed materials.

cc: John Podesta

2/17/95

Relevant Federal Regulations
re FDA Drug Trials

In 1973, the FDA had regulations in place that required that investigations of experimental drugs in a sponsored drug trial be approved by the institutional review committee of the investigator's institution. 21 C.F.R. § 130.3.

Each investigator and institutional review committee were required to provide assurances that:

- the investigator did not participate in the committee's deliberations or in the selection of committee members.
- the investigator would report emergent problems or procedural changes to the committee.
- the committee would review the study for compliance with procedures on an appropriate periodic basis, but no less frequently than annually.
- the committee would retain, for at least three years after the completion or termination of the study, documentation of the records reviewed by the committee and the committee's deliberations.

The regulations further required the investigator to:

- inform any subjects, or their representatives, that the drugs were being used for investigational purposes.
- obtain the consent of the subject (or his representative) except where "this is not feasible or, in the investigator's professional judgment, is contrary to the best interests of the subjects."

In 21 C.F.R. § 130.37(h), "consent" is defined as:

- given by a person with legal capacity
- in an exercise of free power of choice
- after a "fair explanation" of:
 - the nature, expected duration and purpose of administration of the drug.
 - the method and means by which it is to be administered.
 - the hazards involved.
 - the existence of alternative forms of therapy, if any.
 - potential beneficial effects.
- For Phase 1 and Phase 2 investigations, consent was required to be in writing.
- For Phase 3 investigations, the investigator was allowed to obtain oral consent and record that fact in the medical record if the investigator believed oral consent to be necessary or preferable, in light of the physical or mental state of the patient.

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A more detailed informed consent requirement became effective with respect to clinical investigations that commenced on or after July 27, 1981. 21 C.F.R. § 50.21.

The new regulation provides that no investigator may involve a human subject in research without legally effective informed consent of the subject or the subject's legally authorized representative. 21 C.F.R. § 50.20. The investigator must seek consent in circumstances that:

- provide the subject sufficient opportunity to consider whether or not to participate.
- provide the subject information in language understandable by the subject.
- minimize the possibility of coercion or undue influence.
- do not waive or appear to waive any of the subject's legal rights (e.g., in the event of negligence).

An exception from the informed consent requirement is provided in 21 C.F.R. § 50.23 if all of the following conditions are met:

- the subject is confronted by a life-threatening situation necessitating use of the test drug.
- there is an inability to communicate with or receive informed consent from the subject.
- there is insufficient time to obtain consent from the legal representative.
- there is no alternative method of approved therapy with an equal or greater likelihood of saving the subject's life.

The elements of informed consent are defined in 21 C.F.R. § 50.25(a) as:

- a statement that the study involves research.
- an explanation of the purpose, expected duration, and procedures to be followed.
- a description of reasonably foreseeable risks and discomforts.
- a description of reasonably foreseeable benefits to the subject and others.
- a disclosure of alternative treatments.
- a statement of the extent to which confidentiality of records will be maintained.
- an explanation of compensation and/or medical treatments available if injury occurs.
- identification of a contact person for answers to questions.
- a statement that participation is voluntary, is not tied to any other benefits, and can be terminated at any time.

Additional elements to be included in informed consent, as applicable, are set forth in 21 C.F.R. § 50.25(b):

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- a statement that the treatment may involve risks to the subject that are currently unforeseeable.
- anticipated circumstances under which the subject's participation may be terminated by the investigator.
- additional costs to the subject that may result from participation.
- consequences of a subject's decision to withdraw and procedures for orderly termination of participation.
- a statement that significant new findings developed during the course of the research that may relate to the subject's willingness to continue will be provided to the subject.
- the approximate number of subjects involved in the study.

21 C.F.R. § 50.27 (b) provides that consent may be documented by either:

- a written document that sets out all of the elements listed above.
- a short form stating that all of the elements of informed consent have been presented orally to the subject, which is signed by a witness to the oral presentation.

2/17/95

Tennessee Sterilization Law

We have been unable to find a Tennessee statute addressing sterilization procedures, the authority to perform them, or any restrictions thereon.

Our research has found only one Tennessee court case, In re Lambert, No. 61-156 (P. Ct. Mar. 11, 1976), that addresses the issue. In that case, the mother of an 18-year-old girl sought probate court authority to have her daughter sterilized. The court found that the girl was profoundly retarded and had an intelligence quotient in the range of 0 to 20. She also suffered from a gynecological problem that resulted in menstrual irregularities and excessive bleeding, which was found to cause severe difficulties for the girl and her mother. Two physicians recommended a hysterectomy to solve the gynecological problem and to ensure that the girl would not have children, since they did not believe she would be able to care for a child. The probate court denied relief on the ground that it had no authority to order surgery that was desirable but not necessary.

The Tennessee Court of Appeals affirmed, finding that Tennessee courts have no authority to order surgery upon a mentally retarded incompetent, absent compelling necessity for the safety and welfare of the incompetent person. In re Lambert, No. 61-156 (Tenn. Ct. App. Oct. 29, 1976). The Lambert court noted that this was a case of first impression in Tennessee.