QUESTIONS & ANSWERS

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SURGEON GENERAL NOMINEE

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QUESTIONS

GENERAL

1. Why do you want to be Surgeon General?

2. What are your major qualifications for the job?

3. Does the controversy surrounding your nomination lessen your enthusiasm for the job?

OFFICE OF THE SURGEON GENERAL

1. What are your goals in the role as health advisor to the Nation?

2. What particular public health issues do you plan to advocate?

3. How will your role be different than the previous surgeons general? To whom will you report: Secretary Shalala? Dr. Lee?

4. During the Confirmation hearing for Dr. Elders, we learned that the Surgeon General was taking on several new responsibilities -- namely the direct program supervision for the office of minority health, women's health, disease prevention and health promotion, and population affairs (family planning). Will your role include the program management of these offices. Or any other offices?

5. Do you believe that a lack of program responsibility will limit your effectiveness?

6. Is there a need for a Surgeon General? Is it necessary to maintain the Surgeon General separate from the Assistant Secretary for Health? Can't the same person fulfill both roles? Perhaps the Secretary should consider such a consolidation as part of her efforts to streamline government.

7. What will be your priorities for the Public Health Service's Commissioned Corps?

8. What is the budget request for the immediate office of the Surgeon General for FY96 and how many FTEs does the office have?

9. Former Surgeons general have issued major reports on such public health issues as smoking, drunk driving, nutrition, domestic violence, and adolescent health and teen pregnancy. What would be the subject of your major report?

TEEN PREGNANCY

1. Despite massive spending by the federal government and other entities, little progress is made in area of teenage pregnancy. What ideas do you have for curbing the teen pregnancy problem?

2. Can you tell us about your program, "I Have a Future?"

3. What are the causes of the high teenage pregnancy rate in the U.S.?

4. Do you think that teaching abstinence will reduce teen pregnancy rates?

5. Isn't your stress on abstinence unrealistic and potentially deadly, given the fact that most young people are sexually active before the age of 18?

6. There is a statistic that says 70 percent of all teenage pregnancies occur between 3 and 5 in the afternoon. What is the source of this statistic and what does this mean to you in terms of your effort to remedy the problem of teenage pregnancy?

7. Do you know the statistics on how many children in this country are "unplanned and unwanted"? Isn't this rather difficult to measure?

CONTRACEPTION, SEXUALITY, AND HEALTH

1. What are the most pressing health problems facing teens today?

2. At what grade level do you think children should begin health/sex education?

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

4. Why don't we make condoms available in the schools?

5. Do you support the distribution of Norplant to teenage girls as has been done in Baltimore City schools?

6. Would you support federal funding for the distribution of Norplant?

7. Should Norplant be given to minors without parental consent?

8. There are some that claim that Norplant is being used as a form of genocide against African Americans. How do you respond to this sentiment?

9. Do you believe that the teaching of masturbation should be part of the comprehensive, age-appropriate sex education you advocate?

10. Do you plan to support school-based clinics? If so, what role should parents play in these settings?

11. Should all school-based clinics distribute birth control on site? If not, who should decide which programs do?

12. Are there any school-based clinics in Tennessee? If there are any, what evidence is there to support the argument that they bring down the rate of teenage pregnancy?

AIDS AND HIV

1. The American public seems to think AIDS is not an important issue. How can you affect that?

2. Isn't your emphasis on abstinence unrealistic and potentially deadly, given the fact that so many young people are sexually active before the age of 18?

3. Do you support the distribution of clean needles to intravenous drug abusers as a means of slowing the spread of HIV?

4. Why should we spend so much money for AIDS, compared to cancer or heart disease, which kill so many more Americans?

5. How can you justify more of a spending increase in AIDS research at NIH than for the rest of NIH?

6. How do you answer those who suggest cutting the AIDS budget?

7. News reports on the statistics for AIDS in 1994 suggest that the AIDS rate is slowing down. Why do we need more money?

8. But hasn't there been a "relapse" into unsafe sex among gay men?

9. Last year the Administration proposed a freeze in AIDS prevention money. Why an increase this year?

10. Why hasn't the Administration proposed a Manhattan Project for AIDS?

11. There's been talk in Congress about doing away with OAR. What impact would that have?

12. Dr. Paul laid out an AIDS research program in a recent edition of Science magazine. Is there enough money in the President's budget to carry out that plan?

13. Dr. Paul just published an article in Science magazine suggesting that there is too much focused research at NIH. Doesn't that argue against a strong Office of AIDS Research?

14. Why have a special program for AIDS care when there isn't for any other disease?

15. Why not block grant Ryan White?

16. CDC is reorganizing its AIDS programs. How will that work?

17. Can you explain how the CDC block grant would work?

18. What will prevent HIV money from being diverted to other problems under the consolidation at CDC?

19. Why don't we just test everyone so that we know who is infected with HIV and who isn't?

20. The new proposed Public Health Service guidelines on HIV testing recommend that all pregnant women be tested for HIV, but they do not mandate it. Why not make it mandatory, especially given AZT's potential for significantly reducing perinatal transmission of the virus?

21. Shouldn't patients be required to tell health practitioners whether they are HIV-positive, and vice versa?

22. Shouldn't the President show more passion about AIDS?

23. Many AIDS activists and health professionals contend that U.S. immigration restrictions barring entrance to HIV-infected foreigners is a violation of their human rights and won't help slow the spread of AIDS. How do you feel about these restrictions?

24. Last year, waivers were made available to HIV-infected homosexuals attending the Gay Games. Wasn't it a stretch to say this event was in the public interest?

WOMEN'S HEALTH

1. What can we do about breast cancer?

2. What do you think of recent research showing that abortions increase the risk of breast cancer?

3. What is your position on how frequently and when women should get mammograms?

4. Does it make a difference if a woman is screened very year or every two years?

5. How can we account for the worse outcomes in cases of breast cancer among African-American women?

6. Do you support regulations such as the so-called "Gag Rule" which aim to separate abortion activities from federally supported family planning services? If not, do you support any limitation on the ability of clinics receiving federal funds to counsel or refer women for abortion?

MARIJUANA AND OTHER NARCOTICS

1. The recent Monitoring the Future (MTF) Survey shows that fewer students believe using marijuana is harmful to their health, and more young people are using marijuana. Is this evidence that the Administration is not sending out a tough enough message on drugs?

2. Do you believe we should legalize illicit drugs? Should we study the legalization of illicit drugs?

3. Do you support the medicinal use of marijuana?

4. Would you endorse allowing new patients into the single patient (compassionate) IND program for the use of marijuana?

5. Should the government support research into the medicinal use of marijuana?

TOBACCO

1. Every Surgeon General since Luther Terry in the mid-sixties has spoken out against smoking. In this tradition, what do you plan to do to get Americans to stop smoking?

2. Do you believe that nicotine is a drug? Do you believe that tobacco companies manipulate the nicotine-content of their tobacco products? Do you believe that tobacco products should be regulated by the FDA?

3. Do you believe that nicotine is addictive? If so, shouldn't tobacco products be banned, like other addictive drugs are?

4. Should tobacco be banned in the workplace? Do you see it as the responsibility of the Surgeon General to advocate the elimination of tobacco use when non-smokers might be affected?

5. Do you support increasing the tax on tobacco products to pay for health care reform initiatives? or for any reason?

6. What is the role of the federal government in regulating the advertising of tobacco products? Should cigarette warning labels be larger? More strongly worded? Should print advertising by tobacco companies be banned altogether? Should product-endorsements for sports and athletic activities be banned?

7. Do you believe that tobacco companies are tailoring their smokeless tobacco products to entice teenage users? Should such practices be controlled or prohibited?

8. How should the use of tobacco products by teenagers be controlled or eliminated? Should the federal government control advertising content, style, or markets?

9. Isn't the use of smokeless tobacco an acceptable alternative to smoking, since it doesn't affect the indoor air that others must breathe and won't cause lung cancer?

10. If you oppose smoking and tobacco use among Americans, will you also bring the message to stop smoking to other countries, especially in the emerging markets in Asia, that import American-grown tobacco? Isn't it hypocritical for the federal government to spend so much effort persuading Americans to stop smoking, meanwhile having the Commerce Department negotiating trade agreements to import American-grown tobacco?

11. Current federal law requires states to prohibit the sale or distribution of tobacco products to persons under the age of 18. How should that law be enforced? Should the local police be required to carry out "sting operations" in local convenience stores? Should vending machines be banned? Or should the federal government regulate their placement so that they are not available in facilities, like video arcades and grocery stores, that are accessible to teenagers?

VIOLENCE

1. Do you believe violence is a public health issue?

2. What can be done to reduce the violence being perpetrated by younger and younger offenders in our country?

3. What are your thoughts on what we should do to reduce domestic violence/violence against women in the United States? [Or, do you regard domestic violence as part of what you will address as Surgeon General?]

4. What is your position on gun control? [Or, Do you favor further regulations on gun ownership?]

5. Isn't the CDC engaged in a campaign to take away guns from Americans and stick its nose into people's lives in the name of stopping violence?

WELFARE REFORM

1. As you know, there are some who claim that denying aid to unmarried teenagers will reduce out-of-wedlock and teen births. How do you respond to that?

2. Do you believe that denying cash benefits to pregnant teenagers will reduce teen pregnancy?

3. Why should Medicaid be an entitlement? What do you think about making Medicaid a block grant?

4. What are the current teen pregnancy and childbearing trends?

5. In the State of the Union Address, President Clinton mentioned his National Teen Pregnancy Prevention Initiative. What exactly is it?

6. What is the Department currently doing to prevent teen pregnancy?

7. What is HHS currently doing in teen pregnancy prevention research?

HEALTH CARE REFORM

1. What will your role be in health care reform?

2. In the course of the health care debate, you charged that the President's health care reform had "the potential to negatively impact medical education." What did you mean?

3. But you criticized the Clinton bill for cutting Medicare funding for graduate medical education; ignoring undergraduate medical education and providing inadequate support for low-income students; and undermining academic health centers with the promotion of managed care.

   And you continually mentioned a "long and difficult session" with Ira Magaziner who wasn't listening to your point of view. Wasn't the Administration threatening the core of the nation's health care quality with its bill?

4. In discussions of health reform, you supported measures that would dictate to medical schools and teaching hospitals the kinds of doctors they could train. How can you advocate such interference with our nation's private health care system?

5. You have called for a physician "draft" to get providers to all parts of this country as we sometimes draft providers to other parts of the world. Do you advocate that policy?

6. You have suggested that Veterans Administration hospitals with empty beds should be used by the broader community. What do you mean?

7. In describing how health care reform would "play out," you talked about a two-tier system. You essentially argued that health care would be rationed; that the American system would and should look like the British system. How could you support such a policy or an Administration that would support such a policy?

8. You have expressed concerns about the impact of Tenncare on the financing of medical education in Tennessee. Isn't Tenncare a product of the Administration you're now going to represent?

9. If Tennessee can control its health care costs with a waiver, can we turn all of Medicaid into block grants and do a better job for the poor with less money?

FETAL TISSUE AND EMBRYO RESEARCH

1. Does the federal government currently fund human embryo research?

2. Wasn't there a recent report to or by the National Institutes of Health recommending that the federal government fund such research?

3. What research did the Panel and the Advisory Committee recommend for funding?

4. Wouldn't federal funding for human embryo research reverse twenty years of government policy?

5. If you believe human embryo research should be federally funded, are there limits to that funding? What standard should be applied to decide which research to fund?

6. Are there any good reasons to do human embryo research?

7. What will happen if there is not federal funding for human embryo research?

8. Has President Clinton authorized fetal tissue research?

MISCELLANEOUS ISSUES

1. You've talked a lot about teen pregnancy and other issues confronting young people. What other children's issues do you plan on addressing as Surgeon General?

2. What is the risk of getting TB on an airplane, and what is recommended to protect the public traveling by air?

3. What should we do about the growing threat of multi-drug-resistant TB?

4. Who has authority to quarantine an individual within a given State and when should quarantine be considered? Who has the authority to quarantine an individual if that person is traveling between states?

5. You said recently that minority youth have to learn "operative English." What did you mean by that?

6. What is your position on physician-assisted suicide?

7. What is your salary arrangement with the Department of Health and Human Services at this time?

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General

Divider Title: _____

REASONS FOR WANTING THE JOB

QUESTION:

Why do you want to be Surgeon General?

ANSWER:

First of all, let me say that I consider the President's nomination of me to be the highest honor of my life and a validation of the hard work and commitment to health care that I have demonstrated during my 38-year professional career.

I believe that the role of the Surgeon General is first and foremost the role of an educator. He or she must use the position to teach the nation about health promotion and disease prevention.

By temperament and training, I am an educator.

Throughout my career, as an obstetrician/gynecologist, a university leader, a mentor and a teacher, I have worked to educate people -- particularly those who are in greatest need -- about good health. I have also sought, through education and training, to increase the number of health care professionals working in underserved areas.

Any good doctor -- but particularly a good OB-GYN -- must be a good educator. There is nothing more critical to ensuring the delivery of a healthy baby than good prenatal care. And that begins with instructing an expectant mother about her responsibilities to herself and to her unborn child during pregnancy.

An informed mother is an empowered mother, and I make sure that she has all the information she needs for maximum health and minimum risk throughout pregnancy and delivery. That is the most basic education I am involved with.

But, I have also taken education beyond the doctor's office -- out into the community to promote health throughout every stage of life.

In the 1970s, I returned to rural Alabama to head up the Maternity and Infant Care Program at Tuskegee Institute. Our purpose was to reduce what was then an extremely high rate of infant mortality and to increase the number of doctors serving this population of mostly poor and mostly African American women.

Some of these women had never even seen a doctor.

We put together a team of doctors, nurses, social workers and nutritionists to provide comprehensive care services with the goal of educating women about prevention for themselves and their newborn children. The Robert Wood Johnson Foundation asked us to replicate this program nationwide.

Another example of my work as an educator is an effort I headed to increase health care services for teenagers throughout the United States. This project targeted young people between the areas of 15 and 24 who lived in areas characterized by high rates of teen pregnancy, violence, drug and alcohol abuse, and mental illness. Under my direction, 20 teaching hospitals developed comprehensive health programs to expand services for young people in their communities, and to train doctors and nurses in the specialized care of high-risk youth.

And, of course, the most well-known example of my leadership as a health educator is the "I Have a Future" program in Nashville, where we are teaching young people to say "no" to sex and "yes" to their education and futures. The President has specifically asked that I use my expertise in this area to mount a nationwide campaign to reduce teen pregnancy.

I believe as Surgeon General, I can build upon all of my experiences to empower more people reclaim the power over their own health, to inspire more people in their communities to put a stop to dangerous and destructive behaviors, and to help draw more attention to the tragic health problems confronting us -- from the epidemic of violence to the spread of HIV/AIDS to the terrible problem of substance abuse. That's why I want to be Surgeon General.

QUALIFICATIONS

QUESTION:

What are your major qualifications for the job?

ANSWER:

I have been a doctor for 38 years. I have been the chair of the Department of OB-GYN at one of this nation's finest medical schools, Meharry Medical College. I have run a major health sciences center comprised of four schools: medicine, dentistry, allied health, and graduate studies. In 1972, I became one of the youngest people ever inducted into the Institute of Medicine of the National Academy of Sciences. I am the founder of the award winning "I Have a Future" program, which was recognized as one of this nation's "Thousand Points of Light" in 1991 by President Bush.

QUESTION:

Does the controversy surrounding your nomination lessen your enthusiasm for the job?

ANSWER:

Not in the least. In fact, I am more determined than ever to win nomination and become the best Surgeon General in the history of this nation.

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OFFICE OF THE SURGEON GENERAL

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ROLE OF SURGEON GENERAL -- GENERAL GOALS

QUESTION:

What are your goals in the role as health advisor to the nation?

ANSWER:

I intend to use the position to educate and empower the American people to prevent illnesses and live healthier lives.

First, I want to help lead a national effort to prevent teen pregnancy. As you know, the President has asked me to build upon my successes in Tennessee and make teen pregnancy prevention a top priority.

We need to teach this and every other generation of young people to say "no" to sex and "yes" to their educations and their futures.

Second, I want to focus like a laser beam on this country's most effective weapon against illness: prevention.

That's right -- prevention. Each year, about 2 million people die in this country -- and about half of these deaths are preventable.
I want to engage the American people in a national discussion about what each and every one of us can do to improve our health and our lives.

I want to use the tool of education to challenge Americans to exercise regularly, improve their diets, and refrain from high-risk behaviors like smoking and drug use.

Finally, I want to build upon the successes of the U.S. Commissioned Corps.

I want to listen to the Corps' dedicated members and find even more effective ways to tap into their vast experience and expertise.

ROLE OF SURGEON GENERAL -- PUBLIC HEALTH CAUSES

QUESTION:

What particular public health issues do you plan to advocate?

ANSWER:

Prevention. Prevention. Prevention.

Why? Because, today, all of us see too many children having children. Too many babies born to women who didn't receive prenatal care. And, too many young people engaged in risky behaviors -- like drinking alcohol, using drugs, and engaging in sexual activity.

Maternal and child health are vitally important to me. When you've been involved in the miracle of birth as many times as I have, you can't stand on the sidelines and watch people throw away their lives.

Take the issue of teen pregnancy.

Every day 8,400 teenagers become sexually active and 2,781 teenagers get pregnant.

That's a national tragedy -- and President Clinton has asked me to help lead a national campaign to turn it around.

I intend to do just that.

It's time for us to make prevention the watch word of our public health efforts: preventing teen pregnancy. Preventing low-weight babies. Preventing the transmission of HIV. Preventing drug and alcohol abuse. Preventing youth violence.

<u>These</u> will be my priorities.

SURGEON GENERAL -- CHANGE IN ROLE

QUESTION:

During the Confirmation hearing for Dr. Elders, we learned that the Surgeon General was taking on several new responsibilities -- namely the direct program supervision for the office of minority health, women's health, disease prevention and health promotion, and population affairs (family planning). Will your role include the program management of these offices. Or any other offices?

ANSWER:

I will not directly manage those programs.

Instead, as a senior member of Dr. Lee's cabinet, I will help develop policy and provide advice and counsel to him on a wide range of health issues -- including, but not limited to, minority health, women's health, disease prevention, and family planning.

I will oversee the 6,500 caring health professionals who make up the U.S. Commissioned Corps.

And, of course, I will speak out and work to empower Americans to prevent illness and live healthier lives.

SURGEON GENERAL ROLE -- EFFECTIVENESS

QUESTION:

Do you believe that a lack of program responsibility will limit your effectiveness?

ANSWER:

Absolutely not.

To the contrary, for the most part, the role of Surgeon General is not that of a program manager -- it's an educator, a communicator, and, a spokesperson looking out for the nation's health.

Freed from day-to-day management activities, my effectiveness will be enhanced, not limited.

I will be able to spend the bulk of my time educating and empowering people to prevent illnesses and live healthier lives. I will be able to engage in real dialogue with the American people -- to <u>listen</u> to their health concerns, and to transmit these concerns back to Washington.

And I will be able to use the position to work with caregivers -- to challenge them to continue this nation's tradition of extraordinary leadership in the health professions.

Moreover, as Surgeon General, I will oversee 6,500 health officials in the U.S. Commissioned Corps -- caring health professionals who bring their skills to areas ranging from environmental protection to the Public Health Service's fight against AIDS.

And, I will play a critical role in Dr. Lee's executive team -- helping to develop policy and provide counsel on the full array of health issues affecting the American people.

ROLE OF SURGEON GENERAL -- ISSUING REPORTS

QUESTION:

Past Surgeons general have issued major reports on such public health issues as smoking, drunk driving, nutrition, domestic violence, and adolescent health and teen pregnancy. What would be the subject of your major report?

ANSWER:

As you know, the President has asked me to build upon my successes in Tennessee and help lead a national campaign to prevent teen pregnancy.

I intend to do just that. And, I also intend to focus on other factors that undermine Americans' health -- factors like sexually-transmitted diseases, inadequate prenatal care, and drug use.

At this time, I can't say whether I will issue a Surgeon General's report.

I've told you what my priorities are. But, I need to serve as Surgeon General for awhile before I am able to determine whether a specific report will help the American people.

ROLE OF SURGEON GENERAL -- COMPARISON TO PREDECESSORS

QUESTION:

How will your role be different from other Surgeons general? To whom will you report: Secretary Shalala or Dr. Lee?

ANSWER:

Beginning over a century ago with Dr. John M. Woodworth, the first Surgeon General, America's Surgeons general have assumed their positions with different backgrounds and mandates.

But all Surgeons general have one important thing in common -- they are the "people's doctor" -- public health leaders who educate, promote healthy habits and policies designed to benefit all Americans.

In the 1960s, Dr. Luther Terry used the prominence of his position to publicize the link between smoking and cancer and other diseases, and in the 1980s, Dr. C. Everett Koop called for sex education and the use of latex condoms to protect against spread of HIV.

I am inspired by this tradition, and if confirmed, I will dedicate myself heart and soul to making a difference for the American people.

Specifically, I will report to Dr. Phil Lee, the Assistant Secretary for Health. I will speak out about key health issues, supervise the U.S. Commissioned Corps, and be a senior health advisor on Dr. Lee's team.

THE ROLE OF SURGEON GENERAL -- IS IT NECESSARY?

QUESTION:

Is there a need for a Surgeon General? Is it necessary to maintain the Surgeon General separate from the Assistant Secretary for Health? Can't the same person fulfill both roles? Perhaps the Secretary should consider such a consolidation as part of her efforts to streamline government.

ANSWER:

To be effective, the unique role of the Surgeon General must remain separate and strong.

The Assistant Secretary for Heath is an administrator with responsibility for the entire Public Health Service -- eight agencies and over 51,000 employees.

That's an extraordinary task.

But, we also need someone to dedicate every hour of every day to establishing a dialogue with the American people about health.

We need someone to give speeches, write op-eds, visit schools, listen to parents, talk with health professionals, -- in short, we need an educator.

No Assistant Secretary of Health can function as both a fulltime administrator and fulltime educator.

Actually, throughout the 1970's the Department experimented with combining the administrative work of the Assistant Secretary for Health with the educational role of the Surgeon General. Needless to say, they weren't pleased with the results.

The Carter Administration quickly re-established the office of the Surgeon General, but combined the duties of the Assistant Secretary of Health and Surgeon General. However, while an improvement over having no Surgeon General, it still did not permit the work of the Surgeon General to reach its full potential.

The Reagan Administration recognized the importance of keeping these two functions separate and moved swiftly to appoint Dr. C. Everett Koop to the position of Surgeon General. They knew that, to be effective, Surgeons general needed to be freed up from day-to-day management activities -- so that they can devote the bulk of their time to being spokespersons for good health.

Their past experiences should help guide our future decisions.

Advocate

SURGEON GENERAL ROLE -- COMMISSIONED CORPS

QUESTION:

What will be your priorities for the Public Health Service's Commissioned Corps?

ANSWER:

I am pleased to have the opportunity to lead the U.S. Commissioned Corps -- 6,500 caring health professionals with expertise in areas like biomedical research, epidemiology, sanitation, and health care administration.

These dedicated health professionals are putting their skills to work improving the health of all Americans -- from pitching in after the Midwest Floods and the Northridge Earthquake to lending their expertise to the fight against AIDS and the Hanta Virus outbreak in the Southwest.

My first priority is to listen to the Commissioned Corps members --and learn what areas we can improve upon.

And, in the long run, my obligation is to ensure that their skills are used wisely and effectively -- that we match up our greatest health needs with the professionals who can best fill them.

Should you have particular concerns regarding the Commissioned Corps, I will be pleased to work with you on those areas.

SURGEON GENERAL -- BUDGET AND FTEs

QUESTION:

What is the budget request for the immediate office of the Surgeon General for FY 96 and how many FTEs does the office have?

ANSWER:

The budget request for the office is $867,000 -- the same as the current fiscal year -- including resources of 7 FTEs.

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TEEN PREGNANCY

QUESTION:

Despite massive spending by the federal government and other entities, little progress is made in area of teenage pregnancy. What ideas do you have for curbing the teen pregnancy problem?

ANSWER:

As the President has said, "Teen pregnancy is one of the most serious social problems facing our country." The statistics are startling. Every day in America, 8,400 teenagers become sexually active and 2,781 get pregnant -- that's 116 pregnancies per hour.

I have dedicated my career to reversing these trends and preventing the tragedy of teen pregnancy. Through my "I Have a Future" program, I have worked to teach young people to say "no" to sex and "yes" to their educations and their futures. I have seen young people walk through the doors with almost nothing and walk out armed with a wealth of self-confidence and bold aspirations for the future.

We must be clear about what teen pregnancy is -- and what it is not. Teen Pregnancy is not a problem of the inner city. It's not a women's problem or a problem confined to certain religious or ethnic groups. And, most important, it is not -- nor will it ever be -- someone else's problem.

It is our problem. And, I am very proud that the President has asked me to help lead a national effort to stop this epidemic. I believe each and every one of us -- parents, doctors, teachers, religious leaders, students, businesses, older siblings, and elected officials -- must be part of this vital initiative.

All of us must work together to send clear and consistent messages to young people about sex. When young people ask about safe sex, we must tell them that abstinence is the only form of truly "safe" sex.

We must teach young people to delay sexual activity until marriage and send this message to every child in America: until you are emotionally and economically able to provide for a child, you should not have sex, and you should not have a child. This message is exactly the same for boys as it is for girls.

But, it is not enough for us simply to ask our children to say "no" -- we must also give them something to say "yes" to. Yes to education. Yes to healthy activities. Yes to a job. Yes to their family. And, yes to a productive future.

Moreover, we need to send a broader message about responsible behavior. While we must encourage young people to delay sexual activity -- we must also insist that they use contraceptives consistently, responsibly, and correctly if they begin.

I know that there is a lot of controversy about school-based sex education and contraceptive distribution. These issues -- like most issues related to teen pregnancy -- are local issues, to be decided by families, communities, and local school boards.

The truth is, it's going to take true leadership at the local level. It's going to take parents talking to their kids, teachers reaching out to young people in need, communities finding positive activities for children to engage in, and the media sending the right message about delaying sexual activity and being responsible.

It's going to take each and every one of us. But, with a little vision and a lot of hard work, I believe that we can turn this thing around and open up horizons for the young people of America.

QUESTION:

Can you tell us about your program, "I Have a Future?"

ANSWER:

I started the "I Have a Future" program to expand adolescent health programs beyond the schools and help the young people in Nashville's public housing projects create futures filled with aspiration and opportunity.

First and foremost, our focus is on abstinence, community and self-esteem.

Let me take a minute and run through the three parts of the program.

First, we equip adolescents with the basic information they need about health, human sexuality, and drug and alcohol use so they understand the benefits of abstinence and the consequences of early sexual activity.

Second, we provide a comprehensive array of adolescent health services, with a focus on abstinence. In some cases, that means access to birth control -- with a very strong emphasis on parental and community involvement.

And, third, and most important, we help young people enhance their life-options through activities that improve their job skills, self-reliance, values, and self-esteem.

For example, the youth entrepreneurial component of our program helps teenagers learn more about themselves and about the world by empowering them to start businesses in their communities.

This kind of skills-development and character-building is not only important for girls and young women -- but, as research is showing us, it is also critically important for boys and young men.

We have to take the time to understand all the unique aspects of young people's lives: Building up their self-esteem, telling them we believe in them, but not simply treating them as collections of problems.

I founded the "I Have a Future Program" because most teen pregnancy programs at the time were limited to advocating contraception. But these programs did not have a significant impact on teen pregnancy because they only addressed the *capacity* to have a child, without addressing the *desire* to have a child. "I Have a Future" was designed to empower teens to take control of their futures and delay childbearing until a more appropriate time -- and it worked.

From 1988-1991, we know of only one of the program's participants who became pregnant -- that's compared to 59 teenage pregnancies in the two other demographically similar Nashville housing projects where "I Have a Future" is not offered.

And, just last year, 16 of the 24 program participants who graduated from high school went on to college. Eight of them were male and eight were female.

It has not been easy -- and results don't happen overnight. But, it shows what one community can do when it makes teenage well-being a real priority.

I believe this kind of success is possible in every community.

CAUSES OF TEENAGE PREGNANCY

QUESTION:

What are the causes of the high teenage pregnancy rate in the U.S.?

ANSWER:

Tragically, each year more than one million adolescent girls in the United States become pregnant. Too often, these young women are unmarried -- too often, their pregnancies are unintended.

The statistics are staggering -- but the causes are complex, numerous, and, in fact, not completely understood. Let's talk about what we do know:

- The proportion of adolescents who are sexually active has been steadily increasing for the past two decades.

- Adolescents are initiating sexual activity at younger ages.

- Yes, contraceptive use among adolescents has increased, but the proportion of adolescents that are sexually active has also increased -- and thus, so has the rate of pregnancies.

  Contraceptive use is positively associated with age. More younger adolescents are becoming sexually active and they are less likely to use contraceptives. And, even though more adolescents are using contraceptives, their use is still far from perfect.

- Social factors also play a role.

  Adolescents from low-income families are more likely to initiate sexual activity at a young age, less likely to use contraceptives and more likely to become pregnant than adolescents from higher income families.

  Too many adolescents who live in poverty don't see positive alternatives. They view their life options as restricted and see little reason for delaying sexual activity and parenthood in favor of pursuing educational and career goals.

  Risk taking behaviors--drug use, alcohol use, early sexual activity--tend to occur together and these behaviors are increasing among adolescents.

  Messages about sex are pervasive in the media. Advertising, television programs, movies, videos and music all tend to portray sex without responsibility or consequences.

It is increasingly recognized that many adolescents become sexually active by force or coercion and that this has serious implications for their development and ability to protect themselves against pregnancy and STD infection.

As I said, these are complex and diverse factors -- and that's why we all need to help lead a comprehensive effort to attack this problem from every possible angle.

Nothing less than the lives of our young people -- and the future of our country -- is at stake.

REDUCING TEEN PREGNANCY THROUGH ABSTINENCE

QUESTION:

Do you think that teaching abstinence will reduce teen pregnancy rates?

ANSWER:

Absolutely.

People always ask me what the "safest" kind of sex is, and I always answer, "There is only one truly safe kind of sex -- and that's no sex." One thing is clear: abstinence education is our best method of preventing teen pregnancy.

In my "I Have a Future" program, we taught young people to say "no" to early sex and "yes" to their futures, their jobs, and their education.

This approach is common sense, it treats young people as individuals -- not collections of problems. And, most important, it works.

That's because, the longer we get teens to delay sexual activity, the more likely they are to stay in school. And, the longer they wait, the more likely they are to use contraceptives effectively, to avoid the danger of exposure to multiple sexual partners, and the risk of sexually transmitted diseases including the HIV virus.

ABSTINENCE

QUESTION:

Isn't your stress on abstinence unrealistic and potentially deadly, given the fact that most young people are sexually active before the age of 18?

ANSWER:

No. Not only is it not unrealistic to focus on abstinence, it is immoral for us to sit back in silence. It is simply not acceptable -- emotionally, physically, and financially, for 14 year-olds and 15 year-olds to be having sex and having children.

All of us must come together and send clear and consistent messages: if you're having sex -- stop. And, if you haven't started -- by all means, don't.

We simply cannot give up on educating our children about healthy lives and productive futures. My emphasis on abstinence is the healthiest thing in the world. Abstinence is the surest way of preventing not only the transmission of HIV, but also pregnancy and sexually-transmitted diseases.

That's the fact -- and I have found that young people respect facts and like it when adults talk honestly with them.

There's another fact that I like to tell young people: Millions of their peers have chosen abstinence. We must not allow our young people to think that being sexually active at their age is the social norm.

At the same time, we cannot give up on those who are already sexually active. We must ensure that they understand the potential consequences of their actions. We must give them age-appropriate sexuality information about access to contraceptives methods. And, we must teach them that the correct and consistent use of latex condoms is effective at preventing pregnancy and sexually-transmitted diseases.

TEENAGE PREGNANCY

QUESTION:

There is a statistic that says 70 percent of all teenage pregnancies occur between 3 and 5 in the afternoon. What is the source of this statistic and what does this mean to you in terms of your effort to remedy the problem of teenage pregnancy?

ANSWER:

The Kantner and Zelnik surveys, done in the 1970s, found that more than 75 percent of adolescents reported their first sexual encounter occurred in either their own home, their partner's home or a friend's home. A comparable proportion reported their most recent sexual encounter also occurred in one of those three places.

Now, what does this mean?

It means that all of us need to take more responsibility for providing our children with adult supervision and healthy after school activities.

The old African adage says "It takes a village to raise a child."

We must be that village -- parents, teachers, religious leaders, older siblings, businesses, and elected officials. All of us must talk straight with our children and teach them to say "no" to sex. But, we must also give them something to say "yes" to.

Not just between those hours of 3 and 5, but on weekends and evenings as well: we need to give them positive alternatives -- like athletics, art, music, and a job. Only then, will we truly be that village, and only then will our children truly have a shot at fulfilling and productive futures.

STATISTICS ON UNINTENDED PREGNANCIES

QUESTION:

Do you know the statistics on how many children in this country are "unplanned and unwanted"? Isn't this rather difficult to measure?

ANSWER:

Estimates of unintended childbearing come from the National Survey of Family Growth (NSFG) conducted by the National Center for Health Statistics at the Centers for Disease Control and Prevention. According to data from the last cycle of the NSFG, which was fielded in 1988, 40 percent of births to American women aged 15-44 years were unintended-- that breaks down to 28 percent mistimed and 12 percent unwanted.

Births are classified at conception. A mistimed birth is one that was wanted, but occurred sooner than desired. On the other hand, a birth is considered to be unwanted if the respondent reported that, at the time of conception, she did not want a birth then or in the future.

An important problem with this methodology is that it measures intent of a birth according to the mother's attitude at the time of conception. For a number of reasons, it may be difficult for a woman to accurately report her initial attitude toward a pregnancy after the child has been born.

Source: Forrest, J.D. and Singh, S., "The Sexual and Reproductive Behavior of American Women, 1982-1988", Family Planning Perspectives, 22(5), 1990.

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CONTRACEPTION, SEX-UALITY, AND HEALTH

Divider Title: _____

HEALTH PROBLEMS FACING YOUNG PEOPLE

QUESTION:

What are the most pressing health problems facing teens today?

ANSWER:

We've all heard the statistics. Too many young people today are giving up their youths, their futures, and sometimes even their lives. That's because too many young people are engaging in risky behavior -- things like drugs and alcohol, sexual activity, and violence.

But, there is one issue, perhaps more than any other, that is keeping young Americans from living productive lives. That issue is teen pregnancy. President Clinton called it one of the most serious social problems facing our nation.

He is absolutely right. That's why I am so pleased that the President has asked me to help lead a national campaign to prevent teen pregnancy.

I have dedicated my career to teaching young people to abstain from sex and embrace their educations and their futures. I have seen children walk in with almost nothing -- and walk out with a wealth of self-confidence and bold aspirations for the future.

Together, we need to send clear and consistent messages to young people about sex and other risky behaviors.

If you're doing it now -- stop. And, if you're not doing it -- by all means, don't start.

At the same time, we need to give young people something to say "yes" to. Yes to healthy activities. Yes to exercise. Yes to spending time with friends. Yes to school. Yes to jobs. Yes to their families. And, yes to their futures.

SEX EDUCATION

QUESTION:

At what grade level do you think children should begin health/sex education?

ANSWER:

Health and sex education need to begin -- and do begin -- at home. Parents are always the first teachers, whether or not they realize it at the time.

It is up to parents and schools to ensure that children have good, accurate, age-appropriate information on all aspects of health throughout the school years.

It makes sense to teach children, even very young children, about washing their hands before eating, about proper diet, and the connection between today's choices and tomorrow's health.

At the same time, we must never forget that how we teach health education and what we teach about human sexuality are fundamentally local decisions: dictated and implemented by the local community -- not by Washington.

That's how it is right now -- and, clearly, that's how it should remain.

CONDOMS

QUESTION:

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

ANSWER:

Let's look at why teen pregnancies and sexually-transmitted diseases continue to increase.

First, early sexual activity -- and therefore, exposure to risk -- continues to increase among teenagers.

Yes, promoting condom use helps us reduce adolescent pregnancy and STDs. The fact is, condoms, when used consistently and correctly, are very effective in preventing pregnancy and reducing the transmission of STD/HIV infection.

But, condoms, alone, are not the answer.

First and foremost, we must focus on abstinence. We need to teach young people to delay sexual activity. We need to teach them to say "no" to sex and "yes" to their educations, their jobs, and their futures.

We also need age appropriate sexuality education for children so that they may eventually make wise and responsible decisions about their sexuality and acquire the skills necessary to avoid unwanted sex.

And, all of us -- parents, teachers, the media, and others -- need to make sure that those adults and adolescents who are sexually active hear our messages about responsibility and practicing safer sex.

BACKGROUND:

The recently observed increase in the adolescent pregnancy rate can be largely attributed to the continued increase in adolescent sexual activity. In short, improved contraceptive use -- and decreased pregnancy among sexually active teens -- was not sufficient to cancel out the effect of a larger proportion of adolescents becoming sexually active.

CONDOMS IN SCHOOLS

QUESTION:

Why don't we make condoms available in the schools?

ANSWER:

Well, that's a matter for local school boards and parents to decide. We can't dictate that from Washington -- and we shouldn't try.

NORPLANT -- DISTRIBUTION IN SCHOOLS

QUESTION:

Do you support the distribution of Norplant to teenage girls as has been done in Baltimore City schools?

ANSWER:

I am not going to comment on Baltimore, as I am not familiar with their specific program.

But, the important point is that decisions about whether Norplant -- or any other contraceptive -- should be made available at schools should never be made in Washington.

They need to be made at the local level by community leaders, teachers, parents, school boards, and other elected officials.

When we're talking about Norplant, it's important to separate fact from fiction.

Norplant cannot just be "distributed." It must be inserted by a trained clinician - and thorough counseling and clinical assessment are key parts of the process.

BACKGROUND

Norplant is a highly effective contraceptive with some obvious benefits in terms of its long lasting effectiveness. It can be a reasonable option for young women. It is not, however, a cure-all, nor is it the best contraceptive for all persons at all times.

Norplant should be offered as part of a range of contraceptive methods, and individual choices about method should be made freely, without any coercion and with full information about effectiveness and side effects.

Contraceptive choice is important. People use best the contraceptive methods they like. Norplant is far more likely to be removed early if the user feels she did not know about all the side effects and make her choice in a fully informed manner.

QUESTION:

Should Norplant be given to minors without parental consent?

ANSWER:

I am going to speak about contraceptives as a group, because I do not believe that Norplant -- or any other contraceptive -- should be singled out for special requirements.

Let's talk about the law. Currently, there are no Federal laws that require parents to give consent or be notified when their children are obtaining contraceptive services.

Nevertheless, I believe that clinicians -- just like teachers, coaches, and other caring adults -- should be aware of the unique risks for sexually active adolescents and encourage them to discuss their needs with parents or other family members.

NORPLANT

QUESTION:

Would you support federal funding for the distribution of Norplant?

ANSWER:

Programs such as Medicaid and Title X, that cover family planning services for eligible women, already cover Norplant along with the other methods of contraception.

QUESTION:

There are some that claim that Norplant is being used as a form of genocide against African Americans. How do you respond to this sentiment?

ANSWER:

I unequivocally reject it.

MASTURBATION

QUESTION:

Do you believe that the teaching of masturbation should be part of the comprehensive, age-appropriate sex education you advocate?

ANSWER:

I would never presume to lay out a precise curriculum for every community. I also strongly believe that families and parents must take the lead in these types of decisions.

SCHOOL-BASED CLINICS

QUESTIONS:

Do you plan to support school-based clinics? If so, what role should parents play in these settings?

ANSWER:

I believe school-based clinics can play an important role in providing health services to children who might not otherwise receive them. At those clinics, students generally receive a wide range of health care services -- including immunizations, nutrition and weight control, physicals, mental health and counseling services, and programs directed at reducing risky behaviors, like violence, suicide, and substance abuse.

The most crucial factor in determining whether a school-based clinic is the appropriate answer for a particular community is whether the school board, and by extension, the parents of the students, support such an approach. Any school board I have ever been acquainted with has wanted to ensure that parents are in agreement with their plans, especially when they involve sensitive issues like sexuality education.

I absolutely support the right of parents to determine -- and be fully aware of -- services their children receive in school settings.

SCHOOL-BASED CLINICS

QUESTION:

Should all school-based clinics distribute birth control on site? If not, who should decide which programs do?

ANSWER:

I would like adolescents to abstain from sexual activity until they are married. However, despite our efforts to encourage abstinence and delay, we know that many choose to become sexually active early.

It is, therefore, important that we provide the information they need to reduce their risk of pregnancy and sexually transmitted disease.

The truth is, most school-based clinics do not provide contraceptives on site. But, the question of whether these contraceptive and disease prevention services should be provided in schools is best answered by the school authorities, their communities, and the parents of the children -- not by Washington.

SCHOOL-BASED HEALTH

QUESTION:

Are there any school-based clinics in Tennessee? If there are any, what evidence is there to support the argument that they bring down the rate of teenage pregnancy?

ANSWER:

According to the Robert Wood Johnson Foundation, as of October 1994, there were six school-based clinics in Tennessee.

I do not know of any evaluations of school-based clinics that have been able to determine their effect on adolescent pregnancy rates. An accurate count of pregnancies must include births, abortions, and fetal losses. Making such a count is difficult for a number of reasons and would be especially so for a school.

For example, students who became pregnant and decided to carry the pregnancy to term might choose to drop out of school before the birth. Students who became pregnant and miscarried or decided to terminate the pregnancy might not report this to the school. It is easy to see why calculating pregnancy rates for a school population is very problematic and, without these rates, it is impossible to assess the effect of a clinic on adolescent pregnancy.

In addition, school-based clinics are often cited in higher risk communities where there are high drop-out rates because of poor academic performance, financial difficulty, family transience, pregnancy and other reasons, making it particularly difficult to track students for evaluations. Also, not all students in a school will use clinic services and those that do will use different services. Finally, school officials and parents often object to asking students questions about sexual behavior.

I would add, however, that there is a growing body of research indicating that providing sexuality education and school-based health services does <u>not</u> increase levels of sexual activity among adolescents.

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Divider Title: **AIDS AND HIV**

QUESTION:

The American public seems to think AIDS is not an important issue. How can you affect that?

ANSWER:

I disagree with your premise. To cite just one example of public awareness, recently schoolchildren surveyed by *Parade Magazine* indicated that AIDS is one of the most important problems facing our nation. If AIDS has reached into the consciousness of our children, then I think many Americans recognize the seriousness of this epidemic.

But you're right -- we all have to do more. No one is born with a knowledge of AIDS -- every generation of young people has to be taught. And every generation of young adults has to be reminded about the tragic consequences of AIDS -- and about what they must do to protect themselves and their loved ones.

I certainly plan to continue speaking out about on AIDS. I know every health leader in this Administration will as well.

QUESTION:

Isn't your emphasis on abstinence unrealistic and potentially deadly, given the fact that so many young people are sexually active before the age of 18?

ANSWER:

No. My emphasis on abstinence is the healthiest thing in the world. Abstinence is the surest way of preventing the sexual transmission of HIV. That's the fact -- and I have found that young people respect facts and like it when adults talk honestly with them.

There's another fact that I like to tell young people: Millions of their peers have chosen abstinence. We must not allow our young people to think that being sexually active at their age is the social norm.

But for those people who are sexually active, the correct and consistent use of latex condoms is highly effective at preventing transmission.

NEEDLE EXCHANGE

QUESTION:

Do you support the distribution of clean needles to intravenous drug abusers as a means of slowing the spread of HIV?

ANSWER:

Several dozen local communities are experimenting with needle exchange programs at their own expense. This is a local decision -- and I certainly support the idea that communities should be able to design prevention strategies that meet their local needs.

However, the federal government has no role in funding these activities. Indeed, federal legislation on this matter is crystal clear. Until there is conclusive data that such programs both reduce the spread of HIV and reduce drug use, federal funding cannot be spent on needle exchange programs.

good answer —

AIDS FUNDING

QUESTION:

Why should we spend so much money for AIDS, compared to cancer or heart disease, which kill so many more Americans?

ANSWER:

I'm not going to pit one disease against another. Every person who is ill deserves our compassion, resources and energy.

AIDS is a growing global epidemic. It has become the leading cause of death among all Americans between the ages of 25 and 44. It is robbing our nation of young people at their most productive ages. Last year alone, some 81,000 Americans were diagnosed with AIDS -- that's 220 Americans every day. And in 1994, an average of 109 Americans died of AIDS every day. That's one person every 13 minutes.

The US must take the lead -- in this country and around the world -- in fighting this epidemic. This means a couple things:

It means making a strong commitment to <u>research</u> -- to find effective treatment strategies and ultimately a vaccine and a cure. Let me emphasize that much of our AIDS research resources are targeted to <u>basic</u> research, which means the findings we generate help us understand the causes of many deadly diseases -- including cancer.

It also means making a strong commitment to <u>prevention</u>. Remember, unlike cancer and heart disease, AIDS is a <u>communicable</u> disease -- so we must devote ourselves body and soul to preventing its transmission. That is what I have tried to do.

AIDS FUNDING

QUESTION:

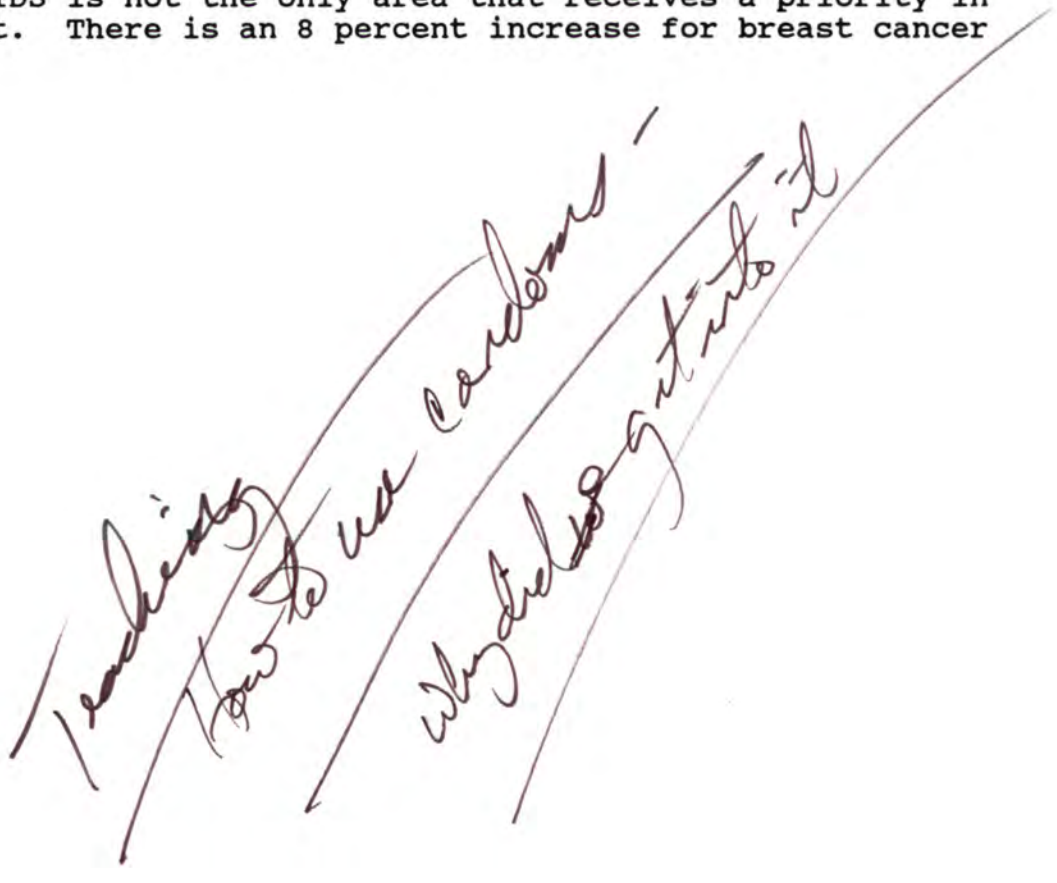
How can you justify more of a spending increase in AIDS research at NIH than for the rest of NIH?

ANSWER:

AIDS is a global epidemic for which we need more effective treatments, a vaccine, and a cure. It will go down in history as one of the defining health challenges of the 20th century -- and it should be one of our highest priorities.

Moreover, all research is integrally related. The understanding we are gaining through AIDS research -- about viruses, about the immune system, about vaccine development -- all are contributing vastly to other fields of biomedical research.

By the way, AIDS is not the only area that receives a priority in the NIH budget. There is an 8 percent increase for breast cancer research.



AIDS FUNDING

QUESTION:

How do you answer those who suggest cutting the AIDS budget?

ANSWER:

I say, that would not be the wisest course of action.

Fortunately, the AIDS Budget receives bipartisan support -- because members on both sides of the aisle recognize that we are facing a national epidemic that claims thousands of precious lives every month.

A recent CDC report shows that AIDS is in every congressional district. It is a growing problem in communities that probably never thought they would have to face this horrible disease. For example, 35 percent of the new cases reported last year were in the South.

We need to continue to make a full commitment to research, treatment, and prevention of AIDS.

AIDS FUNDING

QUESTION:

News reports on the statistics for AIDS in 1994 suggest that the AIDS rate is slowing down. Why do we need more money?

ANSWER:

First, there's been some misunderstanding about that number.

There was a bulge in reported new cases in 1993 because the CDC adopted a new definition of AIDS. That's why it appeared that new cases had declined in 1994. The 81,000 new cases reported in 1994 actually represent a 3% increase over 1993, when you adjust for the new definition.

Second, the statistics show a disturbing trend that the epidemic is spreading to more populations. Heterosexuals and women in particular are an increasing share of the new cases. The prevention lessons learned by the gay community need to be extended to other communities.

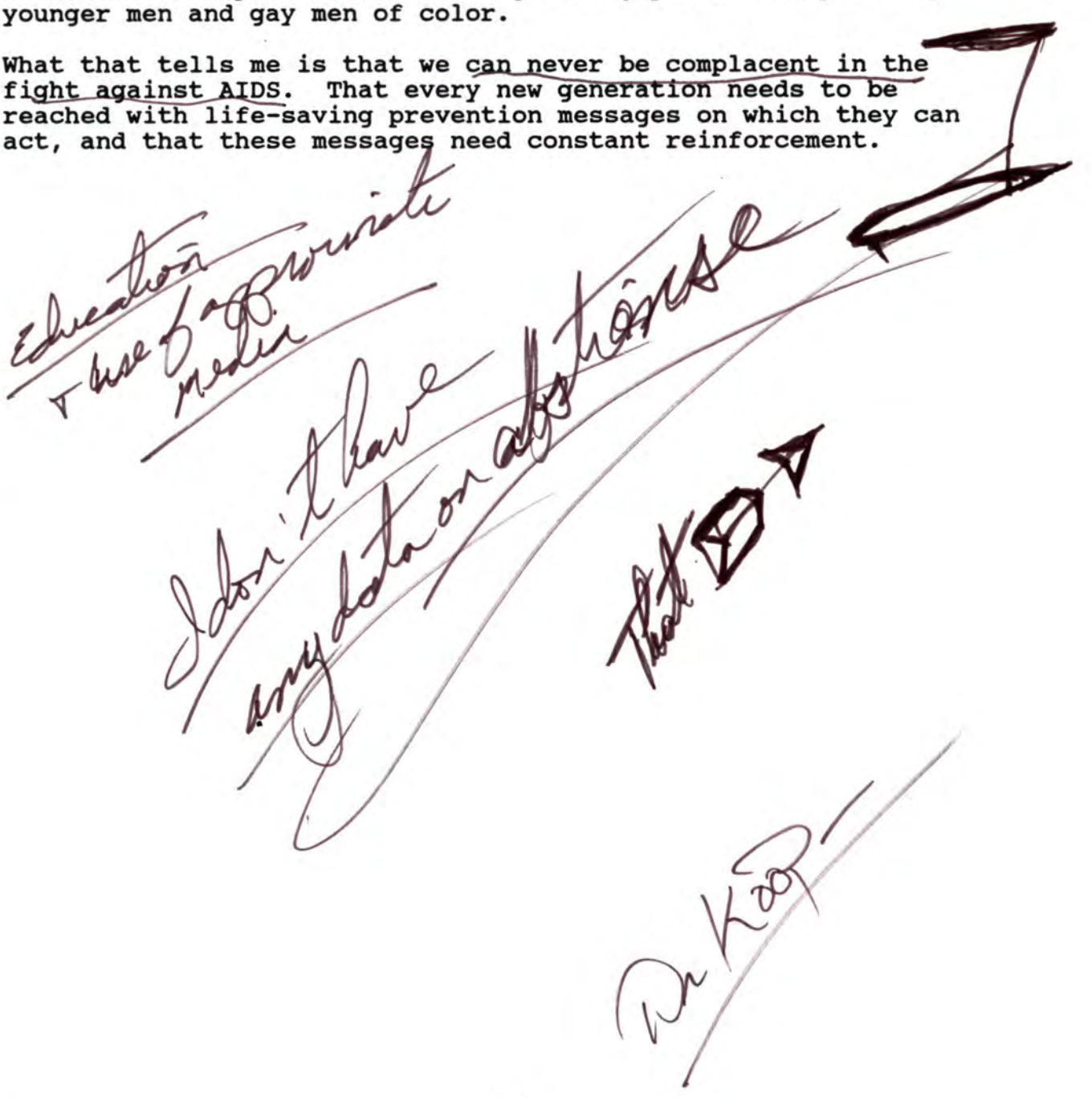
QUESTION:

But hasn't there been a "relapse" into unsafe sex among gay men?

ANSWER:

There's been some data suggesting that there have been slight increases in unprotected sex among some gay men -- especially younger men and gay men of color.

What that tells me is that we can never be complacent in the fight against AIDS. That every new generation needs to be reached with life-saving prevention messages on which they can act, and that these messages need constant reinforcement.



AIDS FUNDING

QUESTION:

Last year the Administration proposed a freeze in AIDS prevention money. Why an increase this year?

ANSWER:

Over the last 18 months, under the leadership of David Satcher, we have seen major changes in the AIDS prevention programs at the Centers for Disease Control and Prevention. We have seen the development of community planning. We have seen a comprehensive external review of the CDC's programs. We have seen an HHS review of prevention programs. And we have seen a major reorganization at the CDC.

Each of these changes has demonstrated ways that more funds can be targeted -- wisely and effectively -- to improve America's prevention efforts.

QUESTION:

Why hasn't the Administration proposed a Manhattan Project for AIDS?

ANSWER:

While it is true that this budget does not propose moving the NIH AIDS program to Manhattan -- New York or Kansas -- I think the Administration's new approach to AIDS -- through the leadership of Bill Paul at the Office of AIDS Research -- does indeed accomplish the same objectives as those intended by supporters of a Manhattan Project.

The OAR is providing focused leadership to make sure that the efforts of scientists are well coordinated without stifling the creative ingenuity that is so much a part of the traditional approach to biomedical research.

QUESTION:

There's been talk in Congress about doing away with OAR. What impact would that have?

ANSWER:

The work of the OAR is very important. It has provided new direction, greater flexibility, and focused leadership to what has been a diffuse effort throughout the NIH.

For the first time we have a real, comprehensive plan that sets out scientific objectives without stifling scientific creativity. We need that leadership. And I am confident Congress -- once it sees this new budget and the new plan for AIDS research -- will recognize OAR's value.

QUESTION:

Dr. Paul laid out an AIDS research program in a recent edition of Science magazine. Is there enough money in the President's budget to carry out that plan?

ANSWER:

Yes. While there will always be some unmet need, this increase -- and the new direction Dr. Paul is giving to existing resources -- should permit the Administration to begin implementing this important effort.

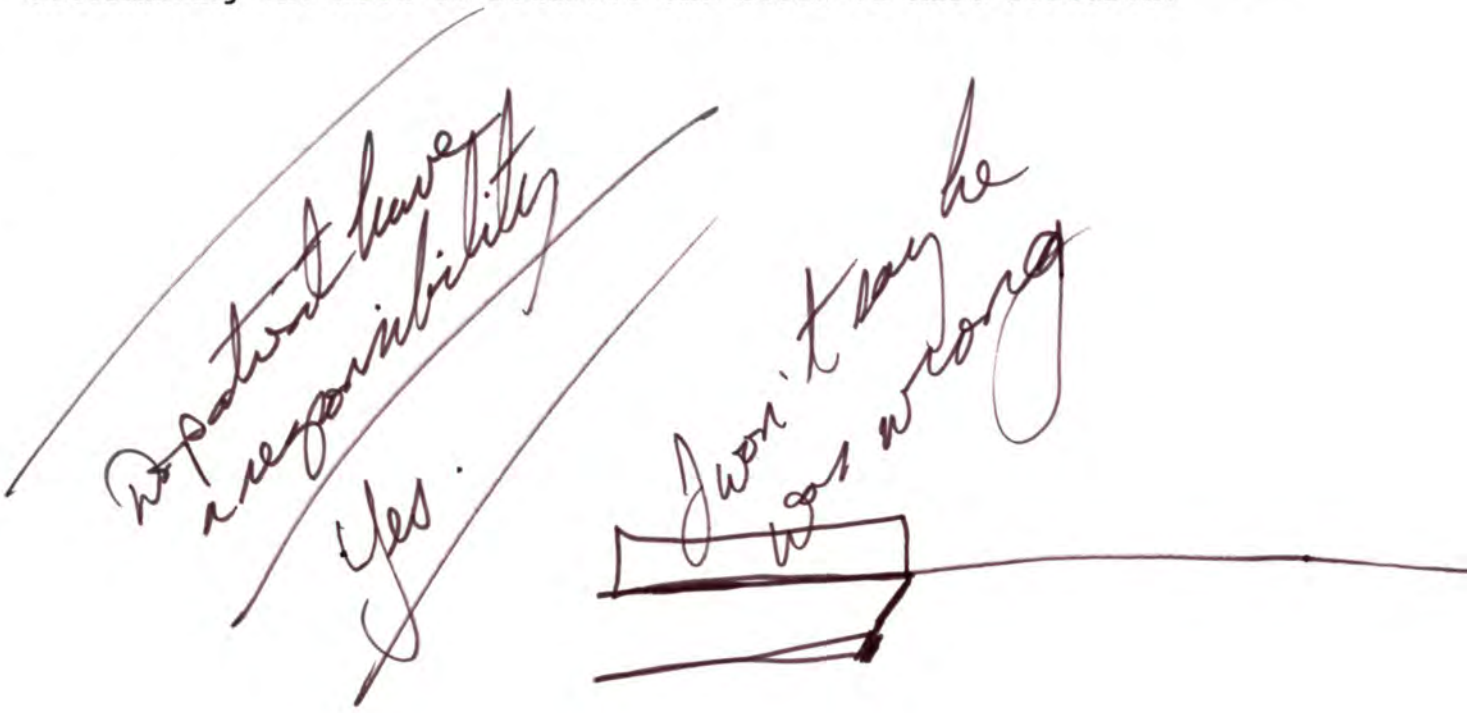
QUESTION:

Dr. Paul just published an article in Science magazine suggesting that there is too much focused research at NIH. Doesn't that argue against a strong Office of AIDS Research?

ANSWER:

Ironically, the opposite is true. It has taken Dr. Paul's leadership at OAR to bring this issue to light and to redirect AIDS research efforts toward investigator-initiated basic research.

We need this kind of basic research so that we have more drugs and vaccines to put into clinical trials. Sometimes it requires an office a little bit detached from the routine of working with grantees to recognize that priorities and funding mechanisms have become skewed in some way. I applaud Dr. Paul for his honesty in determining the need to redirect the focus of AIDS research.



QUESTION:

Why have a special program for AIDS care when there isn't for any other disease?

ANSWER:

The Ryan White CARE Act programs were created because of the new and concentrated -- and rapidly rising -- burden that HIV/AIDS has placed on our nation's health care system. The Ryan White program is designed to keep people out of the hospital -- keeping them productive in the community.

Make no mistake, the AIDS epidemic has placed enormous burdens on the health care systems of many communities. Prior to the enactment of Ryan White, public hospitals and other facilities were often overburdened by people with AIDS and were unable to provide them with the special care they needed. Now, many of these patients are being seen on an outpatient basis in facilities, and by health care professionals, that are designed for their needs. The result is better care at a lower price.

That's why the Ryan White CARE is in place and is so important.

BACKGROUND:

The Act contains four titles.

Title I provides grants to cities severely impacted by AIDS (defined as cities with a cumulative total of 2,000 or more reported cases since 1981). Currently 42 cities receive Title I funding.

Title II provides grants to the states based on a formula. Currently, all 50 states, the District of Columbia, and Puerto Rico receive Title II funding.

Title IIIb provides grants to clinics and community based organizations that provide primary care to people with AIDS.

Title IV provides funds for research and services related to pediatric AIDS.

QUESTION:

Why not block grant Ryan White?

ANSWER:

Ryan White works very much along the same philosophical principles as a block grant: having states and localities determine the best way to spend their money. It makes little sense to dismantle a program that works.

Quite frankly, it is also important to retain a separate identity for AIDS programs because of the changing nature of the epidemic: we need to be able to respond quickly to new care demands -- such as the new findings that AZT treatment for pregnant women with HIV can help prevent the perinatal transmission of the disease.

AIDS PROGRAMS AT CDC

QUESTION:

CDC is reorganizing its AIDS programs. How will that work?

ANSWER:

Until now, the CDC's AIDS programs have been spread throughout a number of centers. They are going to be consolidated, for the most part, into one Center for HIV/STDs/TB. This makes sense: The CDC will bring together related programs to improve their coordination and allow experts in related fields to learn from one another. This change is reflected in the consolidated grant proposal as well.

QUESTION:

Can you explain how the CDC block grant would work?

ANSWER:

First, this is not a block grant, it is a consolidation of programs. CDC will retain its leadership role in monitoring the epidemic, in developing models of prevention, in translating the knowledge of what works in HIV prevention to the field.

As you know, the CDC initiated this year a process of community planning -- where the HIV community and health departments worked cooperatively to develop a needs-based plan for spending federal prevention dollars. This effort will continue, but it will embrace a larger portion of money already going into the field.

Over the next three years, states will transition into including STD and TB programs in this community planning process. This is good for all the programs -- the overlapping populations affected by HIV, STDs, and TB is considerable -- and it will increase the likelihood that people will receive comprehensive services in an integrated fashion.

QUESTION:

What will prevent HIV money from being diverted to other problems under the consolidation at CDC?

ANSWER:

This consolidation does not mean the end of accountability. While states and localities will have greater flexibility, they will continue to do needs assessments and prioritizations that reflect the epidemiology in their communities.

MANDATORY AIDS TESTING

QUESTION:

Why don't we just test everyone so that we know who is infected with HIV and who isn't?

ANSWER:

I think it was H.L. Mencken who said that for every complex problem there is always a simple answer -- and that answer is usually wrong.

Remember what our overriding goal is: To make sure that people have all the information they need to protect their health.

That means educating them about the virus -- both how it's spread and how transmission can be prevented. That means making testing and counseling available in their communities so that people can learn their status. And that means making services available to people with HIV or AIDS so that they can maintain their health as long as possible.

Mandatory testing undermines all these goals. We have learned that mandatory testing only serves to drive people away from seeking out prevention and treatment services. For example, when states began requiring people to be tested before they got married, couples went to other states to get married so that they could avoid being tested.

MANDATORY AIDS TESTING OF PREGNANT WOMEN

QUESTION:

The new proposed Public Health Service guidelines on HIV testing recommend that all pregnant women be tested for HIV, but they do not mandate it. Why not make it mandatory, especially given AZT's potential for significantly reducing perinatal transmission of the virus?

ANSWER:

The results of the 076 trial are indeed encouraging. The trial showed that in some HIV-infected pregnant women, a treatment regimen of AZT reduced the risk of HIV transmission from mother to baby by two-thirds.

That said, I do not favor mandatory testing. I understand its appeal at first glance -- but 38 years of practice tells me that mandatory testing will cost more children's lives than it will save.

Our experience shows that counseling women about the benefits of testing is the best way to ensure that they take the test and participate in follow-up treatment strategies.

However, mandatory testing tends to drive people away from the medical establishment, rather than helping them learn their health status. Under mandatory testing, some pregnant women will avoid seeing a doctor for prenatal care. This is counterproductive -- and ultimately dangerous for children.

Moreover, mandatory testing breaks down the bonds of trust between patients and the medical establishment -- bonds that are crucial to making sure that patients who do test positive for HIV or AIDS stick to their treatment regimen -- which, in the case of AZT, is extremely rigorous.

I support the CDC draft guidelines that recommend routine counseling of all pregnant women in the U.S. on the benefits of HIV testing. Women should be given the option of voluntary testing to learn their HIV status. This counseling should not be judgmental or coercive in nature. Studies show that when women are given this kind of counseling, an overwhelming majority -- 75 to 95 percent -- agree to be tested.

By the way, mandatory testing is also contrary to this nation's tradition of informed consent. It has been rejected by an overwhelming majority of public health experts.

AIDS DISCLOSURE

QUESTION:

Shouldn't patients be required to tell health practitioners whether they are HIV-positive, and vice versa?

ANSWER:

Ideally, patients should feel comfortable sharing this information with their caregivers, who could use the knowledge to improve their care and treatment. But even if patients do not volunteer this information, health care practitioners who follow universal precautions are not at risk.

HIV-positive health care practitioners who follow universal precautions do not risk infecting their patients. I do not believe they should be required to inform them.

QUESTION:

Shouldn't the President show more passion about AIDS?

ANSWER:

The President has shown great passion -- and he has backed up his words with deeds. Look at his budgets. Look at his appointments. Look at the leadership this Administration has shown in moving the AIDS agenda forward. It is an unprecedented record, and it would be an honor to join this team in its effort to save lives and save futures.

AIDS -- IMMIGRATION

QUESTION:

Many AIDS activists and health professionals contend that U.S. immigration restrictions barring entrance to HIV-infected foreigners is a violation of their human rights and won't help slow the spread of AIDS. How do you feel about these restrictions?

ANSWER:

It's the law. In June 1993, Congress passed a law requiring that HIV infection be included on the list of "communicable diseases of public health significance" for purposes of determining ineligibility for visas to the U.S.

However, HIV-infected non-immigrant travelers may visit the U.S. under special waivers.

A 30-day waiver is available to attend conferences, receive medical treatment, visit close family members or conduct temporary business activities in the U.S.

A ten-day waiver is available to attend scientific, professional or academic conferences, or other events which the Secretary of HHS advises are in the public interest.

AIDS -- IMMIGRATION

QUESTION:

Last year, waivers were made available to HIV-infected homosexuals attending the Gay Games. Wasn't it a stretch to say this event was in the public interest?

ANSWER:

No. The Gay Games are an athletic contest modeled on the Olympics. Sports, athletic competitions and physical fitness are all in the public interest. Also, it is in the public interest for all Americans to understand that people living with AIDS and HIV can live full and productive lives, and that includes having the opportunity to compete in world-class athletic events.

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Divider Title: **WOMEN'S HEALTH**

BREAST CANCER

QUESTION:

What can we do about breast cancer?

ANSWER:

We can do a lot, and we must. We must work even harder to educate women and their families about the benefits of early detection and treatment of breast cancer.

As a physician for 38 years, I've seen breast cancer rates skyrocket. Although we have more successful treatment strategies and more successful outcomes now than ever before, we still lose 46,000 women every year to breast cancer.

As a doctor, as an American, as a husband, and as a father, I'm sure everyone in our country today -- including everyone in this room -- knows someone who has developed breast cancer. From my years as an OB, I know that many women are still paralyzed by fear -- and that they do not always act in time to prevent breast cancer.

As Surgeon General, I would work to educate all women about prevention, and all health professionals about their role in making exams and screenings a routine part of their care. The schools should also be involved in this effort.

- We must educate women from an early age about the need to self-examine their breasts.

- Then, as women age, we must make it routine that they come in for regular clinical exams and mammogram screenings.

- And as health professionals, we must do all we can to ensure women get regular clinical breast exams, and educate them that early detection of this disease is the closest we are to a cure.

- All health professionals should also work to help dispel myths and soothe the fears that keep women from asking about routine exams and screenings. The First Lady's campaign to urge older women to have mammograms will be a great help in this regard.

I am honored to have the opportunity to join the Clinton Administration precisely because this Administration has worked hard to prevent the tragedy of breast cancer from doing more harm.

- The President increased research funding dramatically.

- Secretary Shalala convened a 1993 conference that produced the National Action Plan on Breast Cancer, a strategic plan to expand research and promote public awareness that is already getting results.

- And major improvements have been made by the Public Health Service to improve the quality of, and the access, to screenings and mammograms.

BACKGROUND:

SCOPE OF THE ILLNESS

Breast cancer is the most commonly diagnosed cancer -- 186,000 more women each year are diagnosed with the disease. It is the second leading cause of cancer deaths among American women. Breast cancer rates are highest among older women, and mortality is greater among minority, and low-income women.

ACTION BY THE CLINTON ADMINISTRATION

From the start, the Clinton Administration has taken a leadership role in the fight against breast cancer.

- The President met with breast cancer activists in the White House in 1993 and promised women he would increase federal efforts to combat the disease.

- Secretary Shalala organized a December, 1993 conference on breast cancer, calling together policymakers, scientists, researchers, and activists to mount a new and strategic war on breast cancer. An interagency group of 14 federal agencies is now implementing the coordinated National Action Plan.

- Because early detection and treatment are the keys to fighting breast cancer, the Public Health Service has been active in promoting those goals. By the end of 1994, the CDC's National Breast and Cervical Cancer Early Detection Program began offering free mammography screening to uninsured, low-income elderly, minority, and Native American women in 25 states. The CDC is working in partnership with the remaining states to establish greater access to screening and follow-up services. Screening rates are now at their highest levels ever.

- The PHS Agency for Health Care Policy and Research has developed a Clinical Practice Guideline for mammography providers, health care professionals, and consumers, to help provide guidance on quality mammography.

- The PHS Office on Women's Health continues to work with DoD, the CIA, NASA, and others to explore ways in which new research technology from defense, space, and other imaging-related fields can be used in the early detection of breast cancer.

- Since last year the FDA has begun a process to evaluate and certify all 10,000 mammography facilities around the country. This will ensure that women can rely upon the quality of the mammographies they receive.

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QUESTION:

What is your position on how frequently and when women should get mammograms?

ANSWER:

Regular mammograms are recommended for all women over age 50 because their use can cut the death rate from breast cancer by a third. Women younger than age 50 should receive mammograms if their doctor recommends them.

More specifically, women who are age 40 to 49 with risk factors for breast cancer or a family history of the disease should discuss their need for a mammogram with their health professional. Whether or not women in this age group decide to have a mammogram, many experts believe they should have a thorough breast examination by their caregivers once a year. In addition, many doctors recommend breast self-examination.

QUESTION:

Does it make a difference if a woman is screened every year or every two years?

ANSWER:

Experts agree that regular screening with mammography is recommended for women over age 50. Some of the experts recommend that mammography be done yearly; others recommend every two or three years. Studies of mammography evaluated the test when it was performed in regular time intervals. These time intervals varied, but the effectiveness of mammography was about the same whether the interval was one year or two.

BREAST CANCER

QUESTION:

How can we account for the worse outcomes in cases of breast cancer among African-American women?

ANSWER:

I've worked my entire career in medicine to increase access to health care. I've seen the tragic consequences of disparities in health care, and in particular, the disparity in breast cancer rates in African-American women.

It is especially critical that we heighten our public awareness messages about breast cancer in minority communities, where mortality rates are higher. While we recently celebrated the latest results of a study showing that for the first time in four decades, we had an overall decrease in breast cancer mortality -- death rates among minority women actually increased 2.6 percent among African Americans. This disparity must end.

Black and Hispanic women have less access to affordable health care, and are less likely to have insurance to cover treatment once their cancer is diagnosed.

Of course, it is essential to improve the quality of our health care system so that we reach all women, regardless of race, age, or ability to pay. This is cost-effective, as well as good medicine. African-American women are more likely to see a health professional with advanced-stage breast cancer, and this only makes the disease more costly to treat, and more difficult to cure.

As Surgeon General, I will work to promote greater awareness of the need for regular clinical breast exams and mammography screening among minority women. I will also work to inspire other health professionals to join me in this effort. And I will work to strengthen the confidence of minority women in our health system.

While we do not have a complete answer regarding the cause of this disparity, we do know that part of the answer lies in improving early detection and access to care. We must continue to support the work at the CDC to provide states with free mammography screening to uninsured, low-income elderly, and minority women across the country.

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MARIJUANA AND OTHER NARCOTICS

Divider Title: _____

DRUG USAGE

QUESTION:

The recent Monitoring the Future (MTF) Survey shows that fewer students believe using marijuana is harmful to their health, and more young people are using marijuana. Is this evidence that the Administration is not sending out a tough enough message on drugs?

ANSWER:

Absolutely not. This Administration has worked tirelessly on all fronts to combat drug use in this country. I understand that this year's budget provides more funding for the war on drugs than ever before, with a balanced approach that includes law enforcement, treatment, and education. I commend the leadership of Lee Brown on this issue, as well as the work of Attorney General Reno and Secretaries Shalala and Riley. I believe that this Administration is truly serious about getting drugs out of our communities.

It is important to note that total drug use has shown substantial declines over the past decade. The great majority of teens don't use illegal drugs, and drug abuse among our youth today is far lower than it was in the 1980's. However, I am deeply concerned about the increase in adolescent drug use and the changes in young people's attitudes towards marijuana. In my work, I have seen the terrible effects of drugs upon young people and have worked hard in my community to help teens avoid drugs.

The solution to the problem of drug use lies in sending a clear message that drug use is dangerous and wrong. A big problem in recent years has been that the anti-drug message is fading in the media and in the popular culture generally. I applaud the work of groups such as the Partnership for a Drug Free America, which uses the media to educate Americans about the danger of drugs. As Surgeon General, I will work with groups like the Partnership to make sure that we get our anti-drug message out as strongly as we can.

BACKGROUND:

The Monitoring the Future (MTF) Survey, funded by the National Institute on Drug Abuse (NIDA) and conducted by the University of Michigan, measures drug use and attitudes about drug use among high school students. The findings from the 1994 survey were released in December.

The 1994 survey showed a continuation in the increased use of marijuana among 8th, 10th and 12th graders, an increase that has been occurring since 1991. Some other categories of drug use

also rose, and anti-drug attitudes deteriorated, the survey found.

Specifically, the survey found that among 1994's high school seniors, 30.7 percent said they had tried marijuana at least once in the past year, compared to 26 percent of 1993's seniors and 21.9 percent of 1992's. However, the figures remained lower that most past years measured by the survey: in 1979, 50.8 percent of seniors had tried marijuana, and the percentage was over 40 percent from 1975 through 1985. Also, the perception of risk of using other drugs -- such as LSD, cocaine, and crack -- is also declining among younger teens.

The Administration has pointed to drug-glorification images in much of the popular culture as an important factor in the increased use of some drugs among the students and the decreased perception of harm arising from drug use.

LEGALIZATION OF DRUGS

QUESTION:

Do you believe we should legalize illicit drugs? Should we study the legalization of illicit drugs?

ANSWER: No. I firmly believe that illegal drugs should remain illegal. Through my work in local communities, I have seen the devastating toll that drugs are taking on our society, and know that we must do all we can to prevent the use of drugs. I believe that legalizing drugs would only lead to more drug use and I am strongly opposed to legalization or the study of legalization.

I find support for this view in the extremely worrisome results of the recent Monitoring the Future survey of American teenagers. The study showed a rise in use of marijuana in teenagers beginning about three years ago, along with a growing acceptance of marijuana as something that will not cause harm to one's health. I am extremely concerned about this trend. In order to stop it, we must send a strong, clear message about the dangers of drugs -- quite the opposite of legalizing drugs. We must tell our teens unequivocally that drug use is dangerous, unhealthy, illegal, and wrong.

MEDICINAL USE OF MARIJUANA

QUESTION:

Do you support the medicinal use of marijuana?

ANSWER:

As a physician, I would not recommend the use of marijuana to any patient. There is no scientifically sound evidence that smoked marijuana is superior to currently available therapies for any medical problem, and medications that contain the active ingredient in marijuana are currently available.

MEDICINAL USE OF MARIJUANA

QUESTION:

Would you endorse allowing new patients into the single patient (compassionate) IND program for the use of marijuana?

ANSWER:

It is my understanding that PHS has determined that it will not provide marijuana for new participants in the single patient IND program, and I agree with that decision.

MEDICINAL USE OF MARIJUANA

QUESTION:

Should the government support research into the medicinal use of marijuana?

ANSWER:

No. I believe, the government does not have any plans to support research into the medicinal use of marijuana, and I do not believe that it should. There is no scientifically sound evidence that smoked marijuana is superior to currently available therapies, such as Marinol, which contains the active ingredient in marijuana, for any medical problem.

If private researchers want to pursue such research, they are free to do so, as long as they follow the DEA rules on research with controlled substances and the standard FDA rules on clinical research.

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TOBACCO

Divider Title: _____

STOPPING AMERICANS FROM SMOKING

QUESTION:

Every Surgeon General since Luther Terry in the mid-sixties has spoken out against smoking. In this tradition, what do you plan to do to get Americans to stop smoking?

ANSWER:

As the Surgeon General, one of my central responsibilities is to provide Americans with the best information available to improve their health.

The statistics are clear: when you smoke, you endanger your health. According to the Centers for Disease Control and Prevention, more than 400,000 Americans die from smoking-related causes each year -- that's one in five American deaths!

As a physician and an educator, I cannot be indifferent to the toll that smoking exacts on so many Americans.

The truth is, smoking-related diseases not only cut short individual lives, but they also create a serious financial burden for this country. In 1990, smoking-related illnesses cost the nation an estimated $50 billion in health care costs alone.

While tobacco use is a serious, significant health problem, government should not be in the position of banning its use.

Instead, we must use the power of education and persuasion to convince Americans who are smoking to quit -- and those who aren't to stay away from it.

BACKGROUND:

- The Surgeon General has no authority to control the use of tobacco products; the warning that is printed on the label and advertisements of cigarettes is mandated by federal law.

NICOTINE AS DRUG

QUESTION:

Do you believe that nicotine is a drug? Do you believe that tobacco companies manipulate the nicotine-content of their tobacco products? Do you believe that tobacco products should be regulated by the FDA?

ANSWER:

Yes, Nicotine is a naturally occurring drug. And, yes, cigarettes also contain other dangerous elements like tar and carbon monoxide.

But, I personally have no information about tobacco companies influencing the content of nicotine and other chemicals in tobacco products. The question of whether the FDA regulates tobacco is a matter for that agency and the Congress to decide.

My role is clear. The job of the Surgeon General is to make sure Americans have the information they need to understand the health consequences of their actions.

As Surgeon General, I will take every opportunity to urge all Americans to stay away from tobacco products; and I will especially urge young people not to take up smoking.

BACKGROUND:

- There is considerable fear among tobacco interests that FDA will attempt to exert control over cigarettes based on an assertion made last year by Dr. Kessler that tobacco companies may be manipulating the nicotine content of cigarettes, thus making them subject to the Food, Drug and Cosmetics Act. The FDA review is continuing.

IS NICOTINE ADDICTIVE?

QUESTION:

Do you believe that nicotine is addictive? If so, shouldn't tobacco products be banned, like other addictive drugs are?

ANSWER:

Obviously, many of us have seen addicted behavior traits in most people who smoke. And, there appears to be some scientific evidence that nicotine has an addictive influence on the brain.

But, the extent to which nicotine is addictive would be a matter for a medical researcher, not a Surgeon General, to determine.

Moreover, as the folly of Prohibition taught us, we cannot ban a drug merely because it is addictive.

Over the years, tobacco products have been available to those who choose to use them. And, now that we better understand the dangers that those products impose, the role of the government is to encourage its citizens not to choose to use them anymore.

I am fundamentally convinced that the government cannot make these personal individual decisions for our fellow Americans -- they must do so themselves.

QUESTION:

Should cigarette smoking be banned in the workplace? Do you see it as the responsibility of the Surgeon General to advocate the elimination of cigarette smoking when non-smokers might be affected?

ANSWER:

This is a difficult question, since we are only just beginning to understand that smoking has a serious health affect on people who choose not to smoke. There is something fundamentally unfair about that.

The Surgeon General's responsibility is to make sure that all Americans -- those who smoke and those who don't -- understand the real health risks of tobacco products.

However, it is up to the Congress and the appropriate federal agencies to determine the most fair and effective legal solution to the problem of second-hand smoke.

TOBACCO TAX

QUESTION:

Do you support increasing the tax on tobacco products to pay for health care reform initiatives or for any reason?

ANSWER:

According to the Tobacco Institute, in 1993, nearly $12 billion in excise taxes were collected from cigarettes and other tobacco products. That breaks down to:

- $5.5 billion by the federal government.
- $6.2 billion by the states.
- $187 million by local governments.

The amount of this excise tax varies significantly across state lines -- from 65 cents a pack in the District of Columbia to 2.5 cents a pack in Virginia.

Our federal excise tax on cigarettes is 24 cents a pack -- that's the lowest excise tax imposed by any industrialized nation.

At this time, I wouldn't advocate increasing the federal excise tax on cigarettes. I would make the case against smoking on its merits.

CIGARETTE ADVERTISING

QUESTION:

What is the role of the federal government in regulating the advertising of tobacco products? Should cigarette warning labels be larger? More strongly worded? Should print advertising by tobacco companies be banned altogether? Should product-endorsements for sports and athletic activities be banned?

ANSWER:

No doubt, there is considerable evidence that tobacco companies skew advertising to target younger smokers.

Because advertising is an effective medium of persuasion, it seems to me that we have a responsibility to offer sufficient information about the health risks of smoking to make this type of message less effective.

Our goal should be to provide the information citizens need to make their own choices. For my part, I am strongly convinced that if we continue to make smokers and potential smokers aware of the terrible health problems associated with smoking, chewing and dipping, and if we offer strong encouragement to our young people to make the healthful choice -- that more often than not, people will do the smart thing: the healthy thing.

Canada requires cigarettes to carry warning labels covering 25 percent of the major face of the product. These labels are simple and direct, containing frank admonitions like "Cigarettes are addictive" and "Smoking can kill you."

I believe that labels like these can provide useful and effective information. And, I look forward to seeing the behavioral studies.

SMOKELESS TOBACCO ADVERTISING FOR TEENAGERS

QUESTION:

Do you believe that tobacco companies are tailoring their smokeless tobacco products to entice teenage users? Should such practices be controlled or prohibited?

ANSWER:

I believe the most important responsibility the Surgeon General has in the area of tobacco use is to find ways to persuade youngsters not to begin smoking or chewing.

I am deeply concerned about indications that tobacco companies manipulate the contents of their products to make them more attractive to very young users.

Certainly, the numbers should give us cause for concern:

From 1970 to 1986, the prevalence of chewing tobacco among teenage males, 17 through 19, rose from 1.2 percent to 5.3 percent.

Moreover, youngsters are beginning to use smokeless tobacco at early ages. In fact, among present users, a significant number (23 percent) began before 6th grade.

Clearly, the office of the Surgeon General should be devoted to finding effective and imaginative ways to make sure youngsters don't begin smoking, chewing, or dipping.

CONTROLLING TOBACCO USE BY TEENAGERS

QUESTION:

How should the use of tobacco products by teenagers be controlled or eliminated? Should the federal government control advertising content, style, or markets?

ANSWER:

We must send a clear message: Like alcohol, tobacco should not be legally available to teenagers.

We know that the teenage population is far from homogeneous -- and our strategies to combat tobacco use must be varied as well.

We must more effectively restrict the ready access to vending machines -- where many underage purchases of cigarettes occur.

We should also team up with tobacco companies and health education groups -- like the American Lung Association and the American Heart Association -- to create effective advertising that persuades youngsters not to take up tobacco use.

And, we should call on the tobacco industry not to promote their products in a manner that entices young people to smoke.

Finally, the Surgeon General should be engaged in a relentless campaign to find as many opportunities as possible to make the case to teenagers that it is much easier to resist that first cigarette or chewing tobacco -- than it is to stop using it once you've started.

SMOKELESS TOBACCO AS AN ALTERNATIVE TO CIGARETTES

QUESTION:

Isn't the use of smokeless tobacco an acceptable alternative to smoking, since it doesn't affect the indoor air that others must breathe and won't cause lung cancer?

ANSWER:

As a physician, I could never say that the use of smokeless tobacco is an acceptable alternative to smoking.

No one should fool themselves. The health risks associated with smokeless tobacco are serious. It increases the risk of developing cancers of the larynx and esophagus, as well as gum, tongue, cheek, pharynx and other oral cancers. And, the longer you use smokeless tobacco, the greater your of developing these cancers.

What's more, the use of smokeless tobacco products may result in cardiovascular effects similar to those experienced with cigarette use. For example, an increased risk of hypertension has been found among users of smokeless tobacco.

Finally, smokeless tobacco seems to be at least as addictive as cigarette smoking.

PROMOTING TOBACCO ABROAD

QUESTION:

If you oppose smoking and tobacco use among Americans, will you also bring the anti-smoking message to other countries, especially in the emerging markets in Asia, that import American-grown tobacco? Isn't it hypocritical for the federal government to spend so much effort persuading Americans to stop smoking, while the Commerce Department is seeking favorable trade agreements to promote American-grown tobacco?

ANSWER:

It would be questionable to require that other countries impose more stringent requirements on their citizens than we impose on ours.

As a physician, I do not believe that anyone, wherever he or she lives, should use tobacco; however, as Surgeon General, my responsibility would be to the American public.

BACKGROUND:

The office of the US Trade Representative has negotiated several trade agreements to promote the export of American-grown tobacco. Agreements currently in place have been reached with Turkey, Taiwan, China, Thailand and South Korea. The government of South Korea has requested renegotiation of its trade agreement specifically to change the restrictions on advertising and promotion and to allow an ad-valorem tax. The USTR has no objection to tightening the advertising restrictions; however, the Trade Representative's office does object to the tax proposal because it would favor domestic tobacco over American tobacco. The renegotiation is nearly complete and should be finished in mid to late April.

Additionally, the USTR and HHS co-chair a working committee of federal agencies that is reviewing the relationship between international health and US tobacco trade policy. This committee will issue a White Paper on Tobacco Exports.

In May 1990 and December 1992, the GAO produced reports that found that US policy and programs for assisting the export of tobacco and tobacco products work at cross purposes to US health policy and initiatives, both domestically and internationally. To address this discrepancy, the USTR has established a procedure for consulting HHS on issues related to tobacco trade policy and for including HHS on the Trade Policy Review Group.

UNDER-AGE ACCESS TO TOBACCO

QUESTION:

Current federal law requires states, as a condition of receiving federal substance abuse block grant funds, to prohibit the sale or distribution of tobacco products to persons under the age of 18. How should that law be enforced? Should the local police be required to carry out "sting operations" in local convenience stores? Should vending machines be banned? or should the federal government regulate their placement so that they are not available in facilities, like video arcades and grocery stores, that are accessible to teenagers?

ANSWER:

I strongly support the law requiring states to prohibit selling tobacco products to youngsters under age 18, and I believe that states must develop their own strategies for enforcing such a law.

The best way we have to make sure that society does not have to bear the enormous financial and emotional costs of tobacco use is to concentrate on convincing teens not to begin smoking.

But, having dealt with a diversity of teenagers all my professional life, I am convinced that no single approach would work.

In some cases, our best approach might be to devote police time and resources to enforcing the law against selling; but that should be a decision for local police and elected officials to make.

In other cases, it would make more sense to devote our effort to persuading teens not to buy the products in the first place.

And finally, we must also help parents and retailers understand the importance of not providing tobacco products to under-age teenagers. We need parents to speak out: to teach their children about the dangers of smoking and ask their local retailers to be more careful about selling cigarettes to them.

Only working together at the community, state, and federal levels can we make sure tobacco products never play a role in our children's lives -- or their futures.

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Divider Title: **VIOLENCE**

VIOLENCE AS A PUBLIC HEALTH ISSUE

QUESTION:

Do you believe violence is a public health issue?

ANSWER:

Yes, it is a public health issue -- but it is not only a public health issue. Let me explain.

Every year, we have about 25,000 homicides and 30,000 suicides in our country. Violence is the second leading cause of death for Americans between the ages of 15 and 24, and the leading cause of death for African Americans in this age group. If we were having that many deaths from polio or polluted water, we would look for the causes and the ways we could prevent that loss of life. That's what public health is all about.

Of course, the causes of violence are not as easy to isolate as a germ or a bacteria. They are much more complicated. As a result, our remedies have to go far beyond public health approaches -- including effective law enforcement, making jobs available, strengthening families, improving schools, and so on. The causes are complex, so our solutions have to be comprehensive.

But the public health approach helps greatly. It allows us to focus on preventing violence and injury before they occur. It allows us to identify risk factors for health problems and then try to reduce the incidence of the risk. And it allows us to identify protective factors that mitigate against health problems and then do all we can to strengthen them. Also, the public health approach includes a variety of caregivers in violence prevention. It can bring together a broad array of leaders and resources in the fields of medicine, mental health, substance abuse, and education.

Finally, besides being a public health issue, violence is a moral issue. Dr. King taught us that all that has to happen for evil to prevail in the world is for good people to do nothing. The evil of violence must not prevail -- and as your Surgeon General, I will do everything in my power to encourage the good people of our country to lock arms to stop the violence.

YOUTH VIOLENCE

QUESTION:

What can be done to reduce the violence being perpetrated by younger and younger offenders in our country?

ANSWER:

Of course we have to begin with strong law enforcement. Public safety -- safety so people can go to work and children can go to school -- is the prerequisite of a strong civil society.

Everything we can do to provide jobs, strengthen families, improve neighborhoods, and make schools better will serve the cause of violence prevention.

We also have to deal with the values that are being conveyed through the media, films and music, which all too often glorify violence.

We need to send the message from the highest levels of our nation and in every community across America that violence is not the way to settle disputes. That might does not make right. That an eye for an eye makes the whole world blind. As Surgeon General, I will help communicate that message.

But most important is the human touch: That's what the "I Have a Future" program is all about. We have to recommit ourselves to spending time with young people. To being mentors and positive role models. To creating a family-friendly nation where adults have time to spend with their children and their children's friends. The key to youth violence prevention is building healthy relationships between caring adults and young people.

DOMESTIC VIOLENCE/VIOLENCE AGAINST WOMEN

QUESTION:

What are your thoughts on what we should do to reduce domestic violence/violence against women in the United States? [Or, do you regard domestic violence as part of what you will address as Surgeon General?]

ANSWER:

We are finally, all too belatedly, becoming aware of the extent of violence against women in our country. And we are seeing the links between domestic violence and other types of violence. Where women are beaten in their homes, children are also more likely to be abused. And children who witness domestic violence are more likely to fall into the pattern themselves as adults. We have to stop the violence. We have to break the cycle.

The Violence Against Women Act, which was enacted as part of the Crime Bill last year, gives us new funding and new legal tools. HHS is about to fund a 1-800 hotline that will give women across the country a place to turn to for help. There is more money for shelters for battered women and their children. And there is increased funding for the states to support law enforcement and training of professionals of all kinds about domestic violence.

But we have to do much more:

- We have to send very clear messages that we will not tolerate violence against women, that the crimes of assault and sexual assault will be prosecuted to the full extent of the law.

- We have to make it clear to physicians and other health professionals that they should be on the lookout for signs of violence against women who come to the emergency room, and we should do more to train caregivers to respond supportively.

- We have to make clear to police, prosecutors, judges, and social service workers that they must coordinate their efforts against domestic violence.

  We need to create a seamless web of domestic violence efforts in every community: Stopping the violence is everyone's responsibility.

GUN CONTROL

QUESTION:

What is your position on gun control? [Or, Do you favor further regulations on gun ownership?]

ANSWER:

In the wrong people's hands, firearms are enormously dangerous -- whether we're talking about criminals, gang members, or innocent young children who happen to find them in nightstands at home.

I support the efforts made by the President and the Congress last year to keep guns out of the hands of people who should not have them. The Brady Act, which requires a check before a weapon can be sold, is making a clear difference. The ban on assault weapons is keeping guns that have no useful purpose other than to kill people off our streets. The Treasury Department has cracked down on fly-by-night gun dealers who are not legitimate business people.

There's more we can do -- and the things I'd propose will not get us into divisive arguments and debates:

- **We need to educate parents about keeping guns in safe places at home.**
- **We need to explore new technologies to make guns safer.**
- **We need to work with the media and entertainment industries to prevent the glamorization of gun violence in popular culture.**
- **And we need to reach young people with clear and consistent messages that violence is wrong and counterproductive to living productive lives.**

THE ROLE OF THE CENTERS FOR DISEASE CONTROL

QUESTION:

Isn't the CDC engaged in a campaign to take away guns from Americans and stick its nose into people's lives in the name of stopping violence?

ANSWER:

No. The CDC is a science-based set of agencies that supports careful research and closely evaluated public health demonstrations to help solve America's pressing public health problems.

The CDC is studying violence as a public health problem. It is trying to help our country deal with the causes -- not just the consequences -- of violence. This is a valuable field of study -- and it is being conducted primarily by civil servants who have dedicated their careers to improving Americans' health in every possible way.

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WELFARE REFORM

Divider Title: _____

WELFARE REFORM -- DENYING ASSISTANCE TO TEENAGED MOTHERS

QUESTION:

As you know, there are some who claim that denying aid to unmarried teenagers will reduce out-of-wedlock and teen births. How do you respond to that?

ANSWER:

In his State of the Union address, the President highlighted the issue of teen pregnancy, calling it one of this nation's most serious social problems. The President is absolutely right.

We know that children born to teenagers are more likely to have serious health problems, and are more likely to be poor. We know that 80 percent of children born to teenage parents who dropped out of high school now live in poverty. If we want to prevent teen pregnancy, we must offer more than slogans and dependency.

All of us must send the strongest possible signal to teens that pregnancy and childbirth should be delayed until they are married and able to provide for a child both financially and emotionally. And, to prevent welfare dependency in the first place, teenagers must get the message that staying in school, postponing pregnancy, and preparing to work are the right things to do.

The President has called on community leaders and all kinds of organizations to mobilize their communities and send youth a clear message; delay sexual activity. And if you are sexually active, practice safe and responsible sex. These are the principles we emphasize in my "I Have a Future" program in Nashville and it is working.

However, I believe that simply cutting off benefits to children of teen mothers might be, at best, ineffective -- and, at worst, counterproductive and cruel.

It's difficult to predict what would happen to the rate of out-of-wedlock births if young girls were denied assistance. Most social scientists would tell you that teenagers have babies for reasons unrelated to AFDC benefits -- and the effect of cutting them off is likely to be negligible.

Instead of simply giving up on teen mothers, we should require them to take responsibility for their actions. We should act on the Administration's proposals by requiring minor mothers stay at home, stay in school and identify the father.

And, we must ensure that the father is held accountable as well. Boys and girls, men and women must understand that having a child is a lifelong responsibilities.

CUTTING OFF TEEN MOTHERS -- BEHAVIORAL IMPACT

QUESTION:

Do you believe that denying cash benefits to pregnant teenagers will reduce teen pregnancy?

ANSWER:

We really don't have a lot of evidence about what the effect would be. But rather than simply cutting off young mothers and their children, I believe a wiser approach would to require minor mothers to live at home, stay in school, make progress toward self-sufficiency, and identify the father of the child.

And, that's what the Administration has proposed. The President has asked me to help lead a national campaign to prevent teen pregnancy. All of us need to send a clear and consistent message that it is wrong to have children before you are financially and emotionally able to support them. These are the principles we emphasize in my "I Have a Future" program in Nashville.

Yes, a State should have the option of not increasing benefits for children born to mothers on welfare, but, this decision should be made by the State, not the Federal government.

As we move forward with this discussion, it is important to remember that while part of the responsibility for a teenage pregnancy belongs with the teenage mother, the other half resides with the father --- who often is not a teenager at all, but an adult who is considerably older than the teenage girl.

That's why strong child support measures are so important -- to send a clear message that bringing children into this world is a life-long responsibility for both parents. We must hold <u>both</u> parents responsible for supporting their children.

WELFARE REFORM -- MEDICAID BLOCK GRANT

QUESTION:

Why should Medicaid be an entitlement? What do you think about making Medicaid a block grant?

ANSWER:

The Administration has made a commitment to protecting needy Americans and working to promote cost containment and state flexibility. And, I believe that this is a sound approach.

The Administration is saying to the states, "Federal matching funds will be available to pay for the health care needs of your vulnerable citizens -- so that you do not have to bear these costs on your own."

They are saying to providers who take care of vulnerable populations, "You will be paid for that care -- so that you don't have to shift these costs to other payers."

And, the Administration is saying to low-income children, people with disabilities, and other vulnerable populations, "You will have access to health care -- so that you won't have to go without needed services."

TRENDS -- TEEN PREGNANCY AND CHILDBEARING

QUESTION:

What are the current teen pregnancy and childbearing trends?

ANSWER:

- **From 1990 through 1993, the proportion of high school students who reported being sexually experienced remained stable, while an increasing percentage of sexually active students used condoms, thereby reducing their risk for unintended pregnancy and sexually transmitted diseases, including HIV infection.**

- Birth Rate

  While the birth rate for teens aged 15-17 increased 27 percent between 1986 and 1991, (from 30.5 to 38.7 per 1000 teens,) the birth rate for this age group declined by 2 percent between 1991 and 1992, to 37.8.

- Contraceptive Use

  The percentage of those currently sexually active students who reported condom use at last sexual intercourse increased significantly, from 46 percent in 1991 to 53 percent in 1993. Oral contraceptive use at last sexual intercourse increased from 14.6 percent in 1990 to 18.4 percent in 1993.

ADMINISTRATION'S FIGHT AGAINST TEENAGE PREGNANCY

QUESTION:

In the State of the Union Address, President Clinton mentioned his National Teen Pregnancy Prevention Initiative. What exactly is it?

ANSWER:

As the President said, teen pregnancy is one of our most serious social problems. That is why he asked me to make this issue my highest priority. We need to send clear and consistent messages to every young person in America: until you are in a position to provide for a child -- both emotionally and financially -- you should not have sex, and you should not have children.

As a country, we need to change the kinds of messages we send about sexual activity, opportunity, and responsibility. And, we need to work to ensure that young people do more than just listen to these messages -- they need to believe them and internalize them. We have been wrestling with this issue in my "I Have a Future" program in Nashville and the President's approach to this is right on target.

Overall Strategy

The Administration's strategy to prevent teen pregnancy is a combination of responsibility and opportunity. It starts with a strong message from the top, it seeks to involve private sector leadership, to mobilize schools and communities, to require real responsibility, and to continue tapping into new strategies that work.

A Strong Message from the Top

The President has taken the lead in discussing this issue. He cited it in the State of the Union address. He dealt with it directly in his welfare reform initiative. He nominated me, in part, because I had passion about and expertise in this area.

Private Sector Leadership

We are calling for action from all sectors of society. Obviously, the government alone can not change behavior. Young people must receive clear and consistent messages from the media, schools, churches, communities, and their families. Delay sexual activity. And if you are sexually active practice safe and responsible sex.

Targeting schools and communities

HHS has proposed teen pregnancy prevention grant programs that will target schools with the highest concentration of at-risk youth. These will be designed to get the message to young people that there are better options, that sex and childbearing must be delayed. The goal is to have everyone in the community do their part to provide better routes to success and better role models for our teens.

Responsibility

The Administration supports measures in welfare reform to have teens take responsibility for their actions. The current system often sends the worst possible message--having a child can be a way to leave home. The Clinton Administration proposed requiring minor mothers stay at home, stay in school and identify the father. And the father must also be held accountable. Boys and girls, men and women must understand that if they parent a child they will have lifelong responsibilities.

Learning More About Strategies that Work

The sad truth is that we still understand far too little about how to really prevent teen pregnancy. There are no silver bullets in the current literature. We are learning more about what works to prevent teen pregnancy, but there is clearly much to learn. At HHS, we have many significant research and demonstration projects currently underway related to teen pregnancy prevention, including studies on adolescent behavior, effectiveness of program models, and access to health care and family planning. And we intend to do more. The federal government has a responsibility to pull together what is known and help communities with their efforts to reduce teen pregnancy.

Communities and schools need access to the latest information from national and local research and demonstrations. This Administration is committed to providing information on promising curricula, model programs, training and technical assistance.

QUESTION:

What is the Department currently doing to prevent teen pregnancy?

ANSWER:

Overall

The programs in the Department and in other Federal agencies either directly address the issue of teen pregnancy prevention or address the multiple factors that contribute to teen pregnancy.

The programs at HHS address many of these interrelated factors. They encourage abstinence; involve teen parents in issues of teen sexuality; fund family planning services; support health education in schools in order to decrease risk such as sexually transmitted diseases, drug, alcohol and tobacco use; assist youth in crisis situations; and provide positive activities to enhance youth development.

HHS PROGRAMS

These programs include:

- The Adolescent Family Life Program funds demonstrations and research projects that focus on encouraging abstinence and involving the parents of teens in issues of adolescent sexuality and parenting.

- The Centers for Disease Control and Prevention funds health education in schools in order to decrease, among other things, sexually transmitted diseases, drug and alcohol abuse, tobacco use, unintentional and intentional injuries.

- Title X of the Public Health Service Act funds family planning services. Improving outreach and services to teens is a priority of the Title X program.

- Runaway and homeless youth programs, alcohol and other substance abuse prevention programs, Community Schools, and Empowerment Zones also address a wide range of risk factors related to teen pregnancy.

- Several block grant programs, including the Maternal and Child Health Block Grant and the Social Services Block Grant can fund family planning, school health and other prevention services.

OTHER AGENCIES

- Other Federal Agencies are funding programs that complement those in HHS. In particular, education and employment training programs are an important part of creating opportunities that are central to teen pregnancy prevention.

ROLE OF SURGEON GENERAL

- The President has asked my to help lead our efforts to prevent teen pregnancy -- both within HHS and for the nation.

QUESTION:

What is HHS currently doing in teen pregnancy prevention research?

ANSWER:

As we move forward to tackle the problem of teen pregnancy, it is critical for us to find out what works -- and what doesn't. That's why, HHS has been actively involved in working to identify and fill our gaps in knowledge -- so that we can take steps to solve the teen pregnancy crisis once and for all.

Overall

- We have extensive research and demonstration projects currently underway in a number of critical areas related to teen pregnancy prevention. For example, there are studies examining existing interventions and evaluations, demonstrations, and data collection and analysis in the areas of adolescent behavior and access to health care and family planning.

Summary of interventions, evaluations and most recent literature

- HHS has funded a study that reviews evaluated pregnancy prevention programs to determine what works. The study also reviews the status of current research and identifies gaps in knowledge and research.

Demonstrations

- There are many demonstrations related to teen pregnancy prevention strategies currently underway or proposed.

- One of the most significant was funded last year. We expect the Centers for Disease Control and Prevention to award $4.5 million worth of grants to communities with high rates of teen pregnancy by the end of FY 1995. The focus of the program will be on the development and evaluation of community partnership coalitions.

Data Collection and Analysis

- As you know, every year HHS collects and disseminates the most comprehensive national fertility information available.

- Last year, the Congress directed the department to conduct a comprehensive, prospective longitudinal national study on adolescent health. The study, known as ADD HEALTH, is expected to be the most comprehensive study on adolescents to date undertaken by DHHS.

- HHS has awarded a five year grant to conduct wide-ranging data analyses on family planning need and service availability, with a focus on adolescents and lower income women. The goal of the project is to learn how to reduce unintended pregnancies and reduce the number of teenage pregnancies.

- The Department is also funding a study that analyzes data on adolescents' use of time in hopes of finding the best places to intervene.

- We are awarding grants to study unwanted and unintended pregnancy in the United States. Two of the studies will focus specifically on adolescents.

I look forward to sharing the findings of these efforts with you -- and putting them to work for the American people.

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HELTH CARE REFORM

Divider Title: _____

HEALTH CARE REFORM

QUESTION:

What will your role be in health care reform?

ANSWER:

The President remains committed to health care reform that will provide the security of affordable health care coverage for all Americans.

He has called upon the Congress to work with him in a step-by-step approach toward that goal, including meaningful reforms in the insurance market; affordable coverage for children, people who lose their jobs and the self-employed; and help for people needing long-term care. I will be proud to work with the President to promote the steps he identified.

The President is also a deep believer in the importance of preventive health care. Here I can be of particular service -- educating the American people about the importance of making healthful choices and preventing illnesses before they occur.

QUESTION:

In the course of the health care debate, you charged that the President's health care reform had "the potential to negatively impact medical education." What did you mean?

ANSWER:

The medical education system is heavily supported by practice income generated by medical school faculty who see patients and teach students and residents. As I indicated at the time, I see managed competition as potentially reducing the revenue going into these practice plans, as well as reducing the number of referrals to teaching hospitals.

The Health Security Act acknowledged this problem and would have established a separate funding stream for support of graduate medical education.

- Along with other representatives of medical schools, I expressed concern that reforms assure adequate levels of support for medical training, and that funds be available at the undergraduate, as well as graduate, level.

- As reform moved through the legislative process, I worked to promote that goal.

QUESTION:

But you criticized the Clinton bill for cutting Medicare funding for graduate medical education; ignoring undergraduate medical education and providing inadequate support for low-income students; and undermining academic health centers with the promotion of managed care.

And you continually mentioned a "long and difficult session" with Ira Magaziner who wasn't listening to your point of view. Wasn't the Administration threatening the core of the nation's health care quality with its bill?

ANSWER:

No. On the contrary, the thrust of the Administration's provisions in the Health Security Act were directed to assuring the future quality of the nation's health care.

The Administration recognized the importance of training the providers this nation needs to assure primary and specialized care in a changing health care system. And, the Administration was concerned that the role of academic health centers in quality medicine be retained.

I, along with other medical school representatives, worked with the administration and the Congress on the best ways to achieve these goals and appropriate funding levels. There was lots of give and take in the process.

QUESTION:

In discussions of health reform, you supported measures that would dictate to medical schools and teaching hospitals the kinds of doctors they could train. How can you advocate such interference with our nation's private health care system?

ANSWER:

Along with other leaders in the medical profession, I supported a change in our medical training to increase the number of primary care providers. That is not an interference; it is a better use of resources government is already devoting to training. Primary care is critical to promoting our nation's health and worthy of considerable attention.

QUESTION:

You have called for a physician "draft" to get providers to all parts of this country as we sometimes draft providers to other parts of the world. Do you advocate that policy?

ANSWER:

No, I was not really calling for a physician draft. But sometimes you need to call people's attention to the fact that in many parts of this country, people do not have access to health care. I want people to know about that.

I believe that State and Federal programs that offer incentives for practice in underserved areas -- like the National Health Service Corps -- can help address these problems. I also think it is important for physicians like me to encourage young people to follow in our footsteps and aspire to become health care professionals.

QUESTION:

You have suggested that Veterans Administration hospitals with empty beds should be used by the broader community. What do you mean?

ANSWER:

Sometimes the VA hospital is the only hospital in an underserved area. I called attention to these circumstances as part of my concern that all communities have adequate health care services. I am not advocating a change in national policy.

QUESTION:

In describing how health care reform would "play out," you talked about a two-tier system. You essentially argued that health care would be rationed; that the American system would and should look like the British system. How could you support such a policy or an Administration that would support such a policy?

ANSWER:

First of all, I think the President's health care plan was the most ambitious effort in our history to make sure that all Americans have access to health care. I have no doubt that, if there were any glitches as the new health system was being implemented, they would have been corrected to make sure we don't have a two tier system.

But make no mistake, right now we have a two-tier system in which citizens with limited resources and no health insurance may go without care. Everyone in this country should have access to quality health care. And, as the President has said, we can move toward that system step-by-step.

QUESTION:

You have expressed concerns about the impact of Tenncare on the financing of medical education in Tennessee. Isn't Tenncare a product of the Administration you're now going to represent?

ANSWER:

I continue to believe that medical education payments--and the research and specialized services that they are linked with--need adequate support. But, I also understand the State's desire to focus all available resources on the immediate needs of its people.

Tenncare is the product of a State exercising its increased flexibility to decide how its Medicaid program should be structured. This Administration made this opportunity possible because of its very profound commitment to state flexibility. I applaud that commitment.

I do think we need to continue to watch the Tenncare experiment carefully and look at its impact on the medical education system and the health care needs in the State over time.

QUESTION:

If Tennessee can control its health care costs with a waiver, can we turn all of Medicaid into block grants and do a better job for the poor with less money?

ANSWER:

Tenncare is a new program and we will learn from it. Medicaid is a critical program serving vulnerable populations. Any changes must assure that these people continue to get the health care they need.

Each state is different with unique characteristics and demographics. i would not want to rush to judgement before we can 'know more about how well these demonstrations work.

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FETAL TISSUE AND EMBRYO RESEARCH

Divider Title: _____

In answer to any question on human embryo research, start with the following:

There has been a great deal of misunderstanding about this issue, so before directly dealing with your question, let me clarify what this research is and is not about.

The research involves studies only of human fertilization -- which is the entry of sperm into a mature egg -- and the subsequent few cell divisions that occur in a laboratory dish.

The work would be done with human eggs and sperm, the one-cell product of fertilization, and the earliest cell divisions that follow fertilization.

At this stage, the cells are smaller than the period at the end of a sentence. They have no organs or nervous system of any kind. These cells have no feeling, no awareness, and they bear no resemblance of a developing fetus. The cells are referred to as a preimplantation embryo because they have not yet reached the point at which they would imbed (implant) into the wall of the uterus.

The research does not involve human embryos or fetuses developing in the body. It does not involve abortion or aborted human fetal tissue.

This issue is still under review at the National Institutes of Health. I trust that whatever policy is finally put in place will be rigorous from an ethical and a scientific standpoint, and will show great respect for the diverse perspectives Americans have about this research.

QUESTION:

Does the federal government currently fund human embryo research?

ANSWER:

No. The question of whether federal funding should be allowed in the future for certain kinds of research involving human in vitro fertilization and the preimplantation embryo is currently under review by the National Institutes of Health.

QUESTION:

Wasn't there a recent report to or by the National Institutes of Health recommending that the federal government fund such research?

ANSWER:

NIH, in 1994, convened the Human Embryo Research Panel, a group of outside experts, to make recommendations about possible federal funding in this area. The panel met repeatedly, and identified areas of research that it considered (1) acceptable, (2) un-acceptable, and (3) requiring further study. The panel also recommended research guidelines. The panel report was reviewed and endorsed by the Advisory Committee to the NIH Director on December 2, 1994.

QUESTION:

What research did the Panel and the Advisory Committee recommend for funding?

ANSWER:

Broadly stated, the recommendation was for valid and meritorious research relying on prior adequate animal studies, where informed consent is obtained and no purchase or sale of embryos is involved and which does not continue beyond the 14th day of fertilization. As I stated before, the research would not involve human embryos or fetuses developing in the human body. Of course, standard ethical and scientific peer review requirements would have to be met as well.

QUESTION:

Wouldn't federal funding for human embryo research reverse twenty years of government policy?

ANSWER:

The Department of Health, Education and Welfare Ethics Advisory Board was created in 1978 to consider such research. In 1979, the Ethics Advisory Board concluded that research involving human in vitro fertilization and the preimplantation embryo was acceptable from an ethical standpoint. In 1980, when that Board's charter expired, their conclusion had not been acted on and no new Board was created or action taken on this subject prior to 1993.

In 1993, Congress passed the NIH Reauthorization Act and made it possible for NIH to consider funding for in vitro fertilization research.

QUESTION:

If you believe human embryo research should be federally funded, are there limits to that funding? What standard should be applied to decide which research to fund?

ANSWER:

Yes, there are limits. President Clinton has directed that no resources be allocated to "support creation of human embryos for research purposes." In addition, the NIH Panel and Advisory Committee made recommendations about other areas of research that were thought unacceptable for federal funding.

NIH is currently considering whether and how to proceed in areas of appropriate research, so a statement of the standard that will emerge from those considerations would be premature.

QUESTION:

Are there any good reasons to do human embryo research?

ANSWER:

Yes, there are very good reasons to do this research because many people stand to benefit from the knowledge that could be gained. This includes infertile couples, particularly women, and their future children, future parents, couples who have experienced repeated miscarriages, couples who wish to prevent pregnancy, couples who carry serious genetic diseases, and patients with diseases such as cancer, spinal cord injury, immune deficiencies, and blood disorders.

This research may lead to advances in the treatment of infertility, prevention of miscarriages, and improvements in contraception. It could also help prevent and treat a number of other health problems, including cancer and birth defects, through a more complete understanding of cell division.

QUESTION:

What will happen if there is not federal funding for human embryo research?

ANSWER:

There are several negative consequences. First, this research will continue to be conducted in the private sector without the benefit of national scientific and ethical oversight. The quality and scope of the research will continue to be uneven and adversely affected. The consequence I care most about, however, is that great opportunities to advance human health will be neglected or delayed.

PRESIDENTIAL AUTHORIZATION OF FETAL TISSUE RESEARCH

QUESTION:

Has President Clinton authorized fetal tissue research?

ANSWER:

From 1988 to 1993, NIH supported research using human fetal tissue for a wide variety of studies, but not for transplantation. In 1993, President Clinton authorized fetal tissue transplantation research. In effect, he extended prior policy regarding the allowable federally-supported research using fetal tissue.

In the 1993 NIH Reauthorization Act, Congress acted to permit broad fetal tissue research.

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MISCELLEANEOUS ISSUES

Divider Title: _____

OTHER CHILDREN'S HEALTH ISSUES

QUESTION:

You've talked a lot about teen pregnancy and other issues confronting young people. What other children's issues do you plan on addressing as Surgeon General?

ANSWER:

I have dedicated my career to doing all that I can to bring healthy babies into this world.

I believe we need to increase education and access and take other strong steps to ensure that women get proper prenatal care -- so that we can finally reduce infant mortality rates. We don't need to look any further than Washington, D.C., a city plagued by high infant mortality rates, to find local communities that are tackling these tough issues -- and thereby serving as models for the entire nation.

For example, in this city -- and in several other large cities -- the Healthy Babies campaign rewards mothers-to-be with coupon books for coming in early for prenatal care. Programs like these bring the entire community together -- schools, churches, civic groups, and others -- in order to make all of us aware of the need for early prenatal care.

Local communities are also stepping up to the plate on another critical front: immunizations.

The President has launched his Childhood Immunization Initiative to turn those numbers around.

The Administration is bringing together doctors, businesses, the media, community leaders and elected officials at the federal, state, and local levels to make this promise to children under two: you will be immunized.

By the year 1996, the goal is to have 90 percent of children under two immunized for the most important vaccines. I am going to work diligently to help the Administration reach that goal.

QUESTION:

What is the risk of getting TB on an airplane, and what is recommended to protect the public traveling by air?

ANSWER:

The risk of transmission on a commercial aircraft is very low.

There is no reason to suspect that the risk of getting TB on an aircraft is any greater than in other confined spaces, including other forms of public transportation, if the time spent there is the same.

To prevent exposure to TB on aircrafts, CDC recommends that, if travel is required, people who know they have infectious TB should travel by private ground transportation or air ambulance -- and not by commercial aircraft.

CDC also suggests that if an airline becomes aware that someone with active infectious TB has flown on a flight longer than eight hours, it should work with state and local health departments to notify the crew and passengers seated in close proximity to that person.

People who are concerned that they might be infected with TB should consult their primary health care provider or local health department -- and have a TB skin test.

BACKGROUND:

Tuberculosis is an airborne infectious disease caused by the bacterium, *Mycobacterium tuberculosis*. The bacteria are spread from person-to-person through the air in tiny airborne particles. These particles are produced when someone with active TB of the lungs or throat coughs, sneezes, talks, or sings.

Persons sharing the same air space are at risk of inhaling these particles and becoming infected with TB. The risk of acquiring infection is increased when susceptible persons share air space for prolonged periods of time with a person who has untreated active TB of the lung or throat. Being infected does not mean a person has or will have the disease.

TB is a treatable and preventable disease. Once infected a person's body may harbor TB organisms for years, or for life, without progressing to active TB disease. In certain cases of infection, preventive treatment is recommended to prevent infection from progression to disease.

QUESTION:

What should we do about the growing threat of multi-drug-resistant TB?

ANSWER:

The central goal of TB-control programs is to ensure that TB patients complete their prescribed course of therapy. The truth is, directly observed therapy (DOT) has been shown to be the most cost-effective method of increasing patient-adherence to therapy.

Therefore, it is essential that all infectious TB patients complete therapy so they can be cured, stopped from transmitting to others, and prevented from experiencing drug resistance.

It is also important that health care providers work together to identify TB as it occurs in conjunction with other illnesses such as HIV/AIDS so that treatment can be prompt.

It's going to take a sustained effort at the federal, state, and local levels.

Most important, to reduce the emergence of multi-drug resistant TB (MDR TB), all patients with TB must receive appropriate treatment, preferably under directly observed therapy (DOT).

We must test all culture-positive TB cases for drug susceptibility -- and use prompt feedback of those results to guide subsequent therapy.

And, we must work quickly to implement the recent CDC guidelines on preventing transmission of TB in health care facilities.

QUESTION:

Who has authority to quarantine an individual within a given State and when should quarantine be considered? Who has the authority to quarantine an individual if that person is traveling between states?

ANSWER:

Authority to enforce intrastate quarantine is vested in the State and local health authority. Accordingly, laws relating to public health and health officers' quarantine authority vary from region to region. Usually, the quarantine of an individual is only enforced when that person poses a significant public health threat to others and cannot be isolated in any other way.

The Public Health Service Act gives the Assistant Secretary for Health authority to make and enforce regulations to prevent the interstate spread of communicable disease.

This authority is intended to be an adjunct to state authorities who are working to prevent interstate spread of communicable diseases by providing temporary federal assistance to them until they are able to assume full responsibility. It is also designed to give the Assistant Secretary the ability to take necessary action if he or she determines that a state is not taking sufficient public health measures to prevent the interstate spread of communicable diseases.

QUESTION:

You said recently that minority youth have to learn "operative English." What did you mean by that?

ANSWER:

Whenever I work with minority young people -- be they African American, Hispanic or Asian -- I tell them to be proud of their ethnic heritage and the idioms of their culture. But I also stress the need to become proficient in "operative English," which is the prevailing dialect of mainstream America. Slangs and dialects are fine in many settings, but when young people are applying for jobs or taking oral exams, it behooves them to speak and enunciate in a manner that is appropriate for the setting.

QUESTION:

What is your position on physician-assisted suicide?

ANSWER:

I haven't reviewed the ethical and legal literature on physician-assisted suicide. While my goal as a physician is to promote good health, I have no firm view on this issue.

SALARY ARRANGEMENT

QUESTION:

What is your salary arrangement with the Department of Health and Human Services at this time?

ANSWER:

I am currently an unsalaried consultant at the Department of Health and Human Services.