

I Have a Future





As part of its historic mission to serve the disadvantaged, Meharry Medical College has a strong commitment to preventing damaging lifestyles and health behaviors among adolescents.

As the nation's only historically black, independent academic health services center, Meharry has a long history of community concern and involvement. Thus, Meharry has taken this opportunity to develop model programs which provide life-enhancement experiences and health services to high-risk adolescents while preparing health professionals to address relevant issues associated with the youth population.

The Department of Obstetrics and Gynecology has initiated "**I Have A Future,**" a program which addresses a burgeoning problem in our communities — adolescent pregnancy. Frequently, life-threatening and health-threatening consequences of early pregnancy and childbearing are devastating for both the young mother and child. When compounded by the emotional, social and economic traumas faced by the teenage father, families and the community as a whole, the problems of adolescent pregnancy impose an imperative for innovative solutions.

The challenge is to develop a system which successfully educates and motivates adolescents to pursue a myriad of constructive life options and delay parenthood. The program was built on the premise that changes in sexual behavior should be addressed within a framework that provides strategies for positive decision-making while enhancing self-image.

The major thrust of this longitudinal, research-intervention project is to develop a model program to prevent teenage pregnancy, substance abuse, and unemployment. Since 1987, the Department of Obstetrics and Gynecology of Meharry Medical College has developed and instituted a comprehensive community-based adolescent pregnancy prevention program involving four municipal housing developments in Nashville, Tennessee.

Previous efforts to prevent teenage pregnancy have focused on giving adolescents the capacity to control their fertility. It has been clear from pregnancy and fertility rates that many high-risk youths are not being reached effectively. Economically disadvantaged adolescents with little hope and limited aspirations frequently cannot understand that having a baby can adversely affect their lives. To the contrary, it is often viewed as an enhancement.

Those who have been at the forefront in the battle to delay early pregnancy and childbearing advocate enhancing self-image and presenting positive alternatives for the future. Subsequently, the program attempts to address the issues surrounding adolescent pregnancy from a broader psychosocial context. Success then rests on convincing youth that the future is theirs to control. The name of the project itself — **"I Have A Future"** — is based on this premise.

Project Objectives

The **"I Have A Future"** program incorporates a two-pronged delivery system based in the community. Both individual and group interventions are used to meet the following project objectives:

- To develop a replicable community-based, life-enhancement program that promotes a significant reduction in the incidence of early pregnancy and childbearing among high-risk adolescents.

To improve knowledge, attitudes and behaviors related to personal health, human sexuality, drug and alcohol abuse and other factors which may place them at risk.

- To provide greater access to, and increase utilization of, comprehensive adolescent health services and social services, including contraceptive availability.
- To improve socially adaptive/appropriate behaviors with particular focus on school achievement, pre-vocational skills development and delinquency rates.
- To enhance the ability of high-risk adolescents to overcome environmental barriers in attaining the skills necessary to pursue meaningful employment and educational opportunities with the promise of upward mobility.

To engender a more positive self-concept and constructive attitude towards community, family life and the future.

Each objective has been further delineated such that components may be addressed specifically via baseline-pre/post-measures as well as within specific interventions.

Setting

The **"I Have A Future"** program is located within the municipal housing projects to ensure the following: (a) Provision of services during the times that they are most accessible to all adolescents (without stigmatizing school drop-outs) through an adjunct program (b) Close proximity to the families to increase opportunities for interaction within the context of the full range of situations that characterize life in the public housing projects.



Target Population

The participants in this program are from four public housing sites. Two sites receive the intervention and the others are considered control sites. Baseline data have been collected from all four sites.

Prior to the delivery of services, a "Quality of Life Needs Assessment" was conducted with 497 heads-of-households of homes which had youth between the ages of 10 and 17 residing in them. The assessment was designed to gather demographic information, residents' perception of problems impacting on the youth, community needs and ideas on how to resolve existing problems. Of the 497 completed surveys, we found that the majority of the respondents were females (87%), single head-of-households (83%), of African American origin (98%). Over one-half (58%) of the respondents completed high school, however, seventy-one percent were unemployed. Seventy-nine percent of the families had an annual income of less than \$5,000, however, only sixty-five percent received supplemental financial assistance. The participants reported the following problems as most pervasive: Drug and alcohol abuse (92%), adolescent pregnancy (76%), crime (48%), and youth unemployment (44%). Most importantly, seventy-seven percent of the participants indicated their willingness to be part of a program that strengthens families. This information was important, for it reflects the communities' commitment to work at improving their quality of life and their support for a community-based intervention program.

Description of Services

The program is designed to assist adolescents in learning good health practice and making positive choices. The basic service components are delivered in the context of the following areas of concentration:

Comprehensive Health Services

Currently, services are provided by the staff of the Department of Obstetrics and Gynecology of Meharry Medical College at "I Have A Future" clinics within the housing projects. Services are provided each week, with the clinics emphasizing primary health care and health screenings (e.g., physical examinations and lifestyle assessments) and on-going health services (e.g., screening for sexually transmitted diseases, pregnancy tests and distribution of contraceptives).

Organized Social-Learning Activities

Activities with structured educational and behavioral objectives are offered to "I Have A Future" participants. Emphasis is on creativity, physical awareness, nutrition and personal responsibility.

It is critical that the programming be age-appropriate since the target population spans the ages of 10 to 17. While the curriculum focuses on knowledge, attitudes, and behaviors for all groups, the emphasis is on behaviors for the older adolescent group (14 to 17).

The primary value orientation of the program focuses on the integration and implementation of the NGUZO SABA Principles (Seven Principles of Blackness) into each participant's role as a positive family member and in their practice of responsible health behavior. These principles are: NIA (Purpose), UMOJA (Unity), KUJICHAGULIA (Self-Determination), UJIMA (Collective Work and Responsibility), UJAMAA (Cooperative Economics), KUUMBA (Creativity) and IMANI (Faith).

All aspects of the program promote the following: Self-esteem and pride in individuality; physical and mental well-being; completing school; developing job skills and enhancing employability; sexual responsibility; self-control and handling interpersonal conflict; value of helping others and the community; responsible citizenry and family-life values/appropriate parenting. The adolescents are divided into mixed gender groups. Groups serve as the operating-structure for a majority of the programming, with specific activities serving as incentives and vehicles for discussion.



Examples of on-going and planned activities:

Pro-Social Skills Development

(Focusing on good decision-making and problem-solving with special emphasis on Alcohol and Drug Abuse Prevention)

Conflict Resolution Training/
Violence Prevention

Creative Movement/Dance

Sports

Tutoring

Family-Life Education

Self-defense class

Computer Skills

Outings

CHARM Class for Females

(Choosing How To Adorn & Refine Myself)

MATURE Class

(Males Adorning, Thinking and Using Refined Energies)

Rites of Passage Program

Art Classes

Entrepreneurship Program

(Includes Pre-employment Training)

Peer Counseling

Opportunities

Parent Involvement

Every effort is made to involve parents/residents, to make them feel that it is their program and to give them a sense of empowerment and ownership. One such example is the Parent Empowerment Program, a community-based family alternative program in which the parents receive training in family health promotion with emphasis on increasing their effectiveness in the battle to prevent substance abuse in their community. The training equips the parents with the knowledge and skills they need to run workshops and provide services to families that are in need of assistance on substance abuse issues. Some topics covered during their training include: Effective communication, group leadership, crisis intervention and parent effectiveness skills. Other parent-focused activities include: Parent appreciation nights, spaghetti dinners, weight management classes, etc.

Staffing

The "I Have A Future" staff consists of a multi-disciplinary team that includes psychologists, nurses, public health education specialists, counselors, physicians, tutors and volunteers (from the community and local colleges and universities).

Evaluation

The evaluation plan for the "I Have A Future" project incorporates a longitudinal, quasi-experimental design. There are two intervention sites located at two public housing projects and two comparison sites located at two other housing projects in the Nashville metropolitan area. All four sites are similar demographically. Annual assessments of the youth between the ages of 10 and 17 will be conducted for a minimum of three years. The assessment battery includes instruments for measuring knowledge, attitudes and behaviors related to sexuality, contraception, and pregnancy, as well as measures of self-concept, social support, family environment, and psychosocial maturity.

Baseline data collection was completed in 1989. Baseline data were collected from 998 adolescents within the four housing sites (555 study group, 443 control group). The second phase of data collection was completed in 1990. The third phase will begin in the winter of 1991. Preliminary analyses of the baseline data indicate that approximately seventy-five percent of the youth who are at least 15 years old have engaged in sexual intercourse. Contraceptive practices are very poor and twenty-seven percent of the sexually active females indi-

cated that they had been pregnant at least once. These data indicate a definite need for intervention.

In addition to the annual assessments at the intervention and comparison sites, a process evaluation is incorporated in the evaluation design. The number and type of services provided to youth by the **"I Have A Future"** program in the intervention sites are monitored. This information will be used to determine how much intervention each youth at the intervention sites received. These data will also be used to determine which services were the most effective in achieving the goals of **"I Have A Future"**.

Finally, pre- and post-tests have been developed for each of the **"I Have A Future"** content-oriented modules. These tests are administered at the beginning and the end of each of the modules. These data have been used to refine the modules so that they are most effective in producing the desired outcomes, such as change in knowledge and attitudes.

Community Support

Resident associations at all housing projects are actively involved in the program. Community representatives are on the **"I Have A Future"** Advisory Committee.

Metropolitan Nashville development and housing agencies have assisted in obtaining office space within the community. With their staff acting as liaisons between residents and community centers, the agencies have collaborated with us and helped recruit youth into the program. Many program activities have been sponsored by both **"I Have A Future"** and the local community centers.

National and local advisory committees, representing a cross-section of organizations, institutions and disciplines assist in program planning and act as advocates for **"I Have A Future."**

Currently, **"I Have A Future"** is funded by the Carnegie Corporation, W.T. Grant Foundation, William and Flora Hewlett Foundation, and Bill and Camille Cosby. The Tennessee Department of Mental Health and Retardation has funded the Parent Empowerment Program.

The **"I Have A Future"** staff has been documenting the development of the program from its inception. These chronicles are being developed into protocols for each of the program components. The **"I Have A Future"** staff is available for technical assistance in such areas as program planning, implementation and evaluation strategies.



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HENRY W. FOSTER, M.D., DIRECTOR
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FOR IMMEDIATE RELEASE:
February 9, 1995

CONTACT: Kristi S. Hamrick
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MORE QUESTIONS RAISED:

- * ABSTINENCE ABSENT IN FOSTER'S "FUTURE"
- * ANTI-ABORTION RECORD -- MISSING IN ACTION

WASHINGTON, D.C. -- Family Research Council President Gary Bauer called again on Thursday for President Clinton to withdraw Dr. Henry Foster's nomination for Surgeon General.

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

RHETORIC VERSUS RECORD:

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

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

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

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

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

SIECUS SEX EDUCATION GUIDELINES

WHAT IS SIECUS?

The Sex Information and Education Council of the United States (SIECUS) was chartered in 1964 by Dr. Mary S. Calderone, former medical director of the Planned Parenthood Federation of America.

- The original SIECUS purpose statement was: "To establish man's sexuality as a health entity." To accomplish this goal their plan was to "expand the scope of sex education to all age levels and groups", and to provide, among other things, "indications as to how **constructive attitudes** can be developed about such problem areas as sex in the aging, **premarital sex and homosexuality**."
- SIECUS publications and writings have supported the following:

The use of pornography
Premarital sex
Homosexuality
Dispensing contraception to minors without parental consent
Sex education for all age levels
Abortion on demand

- The present executive director of SIECUS, Debra Haffner, wrote in the October 1989 SIECUS Report:

"We need to tell teens that the **safest sex** doesn't necessarily mean no sex, but rather behaviors that **have** no possibility of causing a pregnancy or a sexually transmitted disease."

She then listed caressing, **undressing** each other, masturbation and mutual **masturbation** as safe sex activities and concluded by adding "Teens could surely come up with their own list of activities."

THE SIECUS SEX EDUCATION GUIDELINES

In October 1991 SIECUS unveiled its guidelines for sex education curriculums entitled Guidelines for Comprehensive Sexuality Education: Kindergarten - 12th Grade. They were developed under the auspices of the "National Guidelines Task Force." These guidelines are presented as a consensus of sex education professionals and education organizations. However, this is not the case.

- At least ten of the groups listed with the guidelines as members of the National Coalition to Support Sexuality Education have not endorsed the guidelines.
- Despite claims of respect for other viewpoints, no conservative organizations were consulted. The following are some of the groups who compose The National Coalition to Support Sexuality Education listed on the back cover: The National

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The Family Institute

The Family Institute in Association with Focus on the Family

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POLICY REPORT

DR. HENRY W. FOSTER, JR. AND "I HAVE A FUTURE"

The Family Institute has been researching Dr. Henry W. Foster, Jr. and his Nashville program, "I Have A Future." What we have found raises profound concerns for Tennessee's families.

Dr. Foster was a member of the board of directors for the Planned Parenthood Federation of America. He served on the National Leadership Committee of Planned Parenthood's Campaign to Keep Abortion Safe and Legal. The main purpose of the committee was to campaign against the *Webster* decision — the decision which allowed for individual states to set restrictions on abortion, such as parental consent and notification laws, a ban on third trimester abortions, waiting periods, etc. In other words, Dr. Foster believes that mothers have the right to kill their pre-born babies during all nine months of pregnancy for any reason without restriction.

Dr. Foster is one of Planned Parenthood's Public Policy Activists. As a public policy advocate, Dr. Foster embraces all of the goals and objectives of Planned Parenthood, including those related to sex education. Planned Parenthood is on the National Coalition to Support Sexuality Education, a group of organizations that endorse the Sex Information and Education Council of the United States (SIECUS) Guidelines for Comprehensive Sexuality Education. These guidelines include the following:

- Teachers are to discuss masturbation with children aged 5-8.
- Children aged 5-8 are to be taught that homosexuality and heterosexuality are equal and that families can be "friends or other combinations of adults and children."
- The promotion of homosexuality, abortion and pornography.

Government officials, including President Clinton and the Department of Health and Human Services, avoid noting Dr. Foster's work with Planned Parenthood. In fact, Dr. Foster's official biography does not even mention his 17-year association with this group.

Dr. Foster was former head of Meharry Medical College's "I Have A Future" (IHAF) program, a health promotion initiative which targets adolescents in the John Henry Hale and Preston Taylor Homes in Nashville. A document obtained from "I Have A Future" states that one of the program's objectives is "to provide greater access to, and increase utilization of... contraceptive availability." The IHAF health clinics commonly give condoms and other birth control devices to adolescents. Furthermore, while the IHAF

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program seeks to delay the outcomes of "early pregnancy and childbearing" (among others), there is no mention in the entire document of abstinence or delaying sexual activity.

The staff of "I Have A Future" are directly involved in running a school-based clinic at Nashville's Pearl-Cohn High School. Dr. Foster also served as a program director for the Robert Wood Johnson Foundation, an organization which heavily funds school-based clinics. In fact, Dr. Foster headed another teen pregnancy prevention program that was funded by the Robert Wood Johnson Foundation.

This research, in combination with his endorsement by former Surgeon General Dr. Joycelyn Elders and Planned Parenthood's executive director in Nashville, indicate that Dr. Foster's policies are more in alignment with those of Dr. Joycelyn Elders than the values of parents and families in Tennessee.

This information calls into question Dr. Foster's ability to serve as surgeon general.



The Family Institute in Association with Focus on the Family

FOR IMMEDIATE RELEASE
February 2, 1995

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FOSTER NOMINATION TO SURGEON GENERAL POST RAISES CONCERNS

**FAMILY INSTITUTE RELEASES RESEARCH
ON DR. FOSTER AND "I HAVE A FUTURE"**

Nashville, TN — The Family Institute, a non-profit communication, research and education organization located in Nashville, is releasing research on Surgeon General Nominee Dr. Henry W. Foster, Jr. and his "I Have a Future" program in Nashville. The information raises profound concerns for Tennessee's families if Dr. Foster's nomination is approved by the U.S. Senate.

"We are happy that a fellow Tennessean has been selected for this important position. However, upon closer examination, we have identified many areas of concern," says Jeff Whitesides, president of the Family Institute.

Dr. Foster was a member of the board of directors for the Planned Parenthood Federation of America. He served on the National Leadership Committee of Planned Parenthood's Campaign to Keep Abortion Safe and Legal. The main purpose of the committee was to campaign against restrictions on abortion. He is one of Planned Parenthood's Public Policy Advocates. His role is to promote Planned Parenthood's goals and programs in the public policy realm.

"Planned Parenthood's assaults on the value of chastity, the sanctity of human life, and parental consent and notification laws for minors' abortions are well-known," says Mark Tolf, communications manager for the Family Institute. "That Dr. Foster is involved in an organization that (1) brings suit against local parents' groups for implementing abstinence-based curriculum in their school, (2) profits from performing abortions, and (3) fights very popular parental consent/notification legislation is a serious issue."

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The staff of "I Have A Future" are directly involved in running a school-based clinic at Nashville's Pearl-Cohn High School. Dr. Foster also served as a program director for the Robert Wood Johnson Foundation, an organization which heavily funds school-based clinics. In fact, Dr. Foster headed another teen pregnancy prevention program that was funded by the Robert Wood Johnson Foundation.

"Dr. Foster's policies have a lot in common with those of Dr. Joycelyn Elders," says Whitesides. Dr. Foster publicly stated that opposition to Dr. Elders was because Elders "favors education over ignorance."

The Family Institute is a non-profit communication, research and education organization working to strengthen Tennessee's families through informed citizenship and improved public policy.

MEHARRY MEDICAL COLLEGE

DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

"I HAVE A FUTURE"

DATE: 1/31/95TIME: 10:30AM

IHAF FAX NUMBER: (615) 327-6992

FAX TO: (Name) Mark Tolp(Company) Family Institute(FAX Number) 782-6695FROM: (Name) Molly McIntoshNumber of pages (Including transmittal sheet) 3Henry W. Foster, M.D.
DirectorLorraine Williams Greene, Ph.D.
Deputy DirectorPRIVILEGED & CONFIDENTIAL

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COMMENTS:

FAX SENT BY: M. McIntosh

"I HAVE A FUTURE" Program

February, 1988, marked the beginning of the Meharry Medical College "I Have A Future" (IHAF) Comprehensive Adolescent Health Promotion Initiative based in two public housing developments in Nashville, Tennessee. This nationally recognized, award-winning program has positively impacted over 850 young people's lives.

"I Have A Future" has been in the forefront in the battle to delay early pregnancy and childbearing, sexually transmitted diseases, homicide and violence and enhancing young people's self-image and presenting positive alternatives for the future. To meet this goal, the program has instituted the following objectives:

- *To improve knowledge, attitudes and behaviors related to personal health, human sexuality, drug and alcohol abuse, homicide and violence reduction and other factors which may place adolescents at risk.

- ✓ *To provide greater access to, and increase utilization of, comprehensive adolescent health services and mental services, including contraceptive availability.

- *To improve socially adaptive/appropriate behaviors with particular focus on school achievement, pre-vocational skill development, and delinquency rates.

- *To enhance the ability of high-risk adolescents to overcome environmental barriers in attaining the skills necessary to pursue meaningful employment and educational opportunities with the promise of upward mobility.

- *To engender a more positive self-concept and constructive attitude toward community, family life, and the future through the use of the Nguzo Saba Principles.

IHAF has demonstrated a capability which heretofore has been extremely difficult for service programs of this type to achieve -- that has been to attract and retain the participation of older adolescents (14-19 years of age) and a large number of African American males (34%).

This results-oriented program has an impressive track record. Research thus far involves comparing youth in two intervention and two comparison sites for 30 months. There was only one known pregnancy among those in the high participant group and 59 known pregnancies in the low-level and comparison site groups. There was also greater knowledge about human sexuality and family life among the high participant group.

Most interesting is the fact that there were statistically significant differences between the intervention and comparison communities. Young people who resided in the intervention site had higher self-esteem, a stronger belief in the Nguzo Saba values -- a stronger sense of community, and a greater belief in the responsibility one has for self, family and community. Most importantly, they believed they had more life-options -- compelling futures.

This sense of having a future was also demonstrated in 1993 when nine IHAF participants graduated from high school. Of this number, seven (7) attended college and remain enrolled. This year 24 of the participants are graduating from high school, and remarkably, 16 have been accepted for

post-secondary education. Twelve participants (12) will attend four-year colleges and four (4) will attend vocational/junior colleges. Four participants will be entering the Armed Services. Also, very striking is the fact that eight (8) of the college-bound students are African American males.

Medical organizations rallying for surgeon general nominee

From Banner wire and staff reports

With a vote of confidence from President Clinton, Dr. Henry W. Foster Jr. is defending his efforts to discourage teen pregnancy as doctor groups rally behind the embattled surgeon general nominee.

Conservative Republican senators vowed Thursday to try to defeat the nomination while a half-dozen Democrats — five of them women — rose to Foster's defense.



Foster

The American College of Obstetricians and Gynecologists and a half-dozen other major medical organizations called a news conference today to reiterate their support for the Nashville obstetrician-gynecologist, whose credibility has been called into question over how many abortions he has performed.

Foster was addressing medical students at George Washington

University Medical Center today on the teen pregnancy prevention program he created in two Nashville housing projects. The program, "I Have a Future," stresses abstinence and self-control, but also distributes condoms.

The president signaled that he won't give up on the medical educator he tapped as successor to the controversial Joycelyn Elders, whom he fired in December.

"I have confidence in him. I think he's a good man. I think he'll be a good surgeon general," Clinton said at a White House news conference with German Chancellor Helmut Kohl.

It "would be a grave mistake" not to let the Senate pass judgment on Foster's qualifications, said Clinton. "I want him to have his hearings. I believe the Senate will support him. And I think we should not back away from this."

Foster said Wednesday night on ABC's *Nightline* that hospital records at Meharry Medical College in Nashville indicated he performed 39 abortions, not the "fewer than a dozen" he claimed last

week.

He also presided over a study of an experimental drug that induced abortions in 55 of 60 women.

Foster also said, "I abhor abortion."

Susan Sevier, executive director of Tennessee Right to Life in Nashville, said she was "very perplexed" by Foster's comments on *Nightline*.

She noted that while Foster said he abhors abortion, he supports the policies of Planned Parenthood, which Sevier says makes money from abortions. Foster is a member of the advisory board of Planned Parenthood of Middle Tennessee.

"Why doesn't he denounce what he's done in the past and help us stop legalized abortion?" she asks.

Dianne D. Gilbert, immediate past president of Planned Parenthood of Middle Tennessee, says her organization, like Sevier's, believes "there should be no abortions."

"But they do happen every day."

"Does (Sevier) want to go back to the back alley? I'm not going to watch women die."



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90	0.78	\$105

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60	0.42	\$355
70	0.44	\$335
80	0.46	\$315
90	0.48	\$295

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LETTERS

2-10-95 NASHVILLE PAPER 12

Foster a victim of right-wing moralists

By Lon Thrasher
Nashville 37217-2597

While I understand the controversial nature of abortion, it remains legal in the United States, and every opinion poll I have seen suggests at least two-thirds of Americans support a woman's right to reproductive freedom. Yet the fact that surgeon general nominee Dr. Henry Foster performed a few abortions is an issue for many Republican leaders. It could keep him from being confirmed.

What do these right-wing-courting politicians expect? Are they so out of touch with modern-day America that they cannot see beyond the millions of votes and dollars the



Dr. Henry Foster

Christian Coalition and conservative preachers produce for their campaigns? Do they not understand that President Clinton respects the Supreme Court's *Roe vs. Wade* decision, and he is not going to nominate someone who is anti-choice to serve as the nation's chief physician?

Abortion is safe and legal. Even if Dr. Foster performed the procedure several hundred times, he did not break the law and he should not be treated like a "baby killer." America is taking a sharp turn backward. If you respect reproductive freedom and are fearful of the radical revolution to legislate right-wing morality, you'd better let your senators know!

Foster visits battered youths, urges them to abstain from sex

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By Paul Bedard
THE WASHINGTON TIMES

Embattled surgeon general nominee Henry W. Foster Jr., flanked by two armed federal agents, yesterday visited a Washington home for battered youths to defend his record and make a case against teen sex.

"Stay on a steady track. Do what's gonna make you better. You'll be the beneficiary," Dr. Foster told a group of 17 youths at the Sasha Bruce House on Maryland Avenue NE.

In a brief encounter with reporters later, Dr. Foster declined to retract a charge made Sunday that he is the target of "white right-wing extremists" who are trying to thwart his nomination because he performed abortions.

The obstetrician-gynecologist also declined knowledge of charges made by a former colleague who said Dr. Foster knew about a government study that left black men with syphilis untreated.

"I haven't heard them," Dr. Foster said of charges made by Dr. Luther McRae.

"If we want to prevent teen pregnancy, we must offer young people more."

Dr. McRae was president of the Macon County Medical Society in Alabama when it was briefed on the syphilis project in 1969. At the time, Dr. Foster was the vice president.

Dr. Foster has been quoted as saying he didn't know of the project until 1972, when it became public. He also has rejected Dr. McRae's charges, even though he said yesterday that he was not aware of them.

During his visit to the Sasha Bruce House, Dr. Foster met with the 17 youths who are receiving counseling and protection there.

"Our ultimate goal is to keep families alive," said George Johnson, director of the project.

Program Director Deborah Shore said the White House requested the visit. She said Dr. Foster's "I Have a Future" teen program in Nashville, Tenn., is similar to the Sasha Bruce program.

Dr. Foster, who may face Senate confirmation hearings later this month, stressed abstinence in his remarks to the youths and representatives of several local youth programs.

He suggested that inner-city youths have little to distract them from having sex and that contraception "is not enough." He said that more programs like the Sasha Bruce project are needed and that youths should be offered field trips to see life outside housing projects.

"If we want to prevent teen pregnancy, we must offer young people more," he said.

Dr. Foster arrived in a two-car motorcade that included armed U.S. marshals. An administration official declined to comment on security threats to Dr. Foster but said the protection is "commensurate [with the] risk."

Wash. Times A1 2-24-95

Proof of Foster effort's success elusive

By Rod Dreher
THE WASHINGTON TIMES

NASHVILLE, Tenn. — Dr. Henry W. Foster Jr. made his reputation with the White House through a Tennessee campaign to curb teen-age pregnancies using a message of self-esteem and abstinence.

If confirmed as surgeon general, Dr. Foster has promised to take his fight nationwide as his top priority.

But the particulars of how he did it, and the statistics to back up the claims of success, are elusive here in Nashville, where the prominent obstetrician-gynecologist founded the "I Have a Future" pro-

Sex-ed program impressed Clinton

gram in 1988.

The director of that program, Lorraine Williams Greene, declines to offer documentation that she says would show that the program has lowered pregnancies among the impoverished minority teens it was designed to serve. Neither she nor officials at Meharry Medical College, under whose auspices the program is operated, would permit inspection of the curriculum to see how abstinence is taught.

The White House did not respond to several requests for comment. Neither would the Department of Health and Human Services. Dr. Foster declined to give an interview.

Critics of the Foster nomination and others in the sex education field are puzzled by what they call secrecy and stonewalling.

"It seems to me that if they're promoting success with the program, they certainly should be willing to provide the study," said Douglas Kirby of ETR Associates,

see FOSTER, page A14

• Democrats rave about nominee for surgeon general. A14



But does it work? Joe Jenkins leads teen-agers in discussion as part of Nashville's "I Have a Future" program, founded by Dr. Henry W. Foster Jr.

FOSTER

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a health-education firm in Santa Cruz, Calif., that evaluates sex-ed programs nationwide.

"If this program is so good, why won't they let anybody see it?" said Kristi Hamrick, a spokeswoman for the Family Research Council, which opposes Dr. Foster's nomination.

Marie Mitchell, who heads a comprehensive sex-ed program in an Atlanta hospital, and Kathleen Sullivan, who works in an Illinois abstinence-based program, don't agree on the best way to teach teens how to avoid pregnancy, but both say that credible sex-ed programs generally make information available to the public.

On an annual budget of \$300,000, "I Have a Future" serves about 150 black teen-agers and adolescents in two Nashville housing projects. It conducts after-school counseling and instruction in a wide variety of areas, including substance-abuse avoidance, violence prevention and employment skills. The youths range in age from 10 to 17. Slightly more than half are males.

Sex education and family planning form only a small part of the overall effort, says the director of the program, which Dr. Foster introduced and directed as dean of Meharry Medical College.

A brochure distributed by the program describes it as built "on the premise that changes in sexual behavior should be addressed within a framework that provides strategies for positive decision-making while enhancing self-image."

In an interview in the program offices near the Meharry campus, Mrs. Greene said a study of the program's effectiveness in its first 30 months found 59 reported pregnancies within a demographically similar group of girls not in the program. Among participants, only one pregnancy was reported.

But she declined to make a copy of the study available for examination and verification of methodology and statistics. The findings, taken four years ago, are withheld,

she says, because "we're writing it up for a journal article."

She says there is not enough money available to properly study the results of its methods. Independent program evaluators say this is a common problem of sex-education agencies.

Mrs. Greene says the program has collected little data to indicate whether participants actually delay sexual activity, but she offers anecdotal evidence.

"I can say that when we generally just talk, and I've heard reporters talk to young people, a number of them are abstaining," she said.

Mrs. Greene said the program doesn't measure its success just on the basis of teen pregnancies reduced, relying as well on high school graduation rates and self-esteem evaluations. The Meharry study, she said, found "statistically significant differences" between program participants and others in a control group monitoring self-esteem, college plans and "psychosocial maturity."

"We wanted to find out: Do they think they have more life options, do they feel better about themselves, do we make them feel better about themselves? Self-esteem, is that increased?"

Abstinence, said Mrs. Greene, is presented as a "life options model," as part of a broader effort to teach "interpersonal relationship" skills. She said youngsters are told they can be intimate without having sex, and are shown strategies for saying no to unwanted sexual attention.

Researchers at the Family Institute, a Nashville-based organization affiliated with Focus on the Family, say their examination of the material provided before the Foster nomination showed no mention of the word "abstinence."

A computer printout offered to a reporter includes the word "abstinence" once in a capsule description of the curriculum. Mrs. Greene said abstinence is discussed in the "Family Life Module" of the curriculum, "so it's not true that it's not written anywhere."

She and Martha Robinson, who heads Meharry's public informa-

tion office, both refused requests to review the material.

Conservative critics of the program argue that in any case the distribution of condoms and birth-control pills undermines the abstinence message.

Mrs. Greene bristles at the suggestion that contraception is easily available to participants. "The clinical staff is going to do a psychosocial history before they even talk to them about birth control," she said.

Gayle Fleming, a public housing resident whose two adult children are graduates of the program, says the program does not merely offer birth-control information and devices. "They teach them what they're giving it to them for."

The program director says 83 percent of the participants come from single-parent families. She says the program takes a "non-judgmental" approach to teaching about the importance of family structure.

"It's very important that they know that we realize that their families are showing a lot of self-determination, and that they need to come together to make sure their family system continues," Mrs. Greene said.

The "I Have a Future" program receives funding from private donors, including the Carnegie Corp., the W.T. Grant Foundation, the William and Flora Hewlett Foundation, and actor Bill Cosby and his wife, Camille.

Rep. Bill Dunn of Knoxville, a Republican state legislator, was permitted to review the program material on Wednesday under supervision of Mrs. Greene and on the condition that he not take notes.

"It is definitely not an abstinence-based curriculum," he said afterward. "In the key concepts area, it mentions contraceptives four times, abstinence zero. There's a session where they break the kids up into pairs give them condoms, have them take it out, put it over their fingers and examine the texture," he said.

"I can see why they're hiding this. I mean, what's the difference between this guy and Joycelyn Elders?"

Sex-education views a problem for Foster

■ **The sexuality philosophy of Planned Parenthood, to which he is closely tied, is at issue.**

By Joyce Price
THE WASHINGTON TIMES

Surgeon general nominee Henry W. Foster Jr. was listed as a "public policy advocate" for Planned Parenthood Federation of America in that pro-choice group's 1992 annual report — a designation that is coming back to haunt him.

Opponents of the nominee — who also was a Planned Parenthood board member — argue that some of the sex-education policies the organization has advocated are far outside the mainstream.

As a "public policy advocate," Dr. Foster "would appear to be of a philosophy . . . that reduces sexuality to being primarily a physiological, biological phenomenon. . . . It's a . . . view that the mind and the body are radically separate from each other," said Onalee McGraw, director of the Educational Guidance Institute, an abstinence advocacy group.

"Our preliminary research indicates Dr. Foster's policies (on sex education) are more aligned with those of [former Surgeon General] Joycelyn Elders than those of most parents," Mark A. Tblf, spokesman for the Family Institute, a family advocacy group based in Nashville, Tenn., said in an interview on "Point of View" on the USA Radio Network.

Dr. Foster, 61, has had an obstetrics-gynecology practice in Nashville. In a statement Friday, he acknowledged he has performed some nontherapeutic abortions in that practice.

Opposition to his nomination has been mounting as a result of that disclosure, his ties with Planned Parenthood, and a health-promotion initiative he began at two Nashville housing projects in which condoms and other contraceptives are provided to adolescents.

The surgeon general nominee was a member of Planned Parenthood's national board from 1979 to 1981. Since 1989, he has served on its National Leadership Committee to Keep Abortions Safe and Legal.

Judie Brown, president of the American Life League, said Dr. Foster and Planned Parenthood's policies are the wrong answers for the mammoth problem of out-of-wedlock births. What's needed, she said, is "to do all we can to reinforce the family unit and strong moral values, not destroy it by inserting the government directly into the sex lives of our children."

Several senators have raised doubts about the confirmation prospects of Dr. Foster, a health-policy fellow at the Washington-based Association of Academic Health Centers.

"If the administration chooses to go forward with this nomination, it will have serious difficulty in the Senate," said Eric Ueland,

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SEX-ED

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spokesman for the Senate Republican Policy Committee.

That group's chairman, Sen. Don Nickles, Oklahoma Republican, led the floor fight against the confirmation of Dr. Elders, who was fired in December for saying masturbation should be taught in schools.

James A. Smith, government affairs director for the Southern Baptist Convention's Christian Life Commission, said Dr. Foster "will be Joycelyn Elders all over again" in terms of policy.

"This nomination is a test of whether the new Republican-controlled Senate is up to fighting the culture war. . . . If Henry Foster is confirmed, we'll have seen an abject failure by the GOP," Mr. Smith said.

Dr. Elders was a strong advocate of a "comprehensive health education program" for children in grades kindergarten through 12, including sex education in the early grades and secondary school clinics providing contraceptives.

Concerns about masturbation instruction and any sex education programs that condone sexual activity by children have been raised by conservative groups unhappy with Dr. Foster, who, as surgeon general, would be expected to lead President Clinton's campaign against teen pregnancy.

During the time that Dr. Foster was a "public policy advocate," Planned Parenthood and a controversial New York-based organization known as the Sex Information and Education Council of the United States (SIECUS) led a powerful lobbying drive for a comprehensive national sex-education

curriculum for children in kindergarten through grade 12.

It was an effort proponents said would help reduce teen-age pregnancy, pointing to sex-education guidelines developed by SIECUS as a possible model curriculum.

"The SIECUS guidelines teach kids to explore their sexuality," said Kristi Hamrick, spokeswoman for the Family Research Council, one of the first groups to condemn Dr. Foster's nomination. "SIECUS is a pro-masturbation group."

"Dr. Elders was a very strong supporter of SIECUS, and they of her. She contributed several articles to their magazine, SIECUS Report," said Pat Funderburk Ware, former director of the Office of Adolescent Pregnancy Programs in the Department of Health and Human Services.

SIECUS officials were not avail-

able to comment.

A 1993 Wall Street Journal report about the guidelines noted that SIECUS advocated teaching schoolchildren that:

- "Girls and boys have body parts that feel good when touched."

- "Homosexual love relationships can be as fulfilling as heterosexual relationships."

- "Some people use erotic photographs, movies or literature to enhance their sexual fantasies when alone or with a partner."

The Educational Guidance Institute's Mrs. McGraw said the SIECUS curriculum is being used by a small number of school districts. She and the Family Institute's Mr. Tolf attacked Planned Parenthood for bringing lawsuits against school systems that have implemented abstinence-based curricula.

THE FOSTER NOMINATION

White House stands by surgeon general pick

Teen-agers have a future, thanks to Foster program

By Andrea Stone
USA TODAY

NASHVILLE — At 17, Tonya Rutledge sees two futures: what might have been and what instead will be.

Her 16-year-old sister cares for a new baby, whose father was killed before the child was born. She struggles along on welfare, often missing school.

Tonya will graduate this spring and attend college in the fall. As her elaborate hairdo at tests, she is on her way to a career as a cosmetologist.

"The big difference is I know how to listen," she says.

Teens like Tonya are testimony to the work of Henry Foster, the doctor President Clinton has tapped as his next surgeon general. Foster's teen pregnancy prevention program, called I Have A Future, has helped keep her going in the right direction. It was supposed to do the same for the Foster nomination, appealing to conservatives and liberals.

But that was before questions arose about Foster and abortion. Now, I Have A Future is being wielded like a sword by conservatives.

A talker on Martin Luther King Jr.'s "I Have a Dream," the program was founded in 1968 to stress abstinence and responsibility to adolescents.

President Bush chose it as his 40th Point of Light. A letter from him lauds staffers for their "shining example."

Run by Meharry Medical College, where Foster once headed obstetrics and gynecology, IHAF is based at two mostly black public housing projects on this city's north side. It offers tutoring and counseling to 150 adolescents. In after-school sessions, they learn job skills, self-esteem, self-control and black history.

Teens even set up businesses to finance field trips to places like Washington and New Orleans. For most, it's the first time they've left Nashville.

They can get medical exams, pregnancy tests and condoms. There's no abortion counseling; pregnant teens are



"The whole idea is to get young people to delay pregnancy, which just doesn't fit into their lives.
"

"
— Lorraine Williams Greene, director

referred to other programs.

"The whole idea is to get young people to delay pregnancy, which just doesn't fit into their lives," says director Lorraine Williams Greene.

Foster's admirers say the project is a model of how he'd approach teen pregnancy as surgeon general.

Conservatives condemn the program for distributing contraceptives. The Family Institute, a conservative Nashville group, says the IHAF brochures they have seen don't mention abstinence and the program has an "activist approach" to birth control.

Gary Bauer, head of the conservative Family Research Council, says Foster's approach "is to say abstinence is best and in the next breath make it clear that birth-control pills and condoms are available. That approach has left a trail of suffering and tragedy."

Supporters say critics distort a program that faces reality: 75% of teens in Nashville's housing projects have sex by



ROLE-PLAYING: Terrell Carter and Amelia Turner participate in an exercise of the "I Have A Future" program in Nashville. The program teaches self-control, self-esteem, job skills and black history.

age 15. In 1993, the adolescent pregnancy rate here in Davidson County was 30 per 1,000.

When Foster and others started IHAF, says David Satcher, director of Centers for Disease Control and Prevention, "They sat down with parents and found out what they wanted. They came out really pushing abstinence, but they also had condoms available."

"There's a lot of pressure" to have sex, says Amelia Turner, 18. Program counselors "let us know that if you want to have sex, here's what you can use. But the best sex is no sex."

Greene says little money is available to document IHAF's effectiveness, but one 30-month survey ending in 1991 showed "statistically significant" declines in teen pregnancy and dropout rates.

IHAF fees include those referred by schools and prob-

ation officers, honor roll students and athletes.

More than half are young men, a reminder that teen pregnancy is not just a female problem. There are many reminders at the bleak John Henry Hale Houses, where single mothers head 83% of families.

Without IHAF, Jason Gordon, 18, says, he'd "be running from the police." Instead, he's a Fisk University freshman. "They ensured I would go to college. They pushed to keep me on my toes."

Terrell Carter, 18, credits the program for teaching him that fathering a child is "nothing to be proud of." He now has "more respect for girls. They're not just sex objects."

"It turns young people's lives around," says Louis Sullivan, secretary of Health and Human Services under Bush. It's "the kind of program that the

country needs."

Urban Institute sociologist Martha Burt "loves" the program. By saturating a small area and sticking with kids for years, it offers "enough peer support that they can withstand the pressure around them."

But it's expensive: 14 staff members counsel teens, who often stay in the program for years. IHAF's \$400,000 budget comes from private foundations and gifts from, among others, actor Bill Cosby. As government funds for social programs dry up, starting similar programs will be tough. IHAF itself has a long waiting list.

But parents think the wait is worth it. Says Sandra Summers, whose daughter Juanna attends IHAF: "It gives them something to look forward to. Something other than what's on the streets."

Contributing: Mimi Hall

Admits background probe could have been 'better'

By Mimi Hall
USA TODAY

The White House acknowledged Wednesday that it should have "done a better job" investigating Henry Foster before nominating him to be surgeon general.

But as the controversial nominee went on ABC's *Nightline* and pledged to fight for the job, President Clinton once again defended him.

Clinton predicted the Nashville obstetrician-gynecologist will be confirmed by the Senate, despite accusations that Foster and the White House were misleading about how many abortions he was responsible for in his 37-year career.

Foster, Clinton said, has "devoted his life to trying to prevent the kind of problems that he is now being criticized for."

He added: "I believe he should be confirmed and I believe he will."

Controversy erupted Monday, when abortion opponents released documents indicating he may have performed many more abortions than the "fewer than a dozen" he previously acknowledged.

A second document released Tuesday said that in the early 1980s, Foster headed a Meharry Medical College experiment using a drug to induce abortions in at least 60 women.

Foster had stayed out of sight, but the Clinton administration accepted the *Nightline* interview in hopes of defusing the situation. He spent Wednesday afternoons being questioned in mock interviews by White House staff.

"It seems that everyone in this country has been defining Henry Foster except Henry Foster," he said, as the ABC interview began. "Washington is a fast town, but I am becoming a quick study."

Asked why he'd changed his version of how many abortions he'd done, Foster said his statement last week was "a guess, and I should not have made it."

He said that in the past three days he'd pored over his records and counted 39 abortions,



By Tim Davis, USA TODAY
FOSTER: Record will stand up very well in Senate hearings

plus the 69 in the medical school study.

Foster defended training residents at Meharry on abortion techniques, saying, "We have a responsibility to teach all residents to manage the complications of abortion."

White House spokesman Mike McCurry said administration staffers had misheard the process by not making accurate information available before abortion opponents released the documents.

"We should have done a better job," McCurry said.

He added, "The question is ultimately who's responsible, and it's the president that nominates and the White House that's responsible."

Opposition to Foster began with abortion opponents, but it has expanded to those who question his credibility.

"They should have taken the finest doctor they could find in the country, someone near retirement without any controversy," said Sen. Joseph Biden, D-Del. "It's not like this is the only doctor in the world."

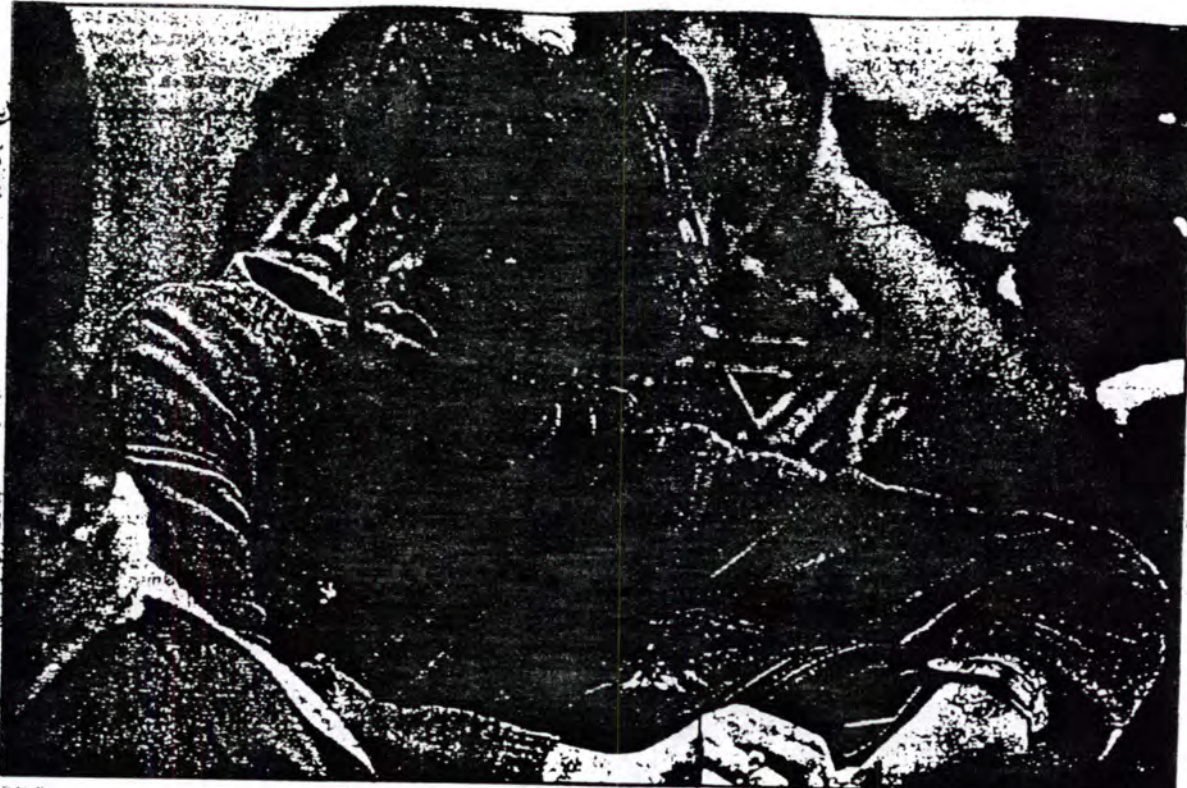
Foster, 61, is a former dean and acting president of Meharry Medical College.

If confirmed, he'd replace former surgeon general Jocelyn Elders, whose tenure was marked by controversial public statements. Elders was fired by Clinton in December after saying schools should consider teaching about masturbation as part of sex education.

NASHVILLE
BANNER

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Families rally behind embattled Foster's program for teen-agers



Banner photo by David Claster

LaShonda Maryland pauses for a moment while listing stereotypes during a discussion in the "I Have a Future" program.

'We try to get them to make good choices'

By Kimberly Hadley
Banner Staff Writer

Teen-agers in Meharry Medical College's "I Have a Future" program gather in the community center of the John Henry Hale public housing development to talk about their history, their future and all of life's decisions in between.

RELATED STORIES

- Foster's backers go on the offensive, A-10
- Editorial: Put doctor's record in focus, A-12

"It built up her self-esteem," Sandra Summers says of her daughter, Juanna Claybrooks, who has participated in the program for six years.

"She's doing real good in school, and I know these people up here are friends of hers," Summers says.

Since President Clinton announced the "I Have a Future" founder, Dr. Henry Foster, as his nominee to be the new surgeon general, the teens and teachers in the program have been caught in the spotlight of media attention, both national and local.



Joe Jenkins (right) leads a discussion with teen-agers enrolled in the "I Have

Among the visitors to this week's classes on cultural history and family life education were a camera crew from CNN and reporters from USA Today and

a Future" program, founded by surgeon general nominee Dr. Henry Foster.

Time magazine.

Clinton cited the success of "I Have a

Please see FUTURE, page A-2



"I Have a Future" participants (from left) Terrance Lawless, Gary Hicks, Rhianon Wilson and LaShonda Maryland perform a role-playing exercise to show the stereotypes about the inappropriate ways men try to meet women.

Future

Continued from page A-1

"I have a Future" in fighting teen pregnancy and said he wanted Foster to lead a national effort to solve the problem.

But conservative and anti-abortion groups have questioned the program's sex education component and the fact that it makes contraceptives available.

Parents of the teens involved in the program are quick to defend it.

Students can't just walk off the street and say, "I have a date tonight, give me a condom," says Gayle Fleming, a parent of two students who went through the program.

The students learn that "abstinence is the safest way to go," says Rico Seay, a freshman at Tennessee State University who has been in the program for nearly seven years.

"It's a life options program," says Dr. Lorraine Williams Greene, "I Have a Future" director and a clinical psychologist.

"We try to get them to make good choices and we teach them problem solving... because somebody is not going to be with them always."

Defining values

During a meeting this week, the students discussed their thoughts about everything from where they want to go to school to how they feel about themselves.

"I want to encourage you to use your family members as counselors," says Joe Jenkins, a facilitator for the family life educational class.

"They may have wanted to do that," he tells the students, "they just were waiting for you to ask."

Jenkins then moves the discussion toward stereotypes and self-esteem.

He asks the 11 students to list four good things about themselves. Adjectives like nice, respectful and good-looking come easily for most of them.

Jenkins explains that positive self-esteem will be needed to avoid wavering from their values.

"One of the biggest challenges of adolescence is defining one's values," Jenkins says. "What is going to change the values more than anything?"

Peers, they agree.

"Many guys that are in trouble with the law will say to me, 'Joey, well, they said I wasn't going to do anything with my life, so I thought I might as well do that,'" Jenkins tells the class.

"I ask, 'Why do you buy into that?'" Jenkins says. "If you buy into the stereotype that says because he's from the projects he's probably selling drugs, you will get the attitude of 'I might not as well try.'"

Stereotypes the students have of others also might reveal how they view themselves, Jenkins explains.

He then points to how many of them spoke negatively when asked to describe people who live in the projects while speaking positively

when describing people who live in the upscale neighborhood of Belle Meade.

In another discussion, Calvin Peters, a program facilitator and a head of the "I Have a Future" entrepreneurship program, asks the 12 students learning about black history to give the name and location of traditionally black colleges and universities in the U.S.

After the first time around the room, the pauses grow between answers.

"A lot of things you take for granted now was not guaranteed to you in the past," Peters says. "Thirty years ago you would've known every black college, because you would've not had a choice to go anywhere else."

'Like a family'

Such sessions usually involve discussions, role-playing and lots of laughter.

"We're like a family," says Jason Gordon, a freshman at Fisk University, who is a peer counselor. He has been in the program about seven years.

He admits, however, that in the beginning the program wasn't looked upon as being the cool thing to do.

"Then they realized how much fun we have," says Terrell Carter, a senior at Pearl-Cohn High School.

Pearl-Cohn football coach Maurice Fitzgerald, who works with the entrepreneurship segment of the program, says supporting the teens is an important aspect of "I Have a Future."

About 20 of Fitzgerald's football players participate.

"I try to be involved with them in other areas than just on the football field," he says.

Supporting the teens intellectually and emotionally helps them to see him in a different light, Fitzgerald says.

The program's ties to Pearl-Cohn's extracurricular activities have helped make it more popular, Peters says.

"These kids are becoming leaders at school," he says, which encourages others to join. Many are also going to college and avoiding becoming teen parents.

Such strides helped earned the program recognition from President George Bush as one of his "Thousand Points of Light."

But never has so much attention been focused on the program as has been since Foster was nominated for surgeon general.

Peters thinks the attention is long overdue for the program, which serves about 150 teens—mostly primarily from Hale and Preston Taylor public housing.

But regardless of whether the program is duplicated nationwide, he and other "I Have a Future" leaders believe it is making a difference in Nashville.

That's evident by the students who line up outside the door, waiting for it to open at 3 p.m. every day, to get help with homework, says Jenkins.

And it's evident, he says, by the parents that encourage their children to attend by telling them, "Go to the Future."



News Release

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FOR IMMEDIATE RELEASE

February 3, 1995

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Henry Foster, Jr., M.D.

When Medical Expertise Becomes Deadly

The nomination of Henry Foster, Jr., M.D., to the post of United States Surgeon General is the latest knee-jerk reaction of Clinton and friends to the problem of teenage out-of-wedlock births. Apparently many in the White House and on Capitol Hill really believe that birth control pills and condoms will solve this problem. What they don't want to believe is that the underlying cause of the problem, the disintegration of the nuclear family, has come about because of their commitment to facilitating irresponsible sexual behavior. When the government sanctions birth control for children and repeatedly assures the electorate that young people simply cannot practice chastity, the results are obvious.

According to the Tennessee Family Institute, Dr. Foster's program, *I Have a Future*, includes the objective of making birth control chemicals and devices available to young people. This is an irresponsible objective.

The best way to assure a child that he or she has a future is to do all that we can to reinforce the family unit and sound moral values, not destroy it by inserting the government directly into the sex lives of our children.

The facts are these:

- Dr. Foster is a proponent and a practitioner of abortion—and abortion kills one child every twenty seconds of every single day;
- Dr. Foster is a proponent of birth control for children—which leads to venereal disease, infertility and worse; and
- Dr. Foster is no friend to the families of this nation, nor will his agenda ever resolve the *out-of-wedlock* pregnancy problem.

Since we know that Foster was actively involved in the Planned Parenthood Federation of America's *Keep Abortion Safe and Legal* campaign, we need not trust his politically correct rhetoric that he wants to reduce the number of abortions or his assertion that he will not advocate abortion as the ultimate solution for the baby conceived out of wedlock.

There is no future for children in having sex outside of marriage; that has become painfully clear. However, there is a multi-million-dollar trough of government dollars ready to be doled out to those groups providing the sex-education programs promoting birth-control chemicals and devices to our children. We hear repeatedly from government sources that children are not going to practice chastity and that they are not going to avoid sex until marriage. What we don't hear is that when our children pursue behavior based on self-respect and chastity, those children save our nation millions of lives and millions of dollars.

Dr. Foster's track record is very clear. If he is confirmed, we will not have a Surgeon General who is committed to our children, their protection and their moral well-being. What we will have is a Surgeon General who has already bought the government lie, the government failures and the government intrusion in family life. We can therefore expect, if Dr. Foster is approved, more abortions among the poor, and an even greater increase in the number of single-parent families who, because of socio-economic misfortune, rely on a government that is definitely not their friend.

America must say no to the nomination of Dr. Henry Foster, Jr. America must say no to failed policies that result in damaged families, hurting teens and dead preborn children.

(Mrs.) Judie Brown, President of American Life League, urges all pro-family groups to fight Foster's nomination as Surgeon General. The future of America's children depends on it.

###

GUIDELINES FOR COMPREHENSIVE SEXUALITY EDUCATION

Kindergarten - 12th Grade

National Guidelines Task Force

ACKNOWLEDGMENTS

The National Guidelines for Sexuality Education were developed by a Task Force of leading health, education, and sexuality professionals. The Task Force members volunteered their time to participate in meetings, review documents, and offer feedback. The Task Force developed the concepts and subconcepts which represent the foundation of the guidelines. This material emerged as consensus beliefs of the Task Force. The guidelines could not have been prepared without their participation.

The format of the guidelines is modeled after the landmark School Health Education Study¹ (SHES) published in the late 1960s. The SHES developed an innovative approach of structuring health knowledge through the identification of broad health areas and related subconcepts. The generalizations were arranged in a hierarchy from kindergarten through grade twelve. It remains an excellent model for curriculum development in health and sexuality education.

William L. Yarber, Professor of Health Education at Indiana University and a member of the SIECUS Board of Directors, chaired the National Guidelines Task Force. Professor Yarber spent numerous hours developing the guidelines approach, chairing meetings, contributing content to the guidelines, and revising the document. This project could not have happened without his commitment.

Carol Hunter Geboy conducted much of the research for the guidelines content and developed the preliminary draft of the developmental messages. We are grateful for his important contributions.

Debra Haffner, SIECUS Executive Director, was the project director. The guidelines result from her vision to improve sexuality education. She provided direction, wisdom and numerous hours developing the final version of the guidelines.

SIECUS Executive Assistant JoAnne Pereira coordinated project logistics, compiled the references, and reworked countless drafts. She played a vital role in developing the document.

The Carnegie Corporation of New York provided the funding for the national Task Force and the development of the guidelines. We are indebted to Gloria Primm Brown Project Officer, for her commitment to the well-being of children and adolescents. The Carnegie Corporation is not responsible for the statements or views expressed in these guidelines.

These guidelines are dedicated to the memory of Mary Lee Tatum, a Task Force member, who died suddenly on June 1, 1991. She was an inspired trainer and educator, and champion of sexual information and sexual rights. We will miss her.

¹ School Health Education Study: *Health Education: A Conceptual Approach to Curriculum Design*. Bloomington: ME Education Press, 1967.

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THESE GUIDELINES ARE NOT A CURRICULUM OR A TEXTBOOK. The guidelines provide a framework to create a new program or improve existing programs. They provide a starting point for curriculum development at the local level, or may guide state policymakers and local school boards in evaluating existing or proposed programs. Classroom teachers may use them to provide a theoretical basis for daily programs. They can be used in teacher preparation or in-service education.

These guidelines present a comprehensive approach to sexuality education. The presentation of these issues is based on a carefully constructed, scoped and sequenced approach to the delivery of comprehensive sexuality education. Specific content have meaning only in the context of the total guidelines, and should not be used out of context to illustrate the guidelines.

Sexuality Education: Goals and Values

Sexuality education is a lifelong process of acquiring information and forming attitudes, beliefs, and values about identity, relationships, and intimacy. It encompasses sexual development, reproductive health, interpersonal relationships, affection, intimacy, body image, and gender roles. Sexuality education addresses the biological, socio-cultural, psychological, and spiritual dimensions of sexuality from (1) the cognitive domain, (2) the affective domain, and (3) the behavioral domain, including the skills to communicate effectively and make responsible decisions.

The primary goal of sexuality education is the promotion of sexual health. In 1975, the World Health Organization defined sexual health as "the integration of the physical, emotional, intellectual, and social aspects of sexual being in ways that are positively enriching, and that enhance personality, communication, and love...every person has a right to receive sexual information and to consider accepting sexual relationships for pleasure as well as for procreation."

Sexuality education seeks to assist children in understanding a positive view of sexuality, provide them with information and skills about taking care of their sexual health, and help them acquire skills to make decisions now and in the future. The life behaviors presented in Table 1 represent the desired outcomes of a sexuality education program.

These guidelines are based on four primary goals for sexuality education:

Information: To provide accurate information about human sexuality, including: growth and development, human reproduction, anatomy, physiology, masturbation, family life, pregnancy, childbirth, parenthood, sexual response, sexual orientation, contraception, abortion, sexual abuse, HIV/AIDS and other sexually transmitted diseases.

Attitudes, Values, and Insights: To provide an opportunity for young people to question, explore, and assess their sexual attitudes in order to develop their own values, increase self-esteem, develop insights concerning relationships with members of both genders, and understand their obligations and responsibilities to others.

Relationships and Interpersonal Skills: To help young people develop interpersonal skills, including communication, decision-making, assertiveness, and peer refusal skills, as well as the ability to create satisfying relationships. Sexuality education programs should prepare students to understand their sexuality effectively and creatively in adult roles. This would include helping young people develop the capacity for caring, supportive, non-coercive, and mutually pleasurable intimate and sexual relationships.

Responsibility: To help young people exercise responsibility regarding sexual relationships, including addressing abstinence, how to resist pressures to become prematurely involved in sexual intercourse, and encouraging the use of contraception and other sexual health measures. Sexuality education should be a central component of programs designed to reduce the prevalence of sexually-related medical problems, including teenage pregnancies, sexually transmitted diseases including HIV infection, and sexual abuse.

National Guidelines: Structure and Utilization

The guidelines answer several basic questions that educators, policy makers, and others must address when they design or evaluate a sound, comprehensive approach to sexuality education. For example:

- What key concepts should be taught in sexuality education?
- What are the components of each major concept?
- At what ages or developmental stages should specific information be taught?
- Does the existing program cover the appropriate content?

Development Process: SIECUS, the Sex Information and Education Council of the United States, convened a National Task Force of leading educators, health professionals, and national organization representatives in 1990. Task Force members, who are listed on the inside front cover of this document, included representatives from the U.S. Centers for Disease Control, the American Medical Association, the National School Boards Association, the National Education Association, the March of Dimes Birth Defects Foundation, the Planned Parenthood Federation of America, experienced school-based sexuality education teachers, and national program consultants and trainers.

The Task Force initially met in September 1990 to formulate the broad concepts of sexuality education, as well as specific subconcepts. Life behaviors and developmental messages for each concept were also generated. Each member reviewed the material during the subsequent months. In March 1991, the Task Force met, refined the initial document, and suggested further content. The guidelines were once again revised, disseminated to Task Force members for comments, and then finalized during the summer of 1991.

Guidelines Components: The guidelines provide an organizational framework of the knowledge of human sexuality and family living within four development levels from kindergarten through senior high school. The guidelines reflect an idealized model of a comprehensive approach to sexuality education.

The guidelines are organized into six key concepts. Each key concept has associated life behaviors, topics, subconcepts, and age-appropriate developmental messages.

Key Concepts: Six key concepts represent the most general knowledge about human sexuality and family living. The key concepts encompass the components of the broad definition of sexuality. Table 2 presents the six key concepts.

Life Behaviors: Several life behaviors, or those desired actions that represent outcomes of instruction, were generated for each key concept. The behaviors reflect optional actions of students either following instruction or during adulthood.

Topics: Each key concept has specific topic areas. A topical outline for a comprehensive sexuality education program can be generated by listing the key concepts with their associated topics. Table 3 presents such an outline.

4) The community must be involved in the development and implementation of the program. School-based education programs must be carefully developed to respect the diversity of values and beliefs represented in the community. Parents, teachers, administrators, community and religious leaders, and students should all be involved.

5) All children and youth will benefit from comprehensive sexuality education, regardless of gender, ethnicity, community, and disability. These guidelines form the basis of a program for young people in communities across the U.S. They must, of course, be adapted to reflect the specific issues and concerns of the community and its culture. They must also be adapted to the special needs of the learners.

6) The Task Force strongly endorses the value of addressing all three learning domains — cognitive, affective, and behavioral — in the sexuality education program. Sexuality education programs are most effective when young people not only receive information, but have the opportunity to explore their own values and attitudes and develop or strengthen social skills.

A wide variety of classroom activities foster learning: lectures, role plays, simulations, individual and group research, field trips, and group exercises. The Task Force believes that local conditions largely influence the nature of the local program; therefore, it chose not to suggest how each subconcept and developmental message should be addressed by using the learning domain approach. Local educators need to determine the instructional strategies and classroom activities.

These guidelines are only a beginning. They represent the first national approach to sexuality information and comprehensive guidelines that will truly help the children of the 21st century become sexually healthy and happy adults.

If you need help in developing or implementing sexuality education programs, contact SIECUS for technical assistance. We would also like to hear from you if you adapt these guidelines for your community.

Key Concept 1: HUMAN DEVELOPMENT

Human development is characterized by the interrelationship between physical, emotional, social and intellectual growth.

Human Development Life Behaviors:

Having learned the human development subconcepts, at the appropriate age the learner will be able to:

- Appreciate one's own body.
- Seek further information about reproduction as needed.
- Affirm that human development includes sexual development, which may or may not include reproduction or genital sexual experience.
- Interact with both genders in respectful and appropriate ways.
- Affirm one's own sexual orientation and respect the sexual orientation of others.

Topic 1: Reproductive Anatomy and Physiology

Subconcept: The human body has the capability to reproduce as well as to give and receive sexual pleasure.

Developmental Messages:

Level 1

Each body part has a correct name and a specific function.

A person's genitals, reproductive organs, and genes determine whether the person is male or female.

Boys and men have a penis, scrotum and testicles.

Girls and women have a vulva, clitoris, vagina, uterus, and ovaries.

Both girls and boys have body parts that feel good when touched.

Level 2

The maturation of external and internal reproductive organs occurs during puberty.

At puberty, boys begin to ejaculate and girls begin to menstruate.

Level 1: middle childhood, ages 5 through 8; early elementary school

Level 2: preadolescence, ages 9 through 12; upper elementary school

Level 3: early adolescence, ages 12 through 15; middle school/junior high school

Level 4: adolescence, ages 15 through 18; high school

Topic 4: Body Image

Subconcept: People's image of their bodies affect feelings and behaviors.

Developmental Messages:

Level 1

Individual bodies are different sizes, shapes and colors.

Male and female bodies are equally special.

Differences make us unique.

The way a body looks (skin color, hair, eye color, shape) is mainly determined by a person's parents and grandparents.

All bodies are special, including those that are disabled.

Good health habits, such as diet and exercise, can improve the way a person looks and feels.

Each person can be proud of the special qualities of his/her own body.

Level 2

A person's appearance is determined by heredity, environment, and health habits.

The media portray beautiful people but most people do not fit these images.

The value of a person is not determined by their appearance.

Level 3

Bodies grow and change during puberty.

The size and shape of the penis or breasts does not affect reproductive ability or the ability to be a good sexual partner.

The size and shape of a person's body may affect how others feel about and behave toward that person.

People with physical disabilities have the same feelings, needs, and desires as people without disabilities.

Level 4

Physical appearance is only one factor that attracts one person to another.

A person who accepts and feels good about his or her body will seem more likable and attractive to others.

Physical attractiveness should not be a major factor in choosing friends or dating partners.

Topic 5: Sexual Identity and Orientation

Subconcept: As young people grow and develop, they begin to feel romantically and sexually attracted to other people.

Developmental Messages:

Level 1

Everyone is born a boy or a girl.

Boys and girls grow up to be men and women.

Human beings experience different kinds of loving.

Most men and women are heterosexual, which means they will be attracted to and fall in love with someone of the other gender.

Some men and women are homosexual, which means they will be attracted to and fall in love with someone of the same gender.

Homosexuals are also known as gay men and lesbian women.

Level 2

Sexual orientation refers to whether a person is heterosexual, homosexual or bisexual.

A bisexual person is attracted to men and women.

It is not known why a person has a particular sexual orientation.

Homosexual, heterosexual, and bisexual people are alike except for their sexual attraction.

Homosexual and bisexual people are often mistreated, called hostile names, or denied their rights because of their sexual orientation.

Some people are afraid to admit they are homosexual because they fear they will be mistreated.

Homosexual love relationships can be as fulfilling as heterosexual relationships.

Gay men and lesbians can form families by adopting children or having their own children.

Level 3

Theories about what determines sexual orientation include physical factors such as genetics and prenatal influences, socio-cultural influence, psychosocial factors, and a combination of all these factors.

Homosexual couples behave sexually in many of the same ways as heterosexual couples.

Many young people have brief sexual experiences (including fantasies and dreams) with the same gender, but they mainly feel attracted to the other gender.

Some young people have brief sexual experiences with the other gender but they mainly feel attracted to their own gender.

When a homosexual person accepts his/her sexual orientation, gains strength and pride as a gay or lesbian person, and tells others, it is known as "coming out".

"Coming out" can be difficult because people fear negative reactions.

It is common for people to feel some attraction to men and women.

A small percentage of people in every culture and society will be homosexual.

People do not choose their sexual orientation.

Sexual orientation cannot be changed by therapy or medicine.

It can be difficult to understand one's sexual orientation.

Gay men, lesbian women, and bisexuals can lead fulfilling lives.

Gay men and lesbian women can establish lifelong committed relationships.

Level 4

Sexual orientation is determined by a person's attractions, fantasies, and behavior. One's understanding and identification of one's sexual orientation may change during life.

Teenagers who have questions about their sexual orientation should consult a trusted and knowledgeable adult.

Parents, teachers, guidance counselors, physicians, religious leaders, and gay and lesbian community centers may offer support for young people who have concerns about their sexual orientation.

The telephone number of the gay and lesbian switchboard is 1-212-777-1800.

Key Concept 2: RELATIONSHIPS

**Relationships play a central role
throughout our lives.**

Relationships Life Behaviors:

Having learned the relationships subconcepts, at the appropriate age the learner will be able to:

- Express love and intimacy in appropriate ways.
- Develop and maintain meaningful relationships.
- Avoid exploitative or manipulative relationships.
- Make informed choices about family options and lifestyles.
- Exhibit skills that enhance personal relationships.

Topic 1: Families

Subconcept: People are raised in families and most live in families as adults.

Developmental Messages:

Level 1

A family consists of two or more people who care for each other in many ways.

There are different kinds of families.

Children may live with one parent, two biological parents, two remarried parents, adoptive parents, grandparents, friends or other combinations of adults and children.

Every family member has a role and individual needs.

Individual families change over time.

Families have rules to help people live together and children develop.

Family members take care of each other.

All the members of a family may not live in the same place.

Family members can show love for each other in many ways.

Level 1: middle childhood, ages 5 through 8; early elementary school

Level 2: preadolescence, ages 9 through 12; upper elementary school

Level 3: early adolescence, ages 12 through 15; middle school/junior high school

Level 4: adolescence, ages 15 through 18; high school

Topic 4: Dating

Subconcept: Dating enables people to experience companionship and intimacy.

Developmental Messages:

Level 1

When two teenagers or unmarried adults spend their leisure time with one another, it is often called dating.

When children become teenagers, they spend more time with their friends and may begin to date.

Sometimes single parents date.

Level 2

Teenagers and adults often have several romantic relationships.

Before people commit themselves to a relationship, they should be friends, spend time together, and get to know one another well.

Level 3

Dating includes sharing recreational activities, learning about new things, and practicing social skills.

Parents usually decide the age when children can begin dating.

When couples spend a lot of time together alone, they are more likely to become sexually involved.

In some cultures, two unmarried people are allowed to spend time together only when accompanied by another person.

People date in different forms such as couple dating, double dating, and group dates.

People date for different reasons such as companionship, to share an experience with someone, friendship, and love.

Not all teenagers or adults date.

Readiness and interest in dating vary among individuals.

When dating involves expenses, either partner or both can pay.

Paying for a date does not entitle one to any type of sexual activity.

Gay and lesbian youth, like heterosexual youth, may or may not date.

Level 4

Dating can be a way to learn about other people, about romantic and sexual feelings, and expression, and about what it is like to be in a love relationship.

There does not have to be prescribed gender roles for dating partners.

Dating relationships are enhanced by honesty and openness.

A dating partner can not meet all the needs of another person.

Responsibility for the quality of the relationship is shared by both dating partners.

Topic 5: Marriage and Lifetime Commitments

Subconcept: Marriage is a legal commitment that two people make to share their lives and family responsibilities.

Developmental Messages:

Level 1

Two people decide to marry or make a lifetime commitment to each other because they love each other and want to share their lives together.

Most men and women will marry.

Some couples who love each other live together in the same home without getting married.

Many gay men and lesbian women live in lifetime committed relationships, even though they may not be recognized as married.

Most people who marry intend it to be a lifelong relationship.

People who are married may get divorced when they decide they do not want to live with each other anymore.

People can have children whether they are married or unmarried.

When parents divorce, children may live with one or both of them.

Divorce is usually difficult for parents and for children.

After a divorce, parents and children continue their lives in new ways and usually become happy again.

Level 2

In our country, people usually choose the person they want to marry.

In some cultures, parents choose the marriage partners for their children.

In the different cultures in the U.S., there are different values about marriage, divorce, living together, and parenthood.

Most married women and men work outside of the home, even after their children are born.

Children are not to blame for their parents' divorce.

Children are not able to get their separated or divorced parents back together regardless of how much they want it to happen.

Children dealing with separation or divorce may need to talk with an adult about their feelings.

Level 3

Marriage is a legal contract between two people and the state.

Marriage is considered a commitment by two people to love one another, live together, and help and support one another.

Committed partners must decide how to share the roles and responsibilities in their lives.

Divorce is the legal ending of a marriage.

In a divorce, decisions about the family, including custody of children and financial resources, may be decided by the couple or the legal system.

Key Concept 3: PERSONAL SKILLS

Healthy sexuality requires the development
and use of specific personal and interpersonal skills.

Personal Skills Life Behaviors:

Having learned the personal skills subconcepts, at the appropriate age the learner will be able to:

- Identify and live according to one's values.
- Take responsibility for one's own behavior.
- Practice effective decision-making.
- Communicate effectively with family, peers, and partners.

Topic 1: Values

Subconcept: Values guide our behavior and give purpose and direction to our lives.

Developmental Messages:

Level 1

Values are strong feelings or beliefs about important issues.

Individuals and families have different values.

Level 2

Values help people decide how to behave and interact with others.

Most parents want their children to develop values similar to their values.

Members of the same family may have different values.

Children receive most of their values from parents, other family members, community cultural and religious teachings, and their peers.

Friends may have different values.

Level 3

Values should be freely chosen after the alternatives and their consequences are evaluated.

Level 1: middle childhood, ages 5 through 8; early elementary school

Level 2: preadolescence, ages 9 through 12; upper elementary school

Level 3: early adolescence, ages 12 through 15; middle school/junior high school

Level 4: adolescence, ages 15 through 18; high school

Men and women in our society may communicate differently; this may cause miscommunication.

Communication can be improved by: (a) listening well, (b) making eye contact, (c) stating feelings, (d) trying to understand the other person's point of view, (e) offering possible solutions to problems, and (f) giving positive nonverbal messages such as a smile or touch.

There are other behaviors that impair communication such as (a) not listening, (b) yelling or talking loudly, (c) blaming, criticizing or name calling, (d) making the other person feel guilty, (e) giving negative nonverbal messages, such as frowning or scowling, and (f) interrupting.

Verbal and nonverbal communication do not always convey the same message.

Words can have different meanings depending on the person, gender, cultural background, and situation.

People are often uncomfortable discussing sexuality in an open manner.

Talking openly about sexuality becomes easier with practice.

Good communication about sexuality enhances relationships.

Level 4

Good communication is essential to personal and work relationships.

Communication can be enhanced by being sure that the other person's feelings and meanings are understood.

Communication about sexual feelings, desires, and limits improves sexual relationships.

Topic 4: Assertiveness

Subconcept: Assertiveness is communicating feelings and needs, while respecting the rights of others.

Developmental Messages:

Level 1

Everyone, including children, has rights.

It is alright to tell trusted people about one's feelings and needs.

Asking is the first step to having needs met.

Children sometimes have to do things they don't want to do because their parents say so.

Level 2

Being assertive means speaking up for what one wants or saying how one feels.

Assertiveness is a skill that can be learned and improved.

Assertiveness is different from aggressiveness; aggressiveness interferes with the rights of others.

Being assertive includes repeating one's position, taking the offensive, offering a compromise, refusing further discussion and walking away.

Being assertive does not ensure that people will always get what they want.

Level 3

In the past, females in our society were taught not to be assertive.

Today, girls and women and boys and men can be assertive.

In some cultures, asking directly for what one wants is still considered impolite or inappropriate.

People have the right to (a) say how they feel even if others disagree,

(b) refuse a request, and (c) expect to be treated fairly and not be intimidated.

Sometimes people must choose between actions they believe are best or their friends' actions.

Behaviors that help people be more assertive include: (a) being honest, (b) being direct, (c) being spontaneous, communicating feelings and needs as they come up instead of waiting, (d) using assertive body language, and (e) speaking for oneself, and (f) taking responsibility for one's feelings and needs.

Behavior that is viewed as aggressive in one culture may be viewed as assertive and appropriate in other cultures.

Being assertive in sexual situations may be especially difficult.

People always have the right to refuse any person's request for any type of sexual behavior.

Failing to be assertive may cause one to feel angry and, as a result, act aggressively at some future time.

Level 4

Sexual partners need to communicate clearly about their needs and limits.

Successful adults are often assertive in their personal and work relationships.

Topic 5: Negotiation

Subconcept: Negotiation allows people to solve a problem or resolve a conflict.

Developmental Messages:

Level 1

Negotiation is a way to get one's needs met without using guilt, anger, or intimidation.

Negotiation requires give and take on the part of both persons.

Negotiation works best when a problem or conflict is addressed in its early stages.

Good negotiation can enhance relationships.

There are many different negotiation techniques.

Effective negotiation requires certain skills, such as (a) careful observation of the other person, (b) use of positive body language, (c) good verbal communication, (d) imagining oneself in the other person's position, (e) identifying all the options in a situation, and (f) reaching a mutual agreement.

Level 2

Teenagers who date need to learn to negotiate decisions about sexual behaviors and limits.

Many relationship and sexual concerns can be resolved through negotiation.

Level 3

Sexual feelings, fantasies, and desires are natural.

Sexual feelings, fantasies, and desires occur in all stages of life.

Sexuality is more rewarding and positive when expressed in a sharing, enhancing, and non-exploitative way.

Level 4

Healthy sexuality enhances total well-being.

Sexuality is one component of total well-being to be expressed in harmony with other life needs.

Sexuality is multifaceted; sexuality has biological, social, psychological, spiritual, ethical, and cultural dimensions.

Sexuality is an integral, joyful, and natural part of being human.

American society tends to equate sexual functioning with reproductive ability, especially for women.

The traditional gender roles about sexuality in our society are becoming more flexible.

Middle age may result in some changes in physiological sexual responses, but most men and women still desire sexual contact and remain orgasmic.

People who are sexually active in middle age have less decline in sexual expression as they age.

Elderly people who are sexually active and have intimate relationships are often happier than peers without those relationships.

Barriers to sexual fulfillment in later life are often more psychosocial than physical.

Topic 2: Masturbation

Subconcept: Masturbation is one way human beings express their sexuality.

Developmental Messages:

Level 1

Touching and rubbing one's own genitals is called masturbation.

Some boys and girls masturbate; others do not.

Masturbation should be done in a private place.

Level 2

Masturbation is often the first way a person experiences sexual pleasure.

Many boys and girls begin to masturbate for sexual pleasure during puberty.

Some boys and girls never masturbate.

Masturbation does not cause physical or mental harm.

Level 3

How often a person masturbates varies for every individual.

A person worried about masturbation might talk to a trusted adult.

Most people have masturbated at some time in their lives.

Masturbation, either alone or with a partner, is one way a person can enjoy and express their sexuality without risking pregnancy or an STD/HIV.

There are many negative myths about masturbation.

Some religious groups oppose masturbation.

A few boys engage in a very dangerous and sometimes fatal form of masturbation that involves limiting their air supply.

Level 4

People who are single, married, or in committed relationships may masturbate.

Masturbation may be an important part of a couple's sexual relationship.

Topic 3: Shared Sexual Behavior

Subconcept: Individuals express their sexuality with a partner in diverse ways.

Developmental Messages:

Level 1

Adults often kiss, hug, touch and engage in other sexual behavior with one another to show caring and to share sexual pleasure.

Level 2

Couples have different ways to share sexual pleasure with each other.

Being sexual with another person usually involves more than sexual intercourse.

Level 3

When two people express their sexual feelings together, they usually give and receive pleasure.

Sexual relationships are enhanced when a couple communicates with one another about what forms of sexual behavior they like or dislike.

A person has the right to refuse any sexual behavior.

Some sexual expressions are prohibited by law and disapproved of by certain religion and cultural groups.

People with disabilities have sexual feelings and the same need as all people for love, affection, and physical intimacy.

Level 4

For most people, sharing a sexual experience with a partner is the most satisfying way to express sexuality.

Couples and individuals need to decide how to express their sexual feelings.

Some common sexual behaviors shared by partners include kissing, touching, caressing, massage, sharing erotic literature or art, bathing/showering together, and oral, vaginal, or anal intercourse.

There are many sexual behaviors that are pleasurable that do not put an individual at risk of an unintended pregnancy or STD/HIV.

Individuals are responsible for their own sexual pleasure.

Level 4

Common sexual dysfunctions include lack of desire, inadequate lubrication, erectile difficulties, and difficulties attaining orgasm.

Most sexual dysfunctions can be treated through therapy with a specially trained professional.

What is perceived as sexual dysfunction varies among individuals.

Sexual dysfunctions may result from guilt, fear, anger, anxiety, medical problems, or relationship difficulties.

Some sexual dysfunctions may indicate undiagnosed medical problems.

For some couples, honest communication can solve sexual problems.

At one time or another, nearly everyone will experience a sexual concern or dysfunction.

A person concerned about sexual functioning can talk to a trusted adult or health professional.

Key Concept 5: SEXUAL HEALTH

The promotion of sexual health requires specific information and attitudes to avoid unwanted consequences of sexual behavior.

Sexual Health Life Behaviors:

Having learned the sexual health subconcepts, at the appropriate age the learner will be able to:

- Use contraception effectively to avoid unintended pregnancy.
- Prevent sexual abuse.
- Act consistent with one's own values in dealing with an unintended pregnancy.
- Seek early prenatal care.
- Avoid contracting or transmitting a sexually transmitted disease, including HIV.
- Practice health promoting behaviors, such as regular check ups, breast and testicular self exam, and early identification of potential problems.

Topic 1: Contraception

Subconcept: Contraception enables people to have sexual intercourse without the fear of unintended pregnancy.

Developmental Messages:**Level 1**

All children should be wanted.

Some people have children and others do not.

Each family can decide how many children to have, if any.

Level 2

When a man and woman want to have sexual intercourse without having a child, they can use contraception to prevent pregnancy.

Some religions teach that contraception is desirable; others do not approve of contraception.

Level 1: middle childhood, ages 5 through 8; early elementary school

Level 2: preadolescence, ages 9 through 12; upper elementary school

Level 3: early adolescence, ages 12 through 15; middle school/junior high school

Level 4: adolescence, ages 15 through 18; high school

People who do not engage in certain behaviors do not get STD/HIV.

Children do not need to worry about becoming infected with HIV or STD.

A small number of children are born with HIV from an infected mother.

HIV and other sexually transmitted diseases are usually acquired by teenagers and adults during sexual behavior or intravenous drug use with an infected person.

A person cannot become infected with HIV by being around or touching someone who has AIDS.

Level 2

STD include diseases such as gonorrhea, syphilis, HIV infection, chlamydia, genital warts, and herpes.

To have AIDS means that HIV has done enough damage to the body that certain serious diseases have been acquired.

Level 3

STD cause serious damage to more U.S. teenagers than all other communicable diseases.

STD/HIV is most commonly passed during sexual contact, but can also be passed by sharing drug injection equipment, from an infected mother to her fetus in utero, during birth, and during breast-feeding.

STD/HIV organisms are usually found in the semen, vaginal fluids, and blood of an infected person.

STD/HIV can be passed during vaginal, oral, and anal intercourse.

STD/HIV can be transmitted even if the infected person does not have signs of infection.

Anyone, regardless of age or sexual orientation, can get STD/HIV if he or she practices high risk behavior.

A person can have more than one STD at a time and can get no STD more than once.

HIV is not spread by casual, social, or family contact, by insects, or by donating blood.

Deep, open mouth kissing has not been found to cause HIV infection.

One should discuss concerns about STD/HIV with any sexual partner.

Abstinence from sexual intercourse and not sharing drug injection equipment are the safest ways to avoid STD/HIV.

An uninfected couple can avoid STD/HIV by practicing mutual monogamy and not sharing drug injection equipment.

Sexual behavior such as masturbation and hugging that do not involve exposure to semen, vaginal fluids, or blood pose no risk for STD/HIV infection.

Proper use of latex, lubricated condoms with a tip, along with a spermicide, can greatly reduce, but not eliminate, the chance of getting STD/HIV.

One cannot determine who has STD/HIV by just looking at the person.

The only sure way to know if someone is infected with STD/HIV is from testing and a medical examination.

The symptoms of STD/HIV are sometimes hidden, absent, or unnoticed, especially in women.

The major symptoms of most STD include genital discharge, sores on the genitals, abdominal pain, painful urination, skin changes, genital itching, and flu-like symptoms.

The first symptoms of HIV infection are similar to common minor illnesses and include tiredness, swollen lymph glands, fever, loss of appetite and weight, diarrhea, and night sweats.

It sometimes takes several years after becoming infected with HIV before symptoms of disease appear.

Teenagers who become infected with HIV will probably not develop AIDS until their 20s.

Persons suspecting an STD/HIV infection should stop having sexual intercourse and using drugs, promptly go to a doctor, and refer sexual partners to a doctor.

Public STD/HIV clinics, private doctors, family planning clinics, and hospitals are places for STD/HIV counseling and medical care.

Some communities have support groups for HIV-infected persons, persons with AIDS, and individuals having genital herpes.

Most STD can be cured with proper medical care.

There is no cure for HIV infection, AIDS, and genital herpes, although medications are now available which lessen symptoms and slow the development of the disease.

Professional counseling and support can be helpful for persons infected with STD/HIV.

Teenagers can get confidential testing and treatment for STD/HIV without parental consent.

Some health departments have anonymous testing for HIV infection.

Sexual partners can reinfect each other with an STD unless both get proper treatment.

Persons infected with STD/HIV should encourage their partner to seek medical care.

People who have an STD, HIV infection, or AIDS need the support of family and friends.

Persons infected with STD/HIV can lead satisfying and productive lives.

In this community, call _____ for STD/HIV information and medical services.

Level 4

One can help fight STD/HIV by serving as an accurate source of STD/HIV information, by being a responsible role model and promoting healthy peer norms.

Topic 4: Sexual Abuse

Subconcept: Sexual abuse can be prevented or stopped.

Developmental Messages:

Level 1

A person's body belongs to him or her.

Everyone, including children, has the right to tell others not to touch their body when they don't want to be touched.

There are good reasons for some adults to look at or touch children's bodies, such as a doctor examining a child or a parent giving a child a bath.

Most major medical centers have genetic counselors who can help people with family genetic disorders make decisions about having children.

Level 4

Some women with serious diseases may decide not to continue a pregnancy because of the risk to the fetus or to themselves.

Couples with genetic disorders or infertility problems and desire to have children have several medical options.

Pregnant women and their partners can consider many options for delivering a baby.

Women and men in the workplace should be informed regarding any environmental hazards that could harm their reproductive systems and the precautions necessary to avoid the hazards.

Miscarriages may result from a maternal infection but most often occur because of genetic abnormalities in the fetus.

Women and couples who unsuccessfully attempt to become pregnant can seek infertility counseling, diagnosis, and treatment.

Key Concept 6: SOCIETY AND CULTURE

**Social and cultural environments shape the way
Individuals learn about and express their sexuality.**

Society and Culture Life Behaviors:

Having learned the society and culture subconcepts, at the appropriate age the learners will be able to:

- Demonstrate tolerance for people with different sexual values and lifestyles.
- Exercise democratic responsibility to influence legislation dealing with sexual issues.
- Assess the impact of family, cultural, media and societal messages on one's thoughts, feelings, values and behaviors related to sexuality.
- Promote the rights of all people to accurate sexuality information.
- Avoid behaviors that exhibit prejudice and bigotry.
- Reject stereotypes about the sexuality of diverse populations.
- Educate others about sexuality.

Topic 1: Sexuality and Society

Subconcept: Society influences what people believe and how they feel about sexuality.

Developmental Messages:

Level 3

Every culture communicates norms and taboos about sexuality.

In the U.S., there are people from many different cultural backgrounds and a wide range of views about sexuality.

In a pluralistic society like the U.S. the individual's right to hold different opinions is valued.

American societal messages about sexuality are often confusing and contradictory. Individuals need to examine messages received from different sources and establish guidelines for their own behavior.

Level 1: middle childhood, ages 5 through 8; early elementary school

Level 2: preadolescence, ages 9 through 12; upper elementary school

Level 3: early adolescence, ages 12 through 15; middle school/junior high school

Level 4: adolescence, ages 15 through 18; high school

Topic 4: Sexuality and Religion

Subconcept: Religious views about sexuality affect people's sexual attitudes.

Developmental Messages:

Level 1

Religions teach people how to behave, to love each other, not to hurt others, and what is right or wrong.

Some families go to a church, mosque, or synagogue to worship; some families do not.

Different religions may teach similar or different values.

Level 2

Many religions teach that sexual intercourse should occur only in marriage.

Level 3

Views about sexuality and sexual behavior are culturally determined.

All world religions have views about sexuality and its place in the human experience.

Many religions today acknowledge that human beings were created to be sexual beings, and that their sexuality is good.

Conflicts may result in teenagers and adults who have been raised in a religion that does not fully accept human sexuality.

One's religious values can play an important role in sexual decision-making.

Level 4

Some people continue to respect their religious teachings and traditions but believe that some views are not personally relevant.

Partners with very different religious backgrounds may have more difficulty reaching an agreement about their sexual relationship.

Contemporary religious leaders struggle with many issues related to sexuality and reproduction.

Topic 5: Diversity

Subconcept: Our society has a diversity of sexual attitudes and behavior; some people are unfairly discriminated against because of the way they express their sexuality.

Developmental Messages:

Level 1

There are many differences among individuals in the way they think, act, look, and live.

Talking about differences helps people to improve their understanding of each other.

A concept that generalizes the behavior of all members of a group is a stereotype.

All people should receive fair and equal treatment.

People who are different are often treated negatively or unequally.

Level 2

People are sometimes discriminated against because of such sexuality factors as gender, appearance, sexual orientation, family and living arrangements.

Discrimination can lead to lower self-esteem, unequal opportunities, and physical and emotional problems.

Discrimination limits a society's ability to use the full capabilities of its members. Discrimination has negative consequences for the individual, group, and society.

Level 3

People should speak up when they encounter discrimination.

There are laws, policies, and procedures that can help someone who is the victim of discrimination.

People should try to understand and celebrate diversity.

Topic 6: Sexuality and the Arts

Subconcept: Erotic images are a common theme in art.

Developmental Messages:

Level 3

Sexual images are depicted in music, art, drama, and literature.

Level 4

The nature of sexual images in art has changed through time.

Erotic images in art reflect society's views about sexuality and help people understand sexuality.

Art with sexual images that reflect a culture's norms may be considered obscene in another cultural context.

Some people try to regulate or eliminate sexual images in art.

There is no evidence that erotic images in the arts cause inappropriate sexual behavior.

Topic 7: Sexuality and the Media

Subconcept: The media have a profound effect on sexual information, values, and behavior.

Developmental Messages:

Level 1

Some of what is on television, in the movies, in books and magazines, and on radio is true and some is not.

Some television commercials try to make people and things look different and better than they really are.

Some television programs and movies are not appropriate for young children.

Level 2

People can refuse to watch and/or listen to anything that offends them.

APPENDIX B

ADDITIONAL INFORMATION ON SEXUALITY EDUCATION

SHCUS, the Sex Information and Education Council of the U.S., provides numerous services to help communities design and implement sexuality and HIV/AIDS programs. Below is a listing of additional resources that are presently available at SHCUS.

Services Available

SHCUS Library Services

With over 4,000 volumes, 7,000 articles, 450 curricula and 150 newsletters and journals, the Mary S. Calderone library and information clearinghouse offers the largest collection of sexuality information and education resources open to the public in the United States. All books and journals are indexed in the SHCUS database which also has access to national databases, including MEDLINE, Apeline, The Exceptional Child Education Resources database and the Computerized AIDS Information Network. Database searches can be ordered by telephone. The library is located at 130 West 42 Street, Suite 2500, New York, N.Y. 10036. Please call SHCUS for the current library schedule of hours.

SHCUS Membership Services

SHCUS members are part of a growing network of professionals and concerned individuals dedicated to promoting the delivery of comprehensive sexuality and HIV/AIDS education and information and to protecting individual sexual rights. Members of SHCUS receive a year's subscription to our bimonthly journal, the *SHCUS Report*, free use of the Mary S. Calderone Library and free searches of the SHCUS database, and a 10% discount on all SHCUS publications and educational consultations.

Technical Assistance

Experienced educators are available to help communities design and implement programs. Initial consultations are provided at no charge.

Publications Available

Sex Education 2000: A Call to Action

In June 1989 SHCUS convened "Sex Education 2000: A National Colloquium on the Future of Secondary Education" which was cosponsored by eight organizations and attended by more than 65 representatives of national organizations. This report of the colloquium outlines thirteen goals for the next decade and calls for comprehensive sexuality education for all children and youth by the year 2000. \$12.

Winning the Battle: Developing Support for Sexuality and HIV/AIDS Education

Designed for parents, administrators, community leaders, teachers and school boards, Part One of this guide offers suggestions on how to develop and maintain community support for sexuality and HIV/AIDS programs. Part Two provides different strategies for responding to the efforts of an organized opposition and Part Three includes the answers to twenty frequently asked questions regarding sexuality and HIV/AIDS education. \$18.

SHCUS Position Statements

The SHCUS stance on fifteen major sexuality issues is provided free, with a self-addressed stamped envelope.

Additional publications and annotated bibliographies are also available.

Call for a free SHCUS publications catalog.

For more information, contact:

SHCUS, 130 West 42nd Street, Suite 2500, New York, N.Y. 10036
(212) 819-9770

National Coalition to Support Sexuality Education

The following organizations have joined together to assure that children and youth receive comprehensive sexuality education:

Alan Guttmacher Institute
American Association for Counseling and Development
American Association for Marriage and Family Therapy
American Association of School Administrators
American Association of Sex Educators, Counselors and Therapists
American Home Economics Association
American Medical Association
American Nurses Association
American School Health Association
American Social Health Association
Association for the Advancement of Health Education
Association of Reproductive Health Professionals
Association of State and Territorial Directors of Public Health Education
Bnai Brith Women
Center for Population Options
Child Welfare League of America
Children's Defense Fund
The Coalition on Sexuality and Disability, Inc.
ETR Associates
Girls, Inc.
Herrick-Martin Institute for Gay and Lesbian Youth
National Abortion Rights Action League
National Association of Counties
National Coalition of Advocates for Students
National Council on Family Relations
National Council of State Consultants for School Social Work Services
National Education Association Health Information Network
National Family Planning and Reproductive Health Association
National Gay and Lesbian Task Force
National League for Nursing
National Lesbian and Gay Health Foundation
National Mental Health Association
National Network of Runaway and Youth Services
National Organization on Adolescent Pregnancy and Parenting
National Resource Center for Youth Services
National Urban League
Planned Parenthood Federation of America, Inc.
Sex Information and Education Council of the U.S.
Society for Adolescent Medicine
Society for Behavioral Pediatrics
Society for Public Health Education, Inc.
Society for the Scientific Study of Sex
United Church Board for Homeland Ministries
United States Conference of Local Health Officers
United States Conference of Mayors
University of Pennsylvania
Y.W.C.A. of the U.S.A.

Sterilization

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March 10, 1995

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TO: FAMILY RESEARCH COUNCIL
Attn: Angie (202) 393-2134

FAX TRANSMISSION

FROM: THOMAS STRAHAN

SUBJECT: Dr. Henry Foster

Articles:

Removal of the Normal Uterus, Henry W. Foster, Southern
Medical Journal 69(1):13-15, January, 1976

Voluntary Sterilization, JAMA 225(13):1743-1744, Sept 24, 1973

Compulsory Sterilization, JAMA 221(2):229-230, July 10, 1972

Why Bother with Informed Consent?, Henry Foster, J. Medical Ed. 53:154
Per our discussion I am enclosing the Southern Medical Journal 1978
article on sterilization via hysterectomy. Also I am enclosing
a brief review of the law regarding sterilization at the time
that they were performed. Another article written by Henry Foster
describes his views on informed consent

TWS.

Removal of the Normal Uterus*

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

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

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

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

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

It is believed that the first hysterectomy was performed in 1843 by Charles Clay of Manchester, Eng-

land, although his patient died on the 15th postoperative day. The first completely successful hysterectomy was done by Dr. Walter Burnham of Lowell, Mass, in 1853.² However, it was well into this century before this procedure approached any acceptable mortality and morbidity figures. Thanks to the 20th Century advances in surgical technique, blood banking and infection control, hysterectomy has become a basically safe procedure, although mortality and morbidity have by no means been reduced to zero. In a large, well respected training hospital in this country, the mortality from this procedure was 0.5%.³

Moreover, the associated nonfatal complications are not to be taken lightly. Though infrequent, the most common serious complication of hysterectomy is bleeding requiring postoperative suturing in 0.8%.⁴ Other frequently encountered complications occur in the urinary tract. A study in 1902 reported a 1% incidence of unilateral ureteral ligation associated with total hysterectomy.⁵

Fistula formation frequently complicates hysterectomy. Uterine-vaginal fistula is rare except when the uterus are skeletonized as with radical cancer surgery. Also, rarely, rectovaginal fistulas result from injury to the sigmoid colon or rectum in the course of hysterectomy.

It has been shown that laceration of the urinary bladder occurs in 2% of hysterectomies.⁶ Fistula formation here, however, can be essentially eliminated if the injury is recognized promptly and repaired properly.

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

INDICATIONS FOR OPERATION

The justification for removal of the normal uterus is clearer in some instances than in others. Table 1 lists what I have termed *established* indications for removal of the normal organ, as well as *relative* indications for this procedure.

Although hysterectomy, usually vaginal, is employed

TABLE 1. Indications for Removal of the Anatomically Normal Uterus

Established Indications	Relative Indications
Ovarian cancer	Stenosis
Ovarian cancer	Menstrual retardation
Vaginal cancer	Ectopic pregnancy
Chronic pelvic inflammation	Familial history of cancer
Endometriosis	Pelvic pain
Genital prolapse	Hydrometra
	Postirradiation of uterus
	Benign ovarian disease
	Pelvic tuberculosis
	Persistent hemorrhage
	Dysfunctional bleeding

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

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

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

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

More liberal use of hysterectomy in the presence of the normal uterus could be warranted in patients with a strong family history of genital malignancy, i.e., in a sibling or parent. Such a change in philosophy may be plausible, and it is interesting to note that more women now die annually in this country from ovarian cancer than from cervical carcinoma.¹

Fortunately, the intracavitary use of radium for the control of benign uterine bleeding has been abandoned. Studies have revealed a relatively high occurrence of carcinosarcoma in patients treated in this manner; consequently, prophylactic hysterectomy appears justified.²

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

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

Hysterectomy may be indicated in patients with diabetes mellitus. This consideration seems reasonable since it has been shown that the coexistence of this disease and endometrial carcinoma is frequent. It has been reported that 20% of all patients with endome-

trial carcinoma have overt diabetes and one half of these patients have abnormal glucose tolerance curves.³

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

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

Again, reproductive desires dictate the course of action in severe postpartum hemorrhage. In the young patient who has further procreative desires, ligation of the internal iliac artery should be done. If necessary both ovarian arteries in addition to both hypogastric arteries should be ligated. Pregnancy and delivery can follow these procedures and are completely uncomplicated.⁴

MATERIAL AND DISCUSSION

I have reviewed my experience with hysterectomy over the past ten years at the John A. Andrew Memorial Hospital in Tuskegee, Alabama (Table 2). Between May 1963 and May 1973, 435 hysterectomies were done. Of these, by the criteria set forth in this manuscript, 82 (18.9%) of the uteri removed were normal. Of these 82, 41 (50%) fell into the group defined as having established indications (Fig 1).

Pelvic inflammation by far was the most frequent

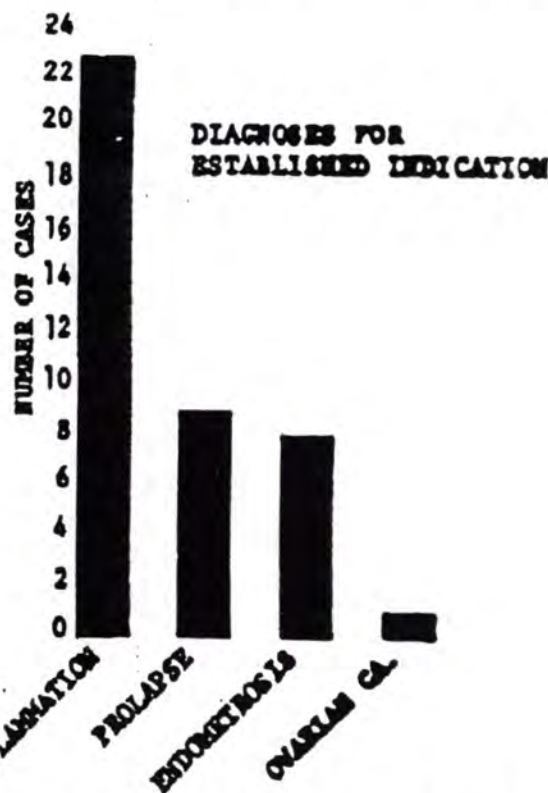


FIGURE 1. Diagnoses for established indication group.

TABLE 2. Ten-Year Experience With Hysterectomy

Time Period Studied	Total No. Cases	Anatomically Normal Uteri No. Cases	Total
May 1963 - May 1964	61	8	12.5
May 1964 - May 1965	40	7	14.2
May 1965 - May 1966	26	7	12.4
May 1966 - May 1967	47	9	20.0
May 1967 - May 1968	30	13	24.0
May 1968 - May 1969	47	5	10.6
May 1969 - May 1970	31	6	11.7
May 1970 - May 1971	33	10	13.0
May 1971 - May 1972	30	11	25.0
May 1972 - May 1973	32	6	11.5
Total	435	82	18.9

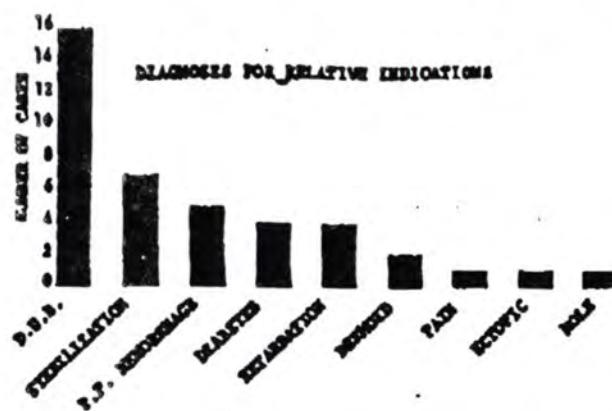


FIGURE 2. Diagnoses for relative indications (n=41).

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

The 16 cases (19.5%) of dysfunctional uterine bleeding constituted the most frequent diagnosis in the group of relative indications (Fig 2). Admittedly, some may choose to put this diagnosis in the group of estab-

lished indications. It is interesting that only one hysterectomy (1.2%) was done exclusively for intractable pelvic pain. Certainly, many of these patients had varying degrees of pain but when more than one symptom was present, only the predominant or primary symptom was recorded as the indicated cause for operation. The single hysterectomy done for ectopic pregnancy (1.2%) was a case of intraligamentous pregnancy.

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

References

1. Fomon L. *Benign Gynecology*. Philadelphia, W. B. Saunders Co., 1969, p 108.
2. F. Lander RW, Mastaglio RP. *Operative Gynecology*. Philadelphia, J. B. Lippincott Co., 1974, p 8.
3. Mangert WF. Practical obstetrics and gynecology—the open book. *Ob-Gyn News* 8:22, 1973.
4. Smith AD, Fran JH. Serious bleeding following vaginal or abdominal hysterectomy. *Obstet Gynecol* 21:534-535, 1963.
5. Prida VC, Torchi D. Uterine injury discovered after pelvic surgery. *Obstet Gynecol* 15:408-409, 1962.
6. Craker EA, O'Rourke JJ, McElrath T. Intra-uterine bladder damage during hysterectomy. *Obstet Gynecol* 23:267-271, 1964.
7. Uraker BII, Madgkinson CP. Ovarian carcinoma—presentation for the 70's. *Am J Obstet Gynecol* 109:825-831, 1971.
8. Scheffer LC. Malignancy subsequent to irradiation of the uterus for benign conditions. *Am J Obstet Gynecol* 44:925-931, 1946.
9. Vondra JB. The association of diabetes mellitus and carcinoma of the endometrium. *Am J Obstet Gynecol* 77:243-245, 1959.
10. Mangert WF, Bartlett RC, Blumstein RW, et al. Pregnancy after bilateral ligation of the uterine tubes and ovarian arteries. *Obstet Gynecol* 34:204-205, 1969.



LAW & MEDICINE

Voluntary Sterilization

An article on these pages on July 10, 1972, discussed the constitutionality and other legal questions pertaining to compulsory sterilization. This article examines the legal problems of voluntary, nontherapeutic sterilization and the constitutional questions involved.

Right to Sterilization

According to most medicolegal authorities, voluntary sterilization of either male or female patients is legal in all states except Utah. Kansas and Connecticut also had prohibitory statutes until quite recently, but both repealed them. Utah allows for therapeutic sterilization.

On Jan 22, 1973, the US Supreme Court in two companion cases, *Doe vs Bolton* (93 S Ct 759) and *Roe vs Wade* (93 S Ct 705), decided that restriction of the right of abortion during the first trimester of pregnancy was an unconstitutional violation of the patient's right to determine whether or not she would bear a child. While the decisions did restrict abortions later in pregnancy to some extent, the principle of the "freedom of decision" is the one that would be applicable in a sterilization case. If a woman has the right to terminate an extant pregnancy, it would seem ludicrous that either a man or a woman would not have the same constitutional right to prevent the same pregnancy from occurring.

Griswold vs Connecticut (381 US 479, 1965) established the principle that a law restricting the right of a married couple to use contraception interfered with their constitutional right of marital privacy. The *Eisenstadt vs Baird* decision (405 US 438), decided by the Supreme Court on March 22, 1972, extended the right to unmarried persons. The court held that providing dissimilar treatment for married and unmarried persons who were similarly situated

violated the equal protection clause of the Fourteenth Amendment. Since the combined force of both cases is to make the right of access to and use of contraception a constitutionally protected right, voluntary sterilization is undoubtedly legally considered to be covered by the same principles. It would, therefore, seem that these two decisions alone would furnish a constitutional basis for the right of voluntary contraception by sterilization without the added impact of the abortion decisions.

Only one decision of a lower court can be located on the subject of a right to voluntary sterilization. In *Jordan vs County of Shasta* (79 Cal Rptr 339, Cal, 1969), a state appellate court ruled that the county had no duty to perform sterilizations on request of persons entitled to receive public health services. The court upheld voluntary sterilization as legal under the laws of the state of California. Because of the absence of adequately prepared briefs and appropriate investigation into the question, however, the appellate court reversed the lower court's ruling that sterilization operations should be provided to the poor, under a public welfare program, as a matter of right by those institutions legally charged with the duty to administer to their "basic and appropriate medical needs."

It should be noted that that decision predates the *Eisenstadt* decisions and the recent abortion decisions. It is altogether possible that an indigent plaintiff can successfully argue that denying him or her access to surgical sterilization is denial of equal protection of the laws in view of the obvious connection between family economics and the desirability of family planning.

Of course, whether or not sterilization should be performed in any given case is a matter of medical judgment. Just as a physician whose conscience forbids him to perform an abortion cannot be compelled to do so, neither should one be compelled to perform a sterilization contrary to his conscience. Beyond that, however, in this situation a physician who has no overall moral objection to sterilization

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JAMA, Sept 24, 1973 • Vol 225, No 13

Sterilization 1349

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in principle may consider it unwise in the case of a particular patient. In that case he may legally and ethically refuse to do it.

Until 1969 the American College of Obstetricians and Gynecologists' Standards included an age-parity formula. However, in that year it was revised and now allows sterilization for "anyone legally capable of giving the obstetrician-gynecologist permission to operate on her."

Considerations of age and parity are, of course, still quite relevant as a matter of medical judgment to the individual physician in each case. A 21-year-old girl engaged to be married for the first time might think she does not ever wish to have children and change her mind later, for example, and the physician might quite properly, as a matter of good medical practice, refuse to perform a tubal ligation and instead prescribe some temporary form of contraception. The same physician is quite justified in seeing another woman, this one 35 and marrying for the first time, in an altogether different light. As the law stands, he is neither obliged nor forbidden to perform tubal ligations on either one of them. The decision is now legally his.

The question of sterilization of the mentally ill or retarded on the application of guardians or of the state was discussed in an earlier article. In brief, however, about half the states have statutory procedures for these cases. Where there is no statutory authorization, however, it is usually held that since the patient cannot consent, the operation cannot legally be performed (eg, *Holmes vs Powers*, 439 SW 2d 579, Ky. 1969; *Fraser vs Levi*, 440 SW 2d 398, Tex. 1969).

Married minors would be considered adults for this purpose, and sterilization of either a male or a female married minor would be legally controlled by the principles applying to adults. In the extremely unlikely event that an unmarried minor, not covered by the laws pertaining to the mentally incompetent, would wish to be sterilized, it would be extremely inadvisable for the operation to be performed without parental consent in the absence of therapeutic necessity, and even in that case parental consent is strongly advised.

Procedures

Georgia, North Carolina, and Virginia have recently enacted statutes providing for procedures required prior to performance of voluntary sterilization operations on patients of either sex. All require consent of the spouse if the patient is married and a waiting period to be sure the decision is final. The Virginia statute requires consultation with more than one physician. With the increasing popularity of sterilization operations as the result of the discovery of the laparoscopy procedure which can be and is performed as outpatient surgery, it is probable that more states will enact legislation authorizing voluntary sterilization. Where such statutes exist, of course, the physician must follow statutory requirements, and it is incumbent upon him to be aware of such requirements.

Consent of Spouse

Except where there is a state statute setting up procedures, there is no law on the subject, specifically, of whether a spouse has the right to veto sterilization of his or her partner. By analogy, however, it would appear clear that such a right probably would be declared if a case arose. All of the abortion and contraception cases view the decision to have children or not to have children as a right of the couple involved, not of the state. The abortion decisions this year did not, as was noted by many commentators on the subject, deal with the question of whether a husband's consent was required before his wife could have an abortion. Presumably this question will be settled in due course, but in the meantime, consent of the spouse should be obtained in order to protect the physician from being the defendant in a test case on the subject. That rule would, however, assume that the couple was living together at the time the request for sterilization was made. If either a man or a woman is legally or informally separated from his or her spouse and has been for some considerable time and the physician's judgment is that a reconciliation is unlikely, it would appear that the patient may be treated as if he or she were unmarried, for this purpose, as long as there is not a specific statutory conflict. Furthermore, if a spouse refuses to consent and the would-be patient consults a physician without telling him that she or he is in fact married, it would hardly be the physician's responsibility to investigate the truth of the patient's story.

Civil Liability

Negligent performance of a sterilization operation would involve the same principles of professional liability as any other type of surgery. Several cases, however, have dealt with the liability of a physician who performs a sterilization operation in a perfectly proper manner but the patient or the patient's wife becomes pregnant. While states disagree on whether or not the birth of an unplanned child is a suitable event for the recovery of damages, it is allowed in some places (eg, *Chudis vs Bower*, 59 Cal Rptr 463, Cal. 1967). Other states have not allowed recovery of damages (eg, *Ball vs Madge*, 391 P 2d 201, Wash. 1964; *Shabou vs Knight*, 11 Pa D&C 2d 41, 1957).

However, this problem can be avoided by making sure that the consent form, which is signed by the patient and the spouse, if any, indicates that the patient knows there is no absolute guarantee of sterility after the operation. Furthermore, the fact that there is a small failure rate in both vasectomies and tubal ligations or laparoscopies should be included in verbal explanations to the patient prior to surgery. The customary tests should be performed after a vasectomy, and the necessity for these tests should be explained to the patient. Even if there is no finding of negligence, it is possible that the physician who seems to "warrant" that a patient is in fact sterile might be liable for breach of contract (eg, *Doerr vs Villate*, 220 NE 2d 767, Ill. 1966).

—ANGELA ROONEY HOLDER, JD

LAW & MEDICINE

Compulsory Sterilization

Many states enacted statutes several decades ago which provided for the compulsory sterilization of mental defectives. While these statutes are not as widely invoked as in former years and the number of decisions in which they are involved has diminished, they remain on the books in many areas and are far from a dead issue in some courts.

The Police Power of the State

In 1927 the US Supreme Court upheld as constitutional state statutes providing for compulsory sterilization of retarded persons. The decision included the famous sentence "Three generations of imbeciles are enough" (*Buck v Bell*, 274 US 200).

Numerous state court decisions of the same vintage approved the statutes as necessary in the public interest. (eg. *State ex rel Smith vs Shaffer*, 270 P 604, Kan 1928). There was, apparently, a consensus that the police power of the state could be used in requiring sterilization for the good of the community as a whole. (eg. *State vs Troniman*, 299 Pac 668, Idaho 1931; *In re Clayton*, 234 NW 630, Neb 1931). There was, either expressly or impliedly, an understanding in these opinions that there was no right to bear children which was transgressed by these statutes. (eg. *In re Male*, 19 P 2d 152, Oida 1935).

As the court stated in *Smith vs Cayman* (204 NW 140, Mich 1925), "No citizen has any right superior to the common welfare." In that case the mother of a retarded 16-year-old girl had petitioned the court to have her daughter sterilized, and the court allowed the procedure.

The number of decisions involving compulsory sterilization has declined sharply in recent years, but two fairly

modern ones have upheld these statutes. *In re Simpson* (180 NW 2d 206, Ohio 1962) also involved a petition by a mother to have her daughter sterilized. The court concluded that the procedure would serve both the welfare of the woman and of society and allowed it to take place.

In re Cavitt (157 NW 2d 171, Neb 1968) involved a retarded woman who had already had eight children and who was confined to a state institution for the mentally deficient. Her sterilization was made a prerequisite of her release. The constitutional attack on the statute failed when the state supreme court upheld it as a valid exercise of the state's police power. It further pointed out that while there is a natural right to have children, which in and of itself was a departure from older decisions, no individual's right to do so is superior to the common good. The court also held that the state did not have to demonstrate that the children the woman might have if she were not sterilized would inherit her retardation.

Where no statute exists, however, the state has no power to order sterilization. In fact, since the would-be patient is legally incompetent to consent even if she wants it, the procedure may not be permissible at all (eg. *Holmes vs Powers*, 439 SW 2d 579, Ky 1969). In *Freder vs Low* (448 SW 2d 393, Tex 1969), the mother of a retarded daughter petitioned for her sterilization. The daughter already had two children. The court denied the request, holding that in the absence of a statute, an incompetent ward did not have the legal capacity to give a valid consent and her guardian had no authority. In some states, however, on a petition from the natural guardian of an incompetent, the courts might deem the consent of the guardian sufficient, as would be the case if the incompetent required an appendectomy, tonsillectomy, or any other form of surgery.

In a recent Ohio trial court decision, the judge who ordered a compulsory sterilization in the absence of any enabling statute was found personally liable for damages. The

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woman had been sterilized pursuant to the court's order and over her objections. The judge argued that he was immune from suit. The court found that if he had merely exceeded his jurisdiction, his point would have been well taken, but if, as in this case, he had no jurisdiction at all to begin with, ordinary judicial immunity did not apply (*Wade vs Bethesda Hospital*, Civil Action #70-225, DC Ohio 1971, *The Citation*, 24:50).

Cruel and Unusual Punishment

Many states also enacted statutes providing for the sterilization of convicted criminals. Many of these made no distinction whatever between types of crimes and made it applicable to anyone convicted of a felony (eg, *Davis vs Walton*, 276 P 921, Utah 1929). Some only applied it to "habitual criminals."

The US Supreme Court, however, held these statutes unconstitutional in *Skinner vs Oklahoma* (316 US 535, 1942). The court held that these statutes violated constitutional protections against cruel and unusual punishment and guarantees of equal protection of the laws. The court said:

Marriage and procreation are fundamental to the survival of the race. The power to sterilize may have subtle, far reaching and devastating effects. In evil or reckless hands it can cause races or types which are inimical to the dominant group to wither and disappear.

News reports indicate from time to time that a state legislature has received a bill which would provide for the compulsory sterilization of women on welfare who have had more than a certain number of children. It is virtually certain that any such legislation, if enacted, would be found unconstitutional under the *Skinner* decision's reasoning. Also, in *Shapiro vs Thompson* (394 US 618, 1969), the court held that state residency requirements for public assistance were unconstitutionally discriminatory, and the same logic would doubtless be applied in a sterilization case in which the classification was based on economic considerations.

Due Process of Law

Before compulsory sterilization can be performed, constitutional guarantees of due process of law mandate that the would-be patient be given notice, a guardian be appointed, and a hearing be held (eg, *State ex rel Smith vs Barber*; *In re Opinion of the Justices*, 162 So 123, Ala 935; *In re Hendrickson*, 123 P 2d 322, Wash 1942; *Brewer vs Valk*, 167 SE 638, NC 1933). No decisions can be located which dealt with the right to counsel at these hearings but presumably such a right would exist if the alien could afford one. The right to appointed counsel for indigents has been restricted to criminal prosecutions until present time, but a good case could be made for appointment of counsel in these cases since the persons involved are inevitably indigent and of necessity incompetent.

New Developments in the Law

An interesting analogy can be drawn between new concepts apparent in decisions involving abortion laws and laws requiring compulsory sterilization. Several decisions within the past few years have indicated that a woman who wants an abortion may have a constitutional right to have one. She may, in short, have a constitutional right not to bear an unwanted child (eg, *Babitz vs McCain*, 310 P Supp 293, DC Wisc, 320 P Supp 219, 1970; *People vs Belous*, 458 P 2d 194, Cal 1969). The same reasoning, applied conversely, might make it quite likely that laws providing for compulsory sterilization for economic or genetic reasons would be declared unconstitutional. If a woman who wants an abortion has the right not to bear a child, then the woman who might be compulsorily sterilized might well be held to have an equal right to have as many children as she wants. No decisions can be found in which the point has been argued, since there are no compulsory sterilization cases on the appellate level, at least in those states where this right has been declared, which do not predate the abortion decisions by many years. This type of challenge may be attempted, however, in any state in which the issue of compulsory sterilization is brought before the courts.

Conclusion

The decline in the number of cases involving compulsory sterilization since the 1920s and 1930s is probably attributable to three factors. In the first place, modern medical research in genetics and new knowledge on environmental and hereditary factors in retardation has served to provide new answers to the problems. Second, modern methods of contraception which are effective for those who are mentally deficient have provided an alternative to sterilization. Third, and most important, however, World War II brought the American people into contact with an enemy who systematically enforced compulsory sterilization against groups the government wished to eliminate. That is, of course, the reference in the Supreme Court opinion in the *Skinner* case. Since that time a great many people in this country might well feel that any system of compulsory sterilization is too near Nazism to be acceptable in a democratic society.

Where these statutes exist, however, the state still has the power to employ sterilization against the mentally deficient, at least until new constitutional challenges are made. The entire question is not simply a medical issue. It has always been and will remain a moral, religious, legal, and sociological issue, as much if not more than a medical one. Changing concepts of social justice, due process of law, and individual freedom inevitably changes the court's outlook on these issues of fundamental freedoms. Greater respect for the rights of the mentally retarded also has been demonstrated in this country in the last few years. This, too, will have an inevitable effect on future developments on the law of compulsory sterilization.—ANGELA R. HOLDER, JD

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Feb, 1978

EDITORIAL

Why Bother with Informed Consent?

Based on the title of this editorial, one might conclude that the concept of providing medically informed consent is either optional or new. From the very onset, let me point out that both implications are false. Morally and legally, the requirement for and the provision of informed consent have existed to some degree for many years.

Prior to 1960, the physician basically felt bound only to inform the patient that a procedure or procedures were being performed and, hence, obtained the consent based upon that rather simple exchange: the patient was simply made aware that a procedure was being done. However, in 1960, this rather simplistic approach changed drastically as a result of *Nathanson v. Kline*. It was from this case that the medical profession became aware of the need to provide much more information to patients; this resulted in the creation of the so-called "collateral risk doctrine." Simply stated, the decision said that not just a physician but also the patient must possess basic knowledge about proposed procedures to make an assessment as to the risk involved. Indeed, the patient must be "informed" if he or she, along with a physician, is to be capable of rationally deciding for or against surgery based upon risk.

Following this decision of *Nathanson v. Kline*, there were numerous law suits brought forth which attempted to define how much must be told patients by doctors, but obviously none has yet accomplished this objective. The battle rages on and the question is unsettled.

Certainly much of the recent and current activity in this area is embodied in the general movement afoot in this country known as consumerism and specifically in that movement's concern with the "right to know." In the medical profession, it is expressed in the requirement for voluntary informed consent giving on the part of the patient. Of course, it is expected that an enlightened public will keenly concern itself with disclosure issues.

sunshine laws, and so forth. And such interest and activity have only been heightened by the recent revelation of past political concealments that occurred in our capital. If for no other reason than these, we as a profession must "bother" with informed consent.

In the years immediately following the *Nathanson v. Kline* decision, it appeared that possibly the "standard of practice" doctrine might settle the quantitative question of how much the patient needed to be told by the doctor. The standard of practice doctrine as it applied to informed consent in essence meant that the doctor was required only to disclose to the patient those informational items that were ordinarily and usually provided in a general geographic/jurisdictional area. However, as a legal concept applicable to informed consent, significant legal challenges were presented. In 1972 the cases of *Cobbs v. Grant* in California and *Canterbury v. Spencer* in Washington, D. C., eliminated the standards of practice concept as an answer to the issue of information quantity. These two decisions beyond question solidly affirmed the patient's right to self-determination regarding collateral risk in those two jurisdictions. Based on these two cases, therefore, it now appears that the court will hold doctors bound to "reasonable disclosure."

As a medical educator and an operating surgeon, I think I now know what is expected by our judicial system; I simply do not know how to accomplish it. I cannot determine what constitutes reasonable disclosure, and quite frankly the courts have not helped. By its simplest interpretation, to be informed means to be knowledgeable. However, as we know, knowledge is relative and never absolute, not for the doctor and least of all for the layman on medical issues. None of us knows everything about anything. Hence, the question of disclosure to the patients boils down to how much or to what degree. The courts will not or most likely cannot tell us how much disclosure is adequate. And even if

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they could, the likelihood for inconsistency among courts is a foregone conclusion. Where are we then? Very simply, we are at the mercy of juries, judges, and arbitrators.

But as dismal as my outlook may be, I do nonetheless believe there is a faint flicker of light at the tunnel's end. I believe we can reduce our risk greatly by increasing our knowledge and understanding of the issues. For example, simply knowing some of the situations in which informed consent is either difficult or impossible to obtain is essential. It behooves us to completely understand state laws on mental competency and age limitations. The latter is of particular importance

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to those who perform abortions and/or provide contraceptive services to minors. Certainly our affinity for misadventure is reduced if we are knowledgeable of particular areas of past difficulties, for example, the question of witnesses, supplemental documentation, risk versus benefit explanation.

Clearly the issue of informed consent is an unsettled one; however, we must nonetheless continue the travail; we must bother with informed consent.

HENRY W. FOSTER, JR., M.D., member,
Editorial Board.

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Writings by Foster Detail Sterilizations

White House Defends '70s Operations

Feb 12, 1995 A-1

By Ann Devroy and David Brown
Washington Post Staff Writers

The White House braced for a new round of political controversy over Henry W. Foster Jr., its announced nominee for surgeon general, following the release yesterday of news Foster had performed hysterectomies on severely mentally retarded women for sterilization and "hygienic" reasons in the 1970s.

The new details of Foster's writings and medical practices came at the end of a week in which the White House found itself struggling to defend its nominee and facing criticism from Republicans and Democrats that it had bungled the nomination. The furor over the obstetrician-gynecologist's abortion record distracted the White House from the budget debate and action on a variety of legislative issues in Congress.

The flap over the Foster nomination has erupted despite efforts by White House Chief of Staff Leon E. Panetta, who took over eight months ago amid hopes he would establish tighter control and prevent this sort of chaos in the Clinton administration. Some White House critics are now complaining that little has changed. [Details, Page A16.]

Yesterday, White House officials distributed more than 50 articles and speeches Foster wrote or co-wrote and offered explanations of segments officials said might be controversial.

An article defending removal of healthy uteruses, published in 1976 in the Southern Medical Journal, was flagged by the White House as potentially the most controversial. In it Foster wrote, "Recently, I have begun to use hysterectomy in patients with severe mental retardation," either to sterilize them or to eliminate menstrual periods. White House officials said Foster's performance of the surgery in these circumstances was at that time in the "mainstream of medicine."

See SURGEON, A8, Col. 1

■ Clinton vows to protect crime bill funds for new police. Page A20

In Nashville, A Portrait of Compassion *Critics Missing 'Total Picture'*

By John Schwartz
Washington Post Staff Writer

NASHVILLE—Ask Justin Brian, 14, what he's learning in the "I Have a Future" program, founded by Henry W. Foster Jr., President Clinton's choice for surgeon general. Brian's answer: "How to be a man." Fourteen-year-old Mike Rucker says afternoons at the center doing homework help him "stay out of trouble" by "not selling drugs."

Just two weeks ago, Foster was mainly known for the seven-year-old program preaching values such as cooperation and personal esteem that he had brought to teenagers such as Brian and Rucker in Nashville's public housing projects. Today, the 61-year-old obstetrician-gynecologist finds himself the touchstone of another national debate on abortion, his every action over a 35-year career the subject of microscopic scrutiny.

But here, those who know Foster find the portrayal of him by antiabortion activists to bear little resemblance to the community-minded former medical school dean whose hard work and easy-going manner have made him

See FOSTER, A8, Col. 1

White House Braces for New Furor Over Choice for Surgeon General

SURGEON, From A1

John Podesta, the White House official in charge of managing the nomination, said yesterday Foster's "anti-choice opponents may try to comb through his writings and distort his record." He said, "Any fair review of his practice, academic work and writings show Dr. Foster to be well within the mainstream of the American medical community, and he has put particular emphasis on helping women with high-risk pregnancies have their babies."

The articles were also delivered this weekend to members of the Senate who will vote on Foster's confirmation.

Overall, the writings of Foster concentrate on several types of high-risk pregnancies, on access to medical care by disadvantaged patients and, more recently, on health care reform. Some articles discuss family planning and one, which cites fears of African Americans that family planning can be genocidal, argues for family planning in the black community.

The 1976 article on hysterectomy lists "established" reasons for removing a normal uterus and "relative indications," that is, reasons that could be acceptable. Under the relative indications, Foster lists sterilization and mental retardation as possible among the reasons for hysterectomies. He writes the procedure can be used to sterilize a mentally retarded woman or "to

eliminate the menses, which is of significant hygienic benefit in these severely handicapped individuals."

The article lists 485 hysterectomies performed 1963 to 1973 at the John Andrew Memorial Hospital in Tuskegee, Ala., with which Foster

"Any fair review of his practice, academic work and writings show Dr. Foster to be well within the mainstream of the American medical community."

—John Podesta, White House aide

was affiliated before moving to Meharry Medical College in Nashville. White House officials said Foster performed "a small number" of hysterectomies on mentally retarded women. A graph in the study indicates no more than four were done at the hospital for that purpose in the decade cited.

Medical ethicists and historians contacted yesterday said sterilization of mentally retarded individuals

and removal of the uterus to abolish menstruation were accepted medical practice in many parts of the country at the time the article was published. Since then, ethical and legal standards have changed, and most states have laws stringently restricting sterilization without consent. With the advent of drugs to control menstruation, hysterectomy is no longer performed for that reason, experts said.

White House officials said Foster told them that in the late 1960s and 1970s, doctors believed severely retarded women routinely had a heavier menstrual flow than normal, causing hygienic problems that could be eliminated by hysterectomy. Such a procedure, officials said, was noted as acceptable in leading gynecology textbooks of the time. Since then, officials said, Foster's views have "progressed with the medical thinking in this area."

At least 60,000 institutionalized Americans were sterilized between 1907 and 1960, and probably another 40,000 got the procedure under the diagnosis of "appendectomy" or other medical problem, said Philip Reilly, author of "The Surgical Solution," a history of involuntary sterilization published in 1991.

Beginning in the 1970s, it became difficult—and then virtually impossible—for an institutionalized retarded person to become sterilized, even if their parents or guardians gave informed consent. Now, the pendulum

See SURGEON, A7, Col. 1

News About Hysterectomies Comes After Controversy Over Abortions

SURGEON. From A6

has swung back to a middle ground, he said. Before a retarded adult woman can be sterilized today, a court must appoint a guardian to represent her interest and a judge must order the procedure before it can be performed.

"I'm worried about people condemning Dr. Foster over standards that have evolved greatly in 20 years. I hope that doesn't happen," said Reilly, who is a physician, lawyer and director of the Shriver Center for Mental Retardation in Waltham, Mass.

The hysterectomy issue is a new problem for Foster, who primarily has faced a firestorm of controversy after his nomination earlier this month when the White House and then Foster put out erroneous information on his record of performing abortions.

He first stated he had performed fewer than a dozen. This week, he corrected that record to state he had performed 39 and supervised a drug trial in which 55 additional women terminated pregnancies. Those numbers come from an intensive Foster review of actual medical records from his practice and tenure at Meharry. He has done no such review of records at Tuskegee, officials said, because Andrew Memorial Hospital is no longer functioning and records have not been found.

Asked if Foster performed abortions while in Alabama, White House

officials said the doctor will not answer questions about that part of his career without access to medical records. The White House has now taken the position that abortion is legal and that the number Foster has performed has no relevance to his qualifications to be surgeon general.

In the area of abortion, Foster consistently advocates in his writings that doctors caring for pregnant women with sickle cell disease should inform patients abortion is an option. Sickle cell disease is an inherited, incurable disorder whose victims are predominantly black. In several articles on managing pregnant patients with sickle

cell disease, Foster also advocates genetic counseling of women who carry the sickle cell gene.

Foster has also written more broadly on family planning, including an address he gave in the 1960s, while chief of obstetrics and gynecology at Andrew Memorial Hospital, in which he discusses the controversial subject of family planning as a white conspiracy to reduce black population. Foster notes various groups have asserted the intent of family planning "is black genocide and the ultimate effect will be black genocide." Such fears, he said, are understandable "and often not without foundation."

Foster noted there has been a history of virtually forcing blacks to forgo pregnancy through belittling, cajolery and verbal abuse by family planners and that the first requirement of family planning be that it is completely voluntary. He noted some had proposed sterilization of women on welfare and other forms of coercion, and cited these as reasons for fears in the black community that family planning—and particularly broad goals of zero population growth—could amount to genocide for blacks, since infant mortality for blacks was cited as twice the national rate.

Foster in the article calls for greater emphasis on providing health care for minority populations, noting family planning for these groups is given a higher priority than high-quality health care.

Foster has also written broadly on family planning.

cell disease, Foster notes the death rate for such pregnant women had been reported as high as 10 percent but makes the case that with skilled medical care, their pregnancies can be successfully managed.

In another article on the disease, published in 1980, Foster noted the loss of the fetus, through abortion or miscarriage, among women with sickle cell ranges as high as 60 percent and advocates alleviating symptoms of the disease and counseling pregnant women, again, that abor-

Backers of choice turn on Foster

■ The sterilizations of retarded women years ago endanger his bid to be surgeon general.

By Joyce Price

THE WASHINGTON TIMES A1 2-12-95

Advocates for the mentally retarded and a women's group leader yesterday expressed anger over reports that surgeon general nominee Henry W. Foster Jr. performed hysterectomies to sterilize mentally retarded women in the 1960s and early 1970s.

"I'm appalled," Diane Welsh, president of the New York City chapter of the National Organization for Women, told CBS Radio yesterday. "NOW is an organization that's for choice for women in any reproductive health matter, and we're utterly opposed to anything remotely resembling forced sterilization."

NOW's criticism should cause concern in the White House. The 250,000-member group has been in the forefront of efforts to save the Foster nomination.

Revelations that Dr. Foster, 61, had sterilized some women he described as being "severely" mentally retarded further imperiled a nomination threatened by his differing accounts of how many abortions he has performed during his decades as an obstetrician-gynecologist.

Emily Perl Kingsley, co-chairman of the Parent Assistance Committee on Down Syndrome in Westchester, N.Y., expressed concern after learning that Dr. Foster, whose nomination she supports, sterilized some mentally retarded

see FOSTER, page A6

FOSTER

From page A1

women.

"Obviously, we're not happy about it, because you have to take each case individually," said Mrs. Kingsley, a former board member of the National Down Syndrome Congress.

She said such sterilization cannot be condoned unless "a real effort was made to include the individuals [who were sterilized] in the decision-making."

"A lot of people who are mentally retarded are capable of being good parents, while a lot of people in the mainstream aren't capable of being good parents. Yet no one applies those kinds of restrictions on people in the mainstream," Mrs. Kingsley said.

Earl T. Shinhoster, interim senior administrator of the National Association for the Advancement of Colored People, which has endorsed the Foster nomination, called the revelation of the sterilizations a "serious and very sensitive issue."

But the practices Dr. Foster engaged in were "not clandestine, unorthodox or unethical at that time" and should not compromise his nomination, Mr. Shinhoster said in a telephone interview.

Nevertheless, he acknowledged "this will be a very difficult fight" and said he hopes the "president will stand firmly behind the nominee" because the "administration's resolve" could be the deciding factor.

Dr. Foster wrote about the hysterectomies in the Southern Medical Journal in January 1976.

In the report, he said doctors must guard against "injudicious and indiscriminate removal of the normal uterus," but added that there are times when it is "acceptable surgical practice."

Dr. Foster said hysterectomies could be performed on retarded women "for sterilization or to eliminate the menses, which is of significant hygienic benefit in these severely handicapped individuals."

How many hysterectomies Dr. Foster performed on handicapped women is not clear. A chart accompanying the article in the medical journal showed that from 1963 to 1973 he performed 485 hysterectomies at the John A. Andrew Memorial Hospital in Tuskegee, Ala., including 82 on women with normal uteruses.

The article said six of those hysterectomies were for the sole purpose of sterilization. It does not say how many of those women were mentally retarded.

Judie Brown, president of the American Life League, said the latest information about Dr. Foster "simply affirms our position that he is unfit to serve in the office of surgeon general."

It is more evidence, she said, that "this man does not respect his fellow human beings."

The White House yesterday played down the significance of the sterilization issue. White House Press Secretary Michael McCurry said this part of Dr. Foster's record was available to the administration before President Clinton selected him to be surgeon general.

Mr. McCurry said Dr. Foster, through scholarly writings, had "eloquently" explained his conduct in the context of medical thinking of that time.

But an article in the new issue of U.S. News & World Report says Republican staffers last week were "scouring" Dr. Foster's medical writings and that "by Thursday night, Clinton staffers at the Department of Health and Human Services knew they had found a time bomb in the sterilization article."

According to the report, HHS officials shared the article only with Sen. Edward M. Kennedy, Massachusetts Democrat, hoping he would put a "favorable spin" on it if it became public, as it did Friday night.

Administration officials yesterday said Dr. Foster, like most physicians today, does not consider sterilization of retarded women by hysterectomy to be appropriate.

WHITE HOUSE TRIES A BOLDER DEFENSE OF ITS NOMINATION

SURGEON GENERAL BATTLE

New Points of Debate Involve
Hysterectomies Performed
on Retarded Women

By TODD S. PURDUM

Reporter for The New York Times

WASHINGTON, Feb. 12 — The White House today angrily defended its nomination of Dr. Henry W. Foster Jr. as Surgeon General and sought to paint his critics as right-wing extremists, even as it coped with new questions about his having performed a handful of hysterectomies on severely mentally retarded women more than two decades ago.

With some prominent Republicans vowing to oppose the nomination and many Democrats openly contemptuous of initial missteps by the Clinton Administration in explaining how many abortions Dr. Foster had performed, the White House unleashed its most vigorous support yet for the nominee and prepared to escort him to courtesy calls on Capitol Hill on Monday.

In a 1976 medical journal article sent to senators by the White House late last week and made public on the weekend, Dr. Foster wrote that he sometimes performed hysterectomies to sterilize or alleviate menstrual bleeding in severely retarded women. Several doctors and medical ethicists said that practice, while controversial, was not uncommon at the time and top Administration officials said Dr. Foster had since changed his views with the advent of drug therapy and advances in medical practice. [Page A15.]

Today, the White House chief of staff, Leon E. Panetta, said President Clinton was committed to fighting for the nomination, which Mr. Panetta insisted was under attack from "the extreme right, who are basically saying, 'We want to make illegal a woman's right to choose.'"

Speaking on the NBC News program "Meet the Press," Mr. Panetta conceded, as he had before, that the White House had made mistakes in its handling of the nomination. But after watching a videotape of complaints about the White House from two Democratic Senators, Joseph R. Biden Jr. of Delaware and Barbara A. Mikulski of Maryland, he reacted sardonically.

"God forbid that we ought to make senators uncomfortable about having to deal with issues like this," Mr.

Continued on Page A15, Column 1

For Foster, more names to fight

Sterilization work in '70s is criticized

By Judi Henson
USA TODAY

Henry Foster, President Clinton's embattled nominee for surgeon general, drew another round of criticism Sunday because he sterilized severely retarded women — a practice once accepted but now shunned by doctors.

For those who have criticized the obstetrician-gynecologist for performing abortions, the disclosure that Foster had performed the hysterectomies added fuel to the fire.

"Every liberal I've known has disdain for that kind of procedure. I don't think people should be involuntarily sterilized," said conservative Sen. Orrin Hatch, R-Utah, who said Foster should withdraw.

The White House again defended Foster. Health and Human Services Secretary Donna Shalala said on ABC's *This Week* with David Brinkley that the procedure was in the "mainstream" of medical practice for the time.

At least 50,000 institutional Americans were sterilized between 1967 and 1980.

In a 1978 article in the *Southern Medical Journal*, Foster said he had begun performing hysterectomies on severely retarded women for two reasons: hygiene and pregnancy prevention.

The hysterectomy disclosures were the latest in a growing controversy over the doctor nominated to replace Joycelyn Elders, fired by President Clinton in December after a series of controversial statements.

Foster, 51, is a former dean and acting president of Meharry Medical College in Nashville. He has a national reputation because of his teen pregnancy prevention program called *I Have a Future*.

His nomination initially hit a snag over abortion. And later the White House had to defend Foster over his changing recollections of how many abortions he has done.

Sunday, Foster declined to talk to reporters about the latest disclosures.

Back home in Nashville for the weekend, he attended First Baptist Church Capital Hill and asked the congregation to pray for him. The Rev. Sherman Tribble's sermon, while not mentioning Foster by name, deplored "the high-tech brooding" of public servants.

Sterilizing mentally retarded adults "is a routine practice of the handicapped, paid by medical



SUPPORT: Nominee Henry Foster, right, with Democratic Reps. Keats Milner, left, Henry Waxman, rear, and Patricia Schroeder.

White House: 'We will fight for his nomination'

By Bill Nichols
USA TODAY

The White House pressed Sunday to stand behind Henry Foster, President Clinton's nominee for surgeon general, despite a new controversy.

Said White House chief of staff Lesca Parnell, an ABC *This Week* host: "We will fight for his nomination."

The White House mounted a new defense this weekend when articles written by Foster surfaced stating he had been involved in the sterilization of severely retarded women in the 1970s.

"This was something that was accepted practice of the time that he wrote the articles. As a result of finding new medications, new drugs, that practice has changed

and Dr. Foster's views have changed as well," Parnell said.

Days after the weekend, the White House, trying to deny that Foster had performed the procedure, began releasing other articles and speeches.

Topics ranged from a discussion of abortion for women with multiple disabilities, an inherited disorder that affects mostly black people, to support for family planning efforts to reduce the birth rate of the poor.

Foster defended his nomination in today's Washington Post, maintaining his fight



SHALALA: Abortion number not relevant

against two-way programs.

The first criticism of Foster's nomination came when he said he had performed "fewer than a dozen" abortions and then said he had done at least 20.

White House officials, who scrambled last week to document how many abortions Foster might have done, now are saying the number doesn't matter.

The latest political strategy is to paint Foster as a martyr to abortion rights opponents who want to punish him.

The number of abortions Foster performed is not relevant.

Health and Human Services Secretary Donna Shalala said on ABC's *This Week* with David Brinkley: "We should not have started it in the first place. And we should not continue with it."

The controversy is "a debate about ... a woman's right to have an abortion."

Republicans say their concerns are fueled by whether he joined the White House and Congress and whether his confirmation would suddenly politicize the country.

Said Sen. Dan Coats, R-Ind., on CBS's *Face the Nation*: "This is a litmus test not on abortion, this is a litmus test on the truth. Every day we get a conflicting, different statement from Dr. Foster, and ... from the White House."

the late 1970s.

In 1976, Foster wrote, "I have begun to see hysterectomy in patients with severe mental retardation."

It was done, he said, for sterility or "to eliminate the expense, which is of significant hygienic benefit in these severely handicapped individuals."

Shalala told Brinkley on ABC, "What we have to do is to look at procedures within the context of the time and of standard medical practice."

the Center for Bioethics of the University of Pennsylvania, says Foster is "being hung out to dry" over a procedure that was acceptable medical practice of the time.

There were "hundreds of thousands performed" until the 1960s and "hundreds in the 1970s," Caplan said.

"There's a long and ugly history of coercive sterilization," Caplan said.

James Thold, vice president of the American Medical Association, which is supporting

was thought to be the state of medicine back then, and a sizable proportion of people approved of it and did it."

Many states now have laws requiring court approval for sterilization of the mentally retarded; some states allow parents to decide.

In a widely reported Philadelphia case, Delores Wadell fought a seven-year court battle for the sterilization of 34-year-old daughter, CI, who has the mental capacity of a 5-year-old. She was still

The young woman's court-appointed legal guardian had argued it was an extreme solution for Cindy, who lives in a 16-month-old group home and suffers from epilepsy. Her guardian argued that more education and supervision would be adequate to prevent pregnancy.

"Today the law has totally changed," says Kathryn LaFollette of the Center for Reproductive Law and Policy. "Sterilization of a mentally retarded person would never happen and court approval"

USA TODAY
2-13
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Charles Krauthammer

A Troubling Medical Act

THE WASHINGTON POST

"Recently, I have begun to use hysterectomy in patients with severe mental retardation," reported Surgeon General-designate Henry Foster in 1974. There was nothing wrong with the sterilities of these women. But because there was a lot wrong with their brains, Foster performed major surgery on them for the sole purpose of preventing them from having children or menstrual periods.

Foster's intentions were no doubt good. The women might be incapable of caring for children. And eliminating their periods would make keeping up their hygiene easier. But was it ethical to perform surgery and permanently sterilize women in no position to give consent?

If a doctor wants to do so today, he must first go to court, get a court-appointed guardian to agree that sterilization is in the woman's best interest and get the judge to order it. There is no indication that Dr. Foster took these steps. I asked the Department of Health and Human Services what kind of consent Dr. Foster obtained for these hysterectomies. They could not tell me. They did tell me that Dr. Foster did not recall the details and that this issue was "under review." They were sure he had followed hospital accreditation regulations, but they did not think there was any judicial review.

These are important questions. These are the crucial questions the Senate needs to ask Dr. Foster. Because without these safeguards of independent and judicial review, sterilizing the retarded, however well intentioned, is unethical medical conduct.

The White House argues that standards of medical conduct have changed since the

Without judicial review, sterilizing the retarded is unethical.

mid-70s and that what Foster did was within "the mainstream of medicine" as practiced at that time.

Was it? Was it just recently that these elaborate judicial safeguards against involuntary sterilization were established?

Foster's announcement that he had "begun" to do sterilizations was first published in January 1976 based on an oral report he had given in early August 1974. But on Feb. 6, 1974—six months before his oral report and fully two years before its publication—the federal government published regulations banning the use of federal funds to involuntarily sterilize the mentally incompetent unless (1) an independent review committee approved and (2) "a court of competent jurisdiction has determined that the proposed sterilization is in the best interest of the patient."

same ones we have today. Moreover, HEW had published similar preliminary regulations in September 1973—nearly a year before Foster's first report.

Now, Foster would have violated no federal regulations because he was using no federal funds. But legality is not the issue. I have no doubt that what he did was legal. The issue here is whether, as the administration argues, he was merely reflecting the moral climate of the time. Yet by the time Foster had first announced the results of his "recent" procedure, that procedure had been deemed impermissible—unless preceded by strict outside review and the proxy consent of a court—for the entire U.S. Public Health Service.

For all its virtues, the federal bureaucracy is not generally known as the locus of the nation's ethical avant-garde. Regulations take time, lots of time, before they are proposed and passed, commented upon and finally codified. By the time these were codified, they would have reflected a general sense that sterilization of the mentally infirm was a morally problematic procedure that required judicial review and consent. Dr. Foster's paper gives no hint of sharing that sensibility.

Assume, however, for the moment and the sake of argument, that Foster's hysterectomies were perfectly in tune with the ethical climate of the time and that the climate has changed. It seems curious that Foster should be the beneficiary of a rule that says: If you have done something that would be considered wrong today but that was considered all right at the time, you get a pass. Would a doctor who had performed, say, frontal lobotomies on psychiatric patients when such procedures were in fashion in the 1950s now be considered a fit candidate for surgeon general?

What about a doctor who had participated in radiation experiments on unconsenting, unsuspecting subjects during the early Cold War years? When these experiments were revealed last year, they elicited an explosion of righteous indignation from this very administration. "While her predecessors brushed off early reports about the experiments," reported *The Post* last year, "[Energy Secretary] O'Leary made an immediate public outcry." Hearings were held, commissions of investigation established, practices—and practitioners—denounced. The kind of sympathetic moral relativism accorded Dr. Foster was nowhere in evidence.

The White House notes, in defensive defense of Dr. Foster, that he performed only "a small number" of sterilizations. True. Foster's paper seems to show that he performed only four. I don't expect that this number will undergo change, as did the number of abortions Foster says he performed. But as with abortion, the White House's very insistence on "a small number" is telling. It betrays an obvious discomfort with what Foster did. It reinforces the sense that the moral climate of the 1970s was not nearly so alien as some pretend and that even in that ancient time surgically sterilizing the retarded was a morally troubling medical act.

LETTERS TO THE EDITOR

WASH POST 3-15 A-18

Henry Foster—Not the Normal Practice of Medicine

Willard Gaylin and Allan Rosenfield [op-ed, March 2] take issue with Charles Krauthammer [op-ed, Feb. 17] for his criticism of the eugenic sterilizations performed by Henry Foster and assert that there was confusion about the question in 1974, when Dr. Foster carried out these operations.

In 1973 and early 1974, there were two cases in federal courts protecting the handicapped from eugenic sterilization. In the *Wyatt* case, the court declared unconstitutional an Alabama law that permitted the sterilization of mentally retarded inmates of state institutions. In the *Relf* case, the court enjoined sterilization of incompetent minors and adults in family planning programs funded by the federal government.

The *Relf* case, which involved efforts to sterilize a child without her parents' permission or even awareness, was a scandal that received national attention in July 1973. Both cases originated in Alabama. It is not possible that Dr. Foster was unaware of these cases when he proceeded to sterilize handicapped young women.

Dr. Foster was in the forefront of the physicians who defended removing a healthy uterus; the article that caused the uproar was his defense of this radical procedure. And he was in a dwindling minority when he performed eugenic sterilizations in the 1970s. But he may have been the only doctor in the nation who combined these two questionable practices, carrying out

eugenic sterilization by hysterectomy. When Oliver Wendell Holmes wrote the 1927 Supreme Court decision permitting eugenic sterilization, he specifically mentioned the less extreme operation, salpingectomy—surgical removal of the fallopian tubes.

Dr. Gaylin and Dr. Rosenfield prefer not to label sterilizing mentally retarded women as "eugenics." But the 1976 Hastings Center conference they mention resulted in a book, edited by Dr. Gaylin, which says that the state laws on involuntary sterilization "were based on the concept of eugenics" (Mental Retardation and Sterilization, p. 63).

JOHN CAVANAUGH-O'KEEFE
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TUSKEGEE

•From Bad Blood, pages 198-199.

"The 1969 meeting with the Macon County Medical Society ended in total victory for the (Public Health Service). Dr. Sencer dispatched Dr. Brown and two other federal officers. Drs. Leslie Norins and Afonso H. Holguin, to Tuskegee, and Dr. Holguin, who was spokesman for the PHS delegation, explained the experiment in detail to the society's members. According to Dr. Brown, the directors listened attentively and immediately, 'volunteered cooperation and approval and support.' Indeed, just as their white predecessors had done nearly four decades earlier, Macon County's black physicians promised to assist the PHS. 'They actually agreed,' Dr. Brown continued, 'If they had a list of the individuals that they would not knowingly give them antibiotics ... but would refer them locally to the health department and to Nurse Rivers.' Needless to add, each of the local doctors was given a list. (Footnote 25, Brown Interview. See also Sencer Interview; Brown to Dr. Alexander Robertson, executive director, the Milbank Fund, November 19, 1969, TF-CDC.)

"Apparently, no one thought to question the morality of withholding treatment that was not specifically limited to syphilis. Antibiotics, it must be stressed, are given for a wide variety of infections."

After the media uncovered this human experimentation in July 1972, many of the medical personnel involved tried to distance themselves.

•Again from Bad Blood, page 209, "The Macon County Medical Society responded to the experiment's disclosure with expressions of concern and pledges of help. Dr. H.W. Foster, the society's president, told reports that he was under the impressions that the PHS would stop the experiment immediately. For its part, the society had voted unanimously 'to identify the remaining living members of this study and make available forthwith appropriate therapy.' (Footnote #9, Ibid -- of Montgomery Advertiser, July 30, 1972.)

"A few days after the statement was released, however, the Montgomery Advertiser, pursuing its story on the state board of health, contacted a spokesman for the society and asked whether it had in fact approved the experiment back in 1969. Dr. S.H. Settler, the society's secretary, acknowledged that they had met with representatives of the PHS in 1969 and admitted agreeing to the study's continuation. He denied, however, that they had been informed about the withholding of treatment, a claim the PHS spokesman who had talked with the group promptly challenged. Dr. Alfonso H. Holguin and Dr. William J. Brown told the Advertiser that the local doctors had been apprised of the nature of the experiment and had agreed that the men should not be treated. (Footnote # 10, Ibid, of Advertiser article. Settler's statement was made a few days after Foster's announcement; however, both statements were released in the same news story.)

Senator Edward Kennedy held hearings on the Tuskegee Study, which resulted in legislation on informed consent.

•From Bad Blood, page 214: In 1973, Kennedy "called the Tuskegee Study 'an outrageous and intolerable situation which this Government never should have been involved in.' The tragedy was compounded by the government's failure to provide health care to the men immediately after the study was disclosed, an injustice that had been left standing for 8 months despite the ad hoc panel's recommendation that health care be made available and despite Dr. Duval's assurances that it would be."

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Tuskegee Study and Henry Foster

The shocking Tuskegee Syphilis Study involved the deliberate withholding treatment for hundreds of syphilitic black men -- without their knowledge or consent -- for forty years. The United States government through the Public Health Service conducted the study with the cooperation of the Macon County Medical Society, Tuskegee Institute and other local organizations, for the sole purpose of examining the effects after death of untreated syphilis.

In 1932, Tuskegee (in Macon County, Alabama) was a poor, rural black town which had the highest rate of syphilis in the nation. About 400 black men who were tested positive for syphilis were told instead that they had "bad blood," a phrase used to explain a variety of ailments at that time, and were urged to come back to local clinics for further tests and follow-up. Men were often promised free lunches and transportation to get follow-up blood tests. The men were probably under the impression they were being treated. According to 1972 news articles, the patients never had explained the nature of their disease or that they were part of a government experiment or study. Even after the introduction of penicillin, the men in the "study" were denied available treatment, without their knowledge, for the sake of the "end point" (death).

Information drawn from the 1981 book Bad Blood by James H. Jones, and related documents, give strong evidence that in 1969 Dr. Henry Foster not only was made aware of the studies but that he, as an officer of the Macon County Medical Society, gave cooperation, approval and support to the experiments. Dr. Foster was vice president of the ten-member society in 1969.

At a 1969 meeting, the U.S. Public Health Service sought and received pledges of support and assistance from the County physicians in continuing the project, according to Jones. The local doctors, even though they were almost all black, gave the experiment their "cooperation and approval and support," as one PHS doctors wrote in a memo at that time.

Dr. Foster has denied being at that meeting or remembering anything about the study until it became public, according to The Washington Post (Feb. 25, 1995). However, Dr. L.C. McRae, president of the Macon County Medical Association in 1969, and secretary Dr. Sheridan Settler, remember that Foster was at the meeting, sitting "two or three chairs down." Dr. McRae does not remember being told the study participants were not being treated, nor do any of the local doctors who were at the 1969 meeting. But the contemporary reports of Drs. William Brown and Alonzo Holguin, the Public Health physicians who briefed the Macon County physicians, indicate that the experiment was explained fully and that the local doctors pledged their cooperation.

It appears that Dr. Foster had knowledge of what is perhaps the most infamous medical experiment in American history and he did nothing to speak up for the rights of those who were subjected to this experimentation.

The study finally ended in 1972 when a newspaper reporter exposed it. The exposure led to multi-million dollar class action lawsuit against the government, a 1973 Senate hearing chaired by Sen. Ted Kennedy (D-MA) and new federal regulations on informed consent.

It is interesting to note Dr. Foster's reaction when the studies were made public. In the July 30, 1972 Montgomery Advertiser Dr. Foster, now president of the Macon County Medical Society, stated that the association had voted unanimously "to identify the remaining living members of this study and make available forthwith appropriate therapy." Yet eight months later Senator Kennedy stated, "the tragedy was compounded by the government's failure to provide health care to the men immediately after the study was disclosed, an injustice that had been left standing for 8 months."



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Carl: Let me just ask you, can you tell me, what's your recollection of the meeting back in May of 1969?

McRae: Relatively clear. It's been a good while ago, but I've had an awful lot of time to refresh my memory lately. And the meeting that we had then, I believe was May 19th, 1969, was a County Medical Society meeting, which I considered a bit special, in that there are only about nine or ten of us in the County Medical Society. And we met once a month and usually didn't have much to discuss. But we always met and we met out at John Andrews Memorial Hospital on Tuskegee Institute campus. This particular meeting was set up downtown Tuskegee, a cafe about four miles outside of Tuskegee, and that, that, number one, was unusual. Number two, I had received correspondence from Dr. Ira Myers, who was State Health Director in Alabama at that time, stating that Dr. Bill Brown, or William Brown, would be down from U.S. Public Health Service and would like to meet with us at our next meeting. So he was, he was invited and we, we met with Dr. Brown and his colleague, and I did not remember his name, but my memory has since been refreshed on that, his name was Dr. Holloquin, and we met and they presented to us, the Tuskegee syphilis study, and that was the first knowledge any of us had of it, was in May of 1969. Excuse me (clears throat), at that time I was President of County Medical Society, and, we conducted the meeting, discussed the study, not in any great detail. We were provided a list of remaining patients 'cause starting in '32, by '69, a number of patients had died, as you can, well you know, goes with, goes with the age, right? And the list as I recall, there were 25 patients on the list, and we each were given a copy of that list, and were asked to endorse the continuation of their study. It was supposed to go over a period of forty years, and they were only three years out from its completion. We had sort of a round table discussion about it, no one raised any objections, and by consensus, not by hand vote, but by consensus, we unanimously endorsed the continuation of the study. The people I remember being at the meeting, let me tell you the members of the County Medical Society at the time, just to give you an idea of how small we were. There's myself, a white physician, Dr. Carl Hester, a white physician, Dr. Thomas Calhoun, a local surgeon, Dr. Howard Settler, a local ophthalmologist, Dr. Calvin Dowe, a local internist, Dr. John Hume, a local orthopedist, Dr. Henry Foster, a local Ob-Gyn at Tuskegee Institute, Dr. Thomas Campbell, who was a semi-retired pediatrician, and that was, that was the number of people we had in our society. Dr. Hester, nor Dr. Campbell were at the meeting. Everyone else was at the meeting: Dr. Hume, Dr. Calhoun, Dr. Dowe, Dr. Settler, he was Secretary-Treasurer of the Society, and Dr. Foster and myself.

Carl: Now I understand from your letter, that you remember pretty specifically where you sat and where Dr. Foster sat. Is that right?

McRae: Yes sir, I do.

Carl: Could you tell me about that?

McCrae: Well, I sat at the end of the table, I don't know if I was on the high end or the low end, but I sat at the end of the table, and Dr. Foster sat two chairs down on my left. Dr. Settler, as I recall sat on the other side of Dr. Foster. Dr. Brown and Dr. Holequin sat on my right in the two adjoining chairs. Dr. Hume sat down near the end of the table, the other end. Dr. Dowe and Dr. Calhoun sat on the same line of seats as Dr. Foster and Dr. Settler did.

Carl: Now, apparently you had no other conversations about this until, when was it, 1972, when the news about it broke. And what was the striking thing about what happened when the news broke to you?

McCrae: Well, I had moved back to Georgia in 1970. The most striking thing about it, when the news broke, number one, up until recently I did not know exactly how it happened, but I saw on television and read in the papers that Dr. Foster was involved in the public outrage about the study having been conducted. And I was struck by that, in that I knew he was at the meeting. That's why its fairly fresh in my mind, is that in '72 I was over here practicing medicine and all of this comes out, and Dr. Foster's name comes up, and I asked myself why Henry didn't go ahead and say something at the meeting that night in 1969! Because he had every opportunity, nobody had a muzzle on him.

Carl: So you were surprised that Dr. Foster, in 1972, tried to make out that he was shocked, that he didn't really understand what happened at that '69 meeting?

McCrae: I was surprised. I was surprised, very much so. He acted in '72 as though he had never heard of it. And I knew he had because I knew he was at the meeting.

Carl: Now, as I understand it from your letter, tell me if I understand this correctly, you don't particularly think, even to this day, that there is anything wrong with the study. Is that right?

McCrae: I, if someone asked me this question in 1932, I would have said totally no, it won't happen. But, asking it 37 years down the road, on a forty year study, I felt that there was more to be gained scientifically, than there was to stop the study and treat everybody. We were not asked not to treat anybody. I had treated at least 3 people on the list for syphilis, not knowing that they were in this ongoing study. I would have known about the study a lot earlier, but when you're dealing with impoverished Macon County Afro-Americans, they can't tell you a great deal, you know. So, from a scientific standpoint, this was the only study that had ever been done, where people were doing a double-blind on treatment and no treatment. Number one, and number two, there could be a lot of numbers, I'll give you a number two. The treatment in 1932 was the use of arsenic or antimony, or mercury. Arsenic could only be used like once because it was so poisonous. It was more effective, but antimony was the treatment, the only treatment available, and it was somewhere between 80 and 85% effective, if that much. I, so that was my approach toward, towards a continuation of the study. That it should go to fruition and that it be published and in the hopes that we could learn, learn a great deal from the study.

Carl: And, you don't have any doubt that the other Doctors who were there at that 1969 meeting understood the same thing you did?

McRae: I have no doubt, because it was very simple to explain. Dr. Brown didn't go all the way back to 1932 and bring us up to date because he hadn't been involved in the program that long. But no one cast any negative reaction, no one brought up any objection, no one came to any conclusion, ultimately, other than that we continue the study, that we endorse, that the study be continued, rather.

Carl: Well, I notice that the White House are saying that your memory must be flawed about these events that happened twenty-six years ago. How do you respond to that?

McRae: That's what I heard. And, that's, my memory is not flawed about those events. I can tell you the color shirt that Dr. John Hume was wearing, and where he was sitting. He was wearing a light yellow shirt, with a tie that had some brown color in it. And it's easier, like I said, to remember it in one respect, in that my mind was shook in 1972, about it, you see what I mean?

Carl: Right

McRae: In other words, if the study had come along last week, and it was first brought out last week, that the study was discovered, then I probably wouldn't be able to remember it. But the fact that it occurred in '72, in a three year period of time, that Dr. Foster became so involved in the outrage about it, it just struck me real strange that he would make a statement like that, knowing that he was familiar with us signing off on the study.

Carl: Okay

McRae: I heard from someone that the Justice said that my memory must be bad on that, but, I'm only telling you the way it happened. I have a great deal of respect for Dr. Foster. I think he's a good doctor, gentlemen, a jovial fellow, very intelligent. I think he's done a great job over the years. And did not bring this up when I was first called to create any static, but I had to tell the truth, that's it.

Carl: Okay, that's very kind of you. I'm sorry, I don't think I explained clearly to you, you know, I was, I told you about an interview, and I want to make sure that you understand I was interviewing you.

McRae: Right

Carl: And if that's okay. And I'm in Radio so I was recording this. Is it okay if I use a little portion of your voice in a news story I'm going to do about this?

McRae: No problem

Carl: Okay, great.

McRae: I could tell you were recording me.

Carl: Yeah, you know, I was so excited to have a chance to talk to you, as we got going I realized I hadn't made it clear to you and I said, well, when I get to the end I want to be sure I made it clear and you understood, 'cause I didn't want you to be recorded under any false pretenses or anything.

McRae: Perfectly all right.

Carl: Okay, well thanks very much. It's very kind of you to take time to talk to me.

McRae: Thank you, sir

Carl: Okay

McCrae: Bye-bye

Carl: Bye-bye

Foster Disputes Alleged Link to Tuskegee Syphilis Experiment

By David Brown and Ann Devroy
Washington Post Staff Writers

Henry W. Foster Jr., President Clinton's nominee for surgeon general, was an officer of a county medical society in Alabama in May 1969 when the U.S. Public Health Service sought the group's cooperation in a notorious federal study of untreated syphilis in black men.

That much is certain.

Nearly everything else, however, about this brief encounter between government medical researchers and an organization of country doctors is in dispute.

That dispute has pulled the White House into another crash effort to defuse the 61-year-old obstetrician—already under attack for having performed abortions during his 20-year career—in a new controversy questioning what and when he knew about the syphilis study.

In an interview last week, Foster said he had known nothing about the study until its public exposure in 1972, and had no recollection of attending a meeting about it three years earlier. One doctor who said he attended the 1969 meeting recalled Foster being there, but records of the meeting, and of other aspects of the controversy, are missing or inconclusive. A number of the participants in those events of more than two decades ago are dead. Among those with direct knowledge, accounts differ widely, leaving broad room for interpretation of what Foster might have known, and when.

The doctor's political critics, mostly in the anti-abortion movement, already have seized on the long-ago study to suggest Foster is unfit to be surgeon general. White House officials said yesterday the doctor, in a Thursday visit to Senate Democrats, was asked to explain his role in the study. One official said the White House anticipated "that this will now move into the full political glare" leading to his confirmation hearings in the spring.

The study is particularly notorious in the black community, where it is considered a prime case of federal government mistreatment, even genocidal treatment, of black Americans. Foster's support in the black community is broad, and many groups have worked for his nomination. This week, for example, when the Southern Baptists voted to oppose Foster's nomination on abortion grounds, the National Baptists, to which most black Baptists belong, endorsed him.

Noting that Foster had said "unbelievably that he was not informed" of the study before 1972, John Podesta, the White House official handling the Foster controversy, said "While we have no doubt that those opposed

to this nomination will try to distort the facts... we are confident that fair-minded people will reject these distortions."

Unlike abortion, an issue on which reasonable people differ, there is little debate about the 40-year syphilis study. Began in 1932 and ended after a 1972 newspaper exposé, the Tuskegee Syphilis Study often is cited as a classic example of scientific curiosity pursued at the expense of human suffering. It studied the progress of the disease in 400 black men who, at the beginning of the project, had had syphilis for more than two years but were without symptoms. The intention of the study was to withhold treatment from the men, and compare their long-term health to that of 200 non-syphilitic black men in a control group.

The study was launched at a time when treating syphilis was extremely difficult, and the usefulness of therapy in people with long-standing, symptom-free cases was a subject of much debate in medicine. The introduction of penicillin in the 1940s, and its acceptance a decade later as effective treatment for "latent" syphilis, however, made the question overcast. It also made virtually indispensable the researchers' failure to urge treatment on the selected subjects.

The study was centered in Macon County, Ala., which at the time it began had one of the highest rates of syphilis in the country. It's county seat, the town of Tuskegee, is the home of Tuskegee University, where Foster served as chief of obstetrics and gynecology at the John A. Andrew Memorial Hospital from the mid-1960s to 1973. Although the existence of the study was not widely known, Public Health Service documents indicate that by 1969 its leaders had become increasingly concerned about possible public revelations, and the moral defensibility of the project.

On Feb. 6, 1969, officials of the National Communicable Disease Center (a branch of the Public Health Service and forerunner of the Centers for Disease Control and Prevention) and several outside consultants met in Atlanta to talk about the future of the Tuskegee study.

NCDC Director David J. Sencer gave a brief history of the research and then, according to the minutes of that meeting, "said the question has come up: Should we terminate the Study or should we continue it? It becomes a political problem. At the time the Study was begun there was no concern about racial problems, discrimination, etc. At that time there

was no problem about not treating the disease. We want your advice in making a decision."

After some discussion, consensus was reached that the study should continue. It was agreed that enlisting the support of the local medical society was crucial, in part as a shield against criticism.

The minutes record that one person "asked how you could answer criticisms for not treating these patients. Dr. Sencer said if we establish good liaison with the local medical society there would be no need to answer criticisms." Later, another doctor said that "if the local physicians agree

there is no need for treating these patients, this would be good public relations."

According to subsequent Public Health Service documents, service doctors arranged to meet with the medical society at its May 19, 1969, meeting. Foster was the vice president of the society, which at the time had fewer than a dozen members.

Foster said last week that he had no recollection of attending such a meeting, or even that he was an officer of the society in 1969. "My knowledge and memory began in 1972," he said, by which time he was president of the medical society. He recalled, and

news accounts of the time indicate, that he publicly demanded that the study be ended and the remaining patients treated.

Foster said he was certain he would have remembered the 1969 meeting if he had been told that possibly curative treatment was being withheld from patients in the name of medical research. Though the venereal infection had done the great bulk of its damage decades before, some patients might still have benefited from treatment with penicillin even that late.

"There isn't any doubt in my mind I would have remembered [a meeting at which the project was discussed]. It would have been a maelstrom... that would have blown the roof off the place," Foster said.

See POSTER, A11, Col. 1

Foster Says He Knew Nothing of Study

POSTER, From A10

The memories of others are inconclusive, and in some extent contradictory, both in terms of who was at the meeting and what was discussed. The group's minutes from that era have been lost, its current president, Robert L. Shary, said, and no contemporaneous accounts are available.

Our former society member said he remembers Foster attending.

"There weren't too many of us. There were about three members who didn't show. I remember where Dr. Foster sat. I was at the end of the table, and to my left he was sitting two or three chairs down," recalled Luther C. McKee, a 64-year-old physician now practicing in Georgia. He was president of the medical society in 1968.

A 1981 account of the study, "Bad Blood," written by James M. Jones, a professor of history at the University of Montana, said the local doctors were provided names of roughly 90 surviving patients and instructions not to treat their syphilis should the men appear in the doctors' offices.

William J. Brown, one of the Public Health Service physi-

cians at the meeting, told Jones in a 1977 interview that the local doctors "volunteered cooperation and approval and support." The society members, he recalled, said "if they had a list of the individuals, that they would not knowingly give them antibiotics which were anti-treponemal [capable of killing the syphilis organism], but would refer them locally to the health department . . . so that we could follow them out."

McKee said in an interview this week that he remembered getting a list of about 25 patients, but said this was "just for our own information." He recalled nothing about being told to withhold treatment from people with latent syphilis, nor about referring the patients to the health department. In fact, he said he was under the impression that the three government doctors there did not know which people on the list had untreated syphilis and which didn't have syphilis at all.

McKee said he recognized three or four people on the list whom he had treated for latent—or long-standing and asymptomatic—syphilis, which he recalled was recommended by government venereal disease officials at the

time. He said he sensed that questions about the morality of the researchers never having explicitly treated all the study participants "was floating around in everyone's head" at the meeting.

"But the fact that the study had been going on so long, and was about to end, and that the study was endorsed by the federal government and conducted by the federal government" made it seem more reasonable. In addition, he said, all the physicians believed that "any damage that had been done by syphilis in the untreated patient had already been done."

Howard Settler, a Tuskegee ophthalmologist who said he was at the meeting, recalled the government officials "weren't really asking for our approval. They were just telling us about something that had been going on since before we were born. We didn't know they [the study subjects] hadn't been treated until it came out in the courts."

McKee recalled that Calvin R. Dowe, an internist, and John Hume, an orthopedic surgeon, also attended. Both said this week they did not remember anything about it. Another physician reportedly there could not be reached.

A letter written by Brown the following November suggested the government researchers had gotten what they considered endorsement from the medical society.

"Since the Advisory Committee meeting last February,

we have met with the Medical Society of Macon County, Alabama, and have furnished each of its members with a list of surviving participants in the Tuskegee study," Brown wrote to a foundation helping underwrite the study. "Although assured of their cooperation, we feel that analysis of the data assembled to date should await a more favorable national climate."

The study was closed on October 27, 1972. A \$1.8 billion class-action suit on the patients' behalf against the government was settled out of court for \$12 million. Living syphilitics got \$37,500, and the non-syphilitic participants received \$15,000. The estates of the deceased got lesser amounts.

Fred D. Gray, the plaintiffs' lawyer, said recently he did not know how much the local doctors knew about the study. But he noted that none were listed as defendants.

"Our research showed that the only ones who really made decisions were persons connected with the federal government and the [state] health department. Our research showed that none of the local doctors were responsible for the study," he said. In 1973, the year after the Tuskegee study was exposed, Foster left Macon County to return to Nashville's Meharry Medical College, where he had completed his residency in obstetrics and gynecology. Eventually, he became dean of the medical school.

Foster denies he OK'd deadly studies on blacks

By Joyce Price
THE WASHINGTON TIMES

Dr. Henry W. Foster, President Clinton's nominee for surgeon general, sought yesterday to counter reports that he once served on an Alabama medical board that endorsed government experiments that deliberately withheld treatment from hundreds of black men with syphilis.

Dr. Foster denied that any such decision had been made by the Macon County Medical Society in 1969, as reported in the 1981 book "Bad Blood" by Texas historian James H. Jones, and a 1972 article in the Montgomery Advertiser, an Alabama newspaper.

White House spokesman John Podesta said late yesterday, "Dr. Foster has stated unequivocally that he was not informed until 1972 that the federal government was conducting its study of untreated syphilis," which had begun 40 years earlier at Tuskegee University.

The conservative Family Research Council, which opposes the Foster nomination and raised the questions about the Tuskegee study, said it hoped the new disclosure would end his candidacy for surgeon general.

Participants in the experiments were left untreated, even after penicillin became widely available. The study was begun by the U.S. Public Health Service (PHS) to test a widely held suspicion that blacks with syphilis run a greater risk of developing cardiovascular disease than whites.

The study denying treatment to about 400 black men with the disease ended only after a PHS field worker told the Associated Press, and the existence of the research became public. By 1992, 28 of the men in the study had died of syphilis.

Dr. Foster, who served at the John A. Andrew Hospital at Tuskegee University from 1965 to 1973, denied reports in the book and the newspaper article, which were reported last night by CBS News.

"I have spent my life devoted to providing health care to those who might otherwise be denied such care," Dr. Foster's statement said. "I was outraged in 1972, when, as

president of the Macon County Medical Society, I first learned the facts of the Tuskegee Syphilis Study.

"Had I learned the facts of the study any earlier, I would have been equally outraged then, and I would have insisted on appropriate treatment, as I did in 1972."

In 1969, the Tuskegee study was winding down. According to Mr. Jones' book, the PHS was interested in continuing the investigations and sought approval to do so from the Macon County Medical Society.

According to the book and the newspaper article, a delegation of federal health officers was sent to Macon County in 1969 and met with its medical society. Dr. Foster was vice president of the society at that time, the reports said.

"The 1969 meeting with the Macon County Medical Society ended in total victory for the PHS," Mr. Jones wrote.

He said one of the PHS officials present at the meeting, whom he identified as Dr. William J. Brown, indicated that the "directors listened attentively and immediately volunteered cooperation and approval and support."

"Indeed, just as their white predecessors had done nearly four decades earlier, Macon County's black physicians promised to assist the PHS," Mr. Jones wrote.

The book said the society's secretary, Dr. S.H. Settler, later acknowledged that the society had met with PHS officials and "admitted (the society's) agreeing to the continuation of the experiment."

Mr. Jones wrote that Dr. Settler "denied (board members) had been informed about the withholding of treatment," but the author contended that two PHS officials who had spoken with the group challenged those recollections.

"Dr. Alfonso H. Holguin and Dr. William J. Brown told the Advertiser that the local doctors had been apprised of the nature of the experiment and had agreed that the men should not be treated," the author wrote.

CBS said Dr. Foster "could not remember attending such a meeting" and that several other members of the medical society it contacted said the board "never voted to continue the study."

White House Seeks to Blur New Questions on Nominee

By NEILA LEWIS

Special to The New York Times

WASHINGTON, Feb. 25 — The White House today tried to repel the latest assault on Dr. Henry W. Foster Jr., accusations that he played a marginal but knowing role in the infamous Tuskegee experiment in which 400 black men were denied treatment for syphilis to study their progress of the disease.

Dr. Foster, President Clinton's choice to be Surgeon General, emphatically denied the accusations that he knew the details of the medical experiment three years before it was publicly disclosed in 1972 in news reports. The charges were made by the Family Research Council, a conservative group that has been at the forefront of efforts to defeat the Foster nomination.

On Friday, the council circulated documents to senators that its president, Gary Bauer, said showed that Dr. Foster was almost certainly informed of the Tuskegee experiment in 1969, when he was the chairman of the obstetrics and gynecology department at Tuskegee University.

John Podesta, a senior adviser to President Clinton, said today, "Once again, the nomination of Dr. Foster, a good, decent and dedicated physician, has entered the land of political distortion." Mr. Podesta described Mr. Bauer as "an anti-abortion extremist committed to stopping this nomination."

The Tuskegee experiment, or as it was formally known, "The Tuskegee Study of Untreated Syphilis in the Negro Male," was conducted by the United States Public Health Service for 40 years beginning in 1932. In the study, the subjects, almost all sharecroppers from the Tuskegee-Macon County, Ala., area, were denied treatment to study the disease.

In 1969, a much-acclaimed book, "Bad Blood" by James H. Jones (Free Press, 1961), said officials of the Public Health Service were deliberating over whether to end the experiment, especially since penicillin had been available for decades, making the study irrelevant.

Mr. Jones wrote that minutes of a meeting showed the senior officials were worried about the public's reaction to what they had done for years and that they had decided to seek the approval of the Macon County, Ala., medical society. Mr. Bauer said that at the time Dr. Foster was the vice president of the county medical society, which had fewer than 12 members and thus he

would have known of the meeting.

In a statement released late Friday through the White House, Dr. Foster said that he first learned of the Tuskegee experiment in 1972, when it was publicly disclosed. "I was outraged in 1972 when, as president of the Macon County medical society, I first learned the facts of the Tuskegee Syphilis Study," he said. "I learned the facts of the study, much earlier, I would have been equally outraged then and I would have insisted on appropriate treatment."

The latest accusations raise new problems for Dr. Foster's nomination. Besides the question of whether

Opponents say Clinton's pick knew of a syphilis study.

he acquiesced in allowing the experiment to continue, it raises again the issue of his credibility.

The Washington Post today quoted the president of the county medical society at the time, Dr. Luther McRae, as saying he recalls the 1969 meeting clearly and is certain that Dr. Foster was there as well.

Dr. McRae, who did not answer his telephone today in Mount Vernon, Ga., was quoted in The Post as saying that he even recalled that Dr. Foster sat two seats away from him.

Mr. Podesta said White House officials talked to Dr. McRae and found his memory unreliable about events 28 years ago. "His recollections on a number of points ranging from how the meeting was set up to the nature of the study to Dr. Foster's role following the public disclosure of the study in 1972 are all inconsistent with the facts as established by the documentary evidence," Mr. Podesta said.

"While we have no doubt that those opposed to this nomination will try to distort the facts and the use of the actions of the Government against Dr. Foster, we are confident that fair-minded people will reject these distortions," Mr. Podesta said.

Mr. Jones, who teaches history at the University of Houston, said he has a letter from William J. Brown, who led the 1969 meeting with the Macon County medical society, in which Dr. Brown said that he won the doctors' cooperation. Dr. Brown also said he gave every member of the medical society a list of surviving participants in the study.

A4 Wash. Times 2-27-95

Foster calls new charge outrageous

NASHVILLE, Tenn. (AP) — Surgeon general nominee Dr. Henry W. Foster Jr. went on the offensive yesterday against "right-wing extremists," whom he accused of attacking his nomination to advance their own agenda.

"The most recent charge — that I, as a young black doctor in Tuskegee, Ala., knowingly cooperated with the most cruel and inhumane experiment ever undertaken by our government — is outrageous. ... And it is without substance," Dr. Foster said.

"How dare these groups accuse me? I was serving the people of Tuskegee. What were they doing? Who were they serving?"

Before his hometown congregation at First Baptist Church, the 61-year-old obstetrician-gynecologist urged church members to help fight "the latest attack from the right-wing extremists that are using my nomination to achieve their radical goals."

The controversy stems from the conservative Family Research Council's allegation that Dr. Foster



A well-wisher greets Dr. Henry W. Foster Jr. in his pew at the First Baptist Church in Nashville, Tenn., before he spoke to the congregation.

learned in 1969 of a federal study that left black Alabama sharecroppers with syphilis untreated, and that he did nothing about it.

Dr. Foster says that he did not find out about the experiment until 1972, and that when he did learn about it, he was outraged and pressed to get proper treatment for the men.

The Public Health Service conducted the Tuskegee Project from 1932 to 1972.

Dr. Foster's nomination has been under fire from anti-abortion

groups and conservative lawmakers since it was disclosed that he had performed a limited number of abortions. Some have also questioned his credibility for giving varying answers about the number of abortions he has performed.

Dr. Foster's nomination is expected to be formally forwarded to the Senate this week. He is continuing a round of face-to-face meetings with the senators who will decide whether he should replace Dr. Joycelyn Elders.

A18 Washington Times 2-28-95

Dr Henry Foster, President Clinton's nominee for surgeon general, is heading into a new firestorm that may overwhelm his earlier skirmishes over abortion and involuntary sterilizations.

Investigators from news organizations, private groups and the White House itself are right now combing the files of the Macon County, Ala., Medical Society in search of records that will shed light on the role Dr. Foster played in the infamous Tuskegee Experiment.

The Tuskegee Experiment was among the darkest episodes in American medical history. Begun in the 1930s by the United States Public Health Service, the experiment started as an effort to study the epidemiology of syphilis. Poor, black men from the rural areas of Alabama surrounding the Tuskegee Institute were recruited for the research.

At first, the study proceeded like any other medical research. But in the 1940s, it took a sinister turn when penicillin became available to treat syphilis. In a decision that defies understanding, the physicians and medical researchers who ran the Tuskegee Experiment decided not to treat 400 of the men in their cohort but simply continued to monitor the effects of the disease over the years. The subjects of the

New cloud adrift over Foster

experiments were not told the nature of the study and were misled into thinking that they were being treated. In truth, they

received only painful spinal taps (to measure the effects of the disease on the nervous system). Their symptoms were noted and recorded and simple burials provided when the disease had run its course.

In 1972, when the truth about the study came to light, the public outrage was enormous. Senate hearings in 1973 (chaired by Sen. Ted Kennedy) led to passage of the National Research Act, which codified strict rules about informed consent.

Dr. Henry Foster was a professor of obstetrics and gynecology at the

Tuskegee Institute — the medical hub of the experiment — during the 1960s. He was also the vice president and later president of the Macon County Medical Society.

According to the book "Bad Blood: The Tuskegee Syphilis Experiment" by Professor James H. Jones of the University of Houston, the Macon County Medical Society was fully briefed about the Tuskegee Experiment in May 1969, three years before the experiment came to public light. Two Public Health Service doctors, Leslie Norins and Alfonso H. Holguin, "explained the experiment in detail to the society's members ... [who] listened attentively and ... volunteered cooperation and approval and support."

Indeed, according to "Bad Blood," the doctors were cautioned against treating any of the men in the study with antibiotics, lest they disturb the experiment. The Macon County Medical Society, 14 of whose 15 members were black, agreed to withhold treatment and asked for a list of names of the men in the study. Lists were provided to each physician.

In 1972, when the experiment had become a national scandal (though somewhat eclipsed by the news of Thomas Eagleton's withdrawal as George McGovern's running mate, which broke on the same day), Dr. Henry Foster, by then the

president of the Macon County Medical Society, expressed a desire to help the subjects of the experiment in any way possible. But he made no reference to the meeting, three years earlier, at which the society had pledged its cooperation with the experiment.

Dr. Foster has told friends that he was not present at the 1969 meeting detailed in "Bad Blood." But even if that is true, was he not informed about it later? How often does a small county medical group get a visit from the Public Health Service? Did the vice president of the society not keep abreast of what happened at meetings he couldn't attend? Would the group's vice president be kept in the dark about something so important? Didn't simple gossip among the small group virtually ensure that Dr. Foster would have heard about it?

It was difficult to credit Dr. Foster's early claim that he had performed fewer than a dozen abortions and all had been in cases of rape, incest or life of the mother. That statement turned out to be, in the old Watergate phrase, inoperative. If Dr. Foster now pleads ignorance about Tuskegee, he may find his nomination "ambushed at credibility gap."

Mona Charen is a nationally syndicated columnist.



Colleague Says Clinton Nominee Learned of Syphilis Study in 1969

By NEILA A. LEWIS

Special to The New York Times

WASHINGTON, Feb. 27 — The former president of the medical society in Macon County, Ala., said today that he was certain Dr. Henry W. Foster Jr. was present at a 1969 meeting in which a small number of local doctors were informed of the infamous Tuskegee experiment, in which black men were denied treatment for syphilis in order to study the disease.

Dr. Luther C. McRae said in an interview that Dr. Foster, an obstetrician-gynecologist who is Presi-

dent Clinton's choice to be Surgeon General of the United States, learned some details of the experiment at the 1969 meeting. Dr. McRae said that like all the doctors present that day, including himself, Dr. Foster did not express any moral qualms about the study. At the time, Dr. Foster was chairman of the department of obstetrics and gynecology at Tuskegee University.

Dr. Foster has emphatically denied knowing anything about the experiment until 1972 when it was publicly disclosed.

White House officials have said

they believe Dr. McRae's memory is flawed about the 26-year-old events.

Michael D. McCurry, the White House press secretary, said today that Dr. Foster's nomination would be sent to Capitol Hill soon, possibly this week, and that the physician would make more courtesy calls on senators on Wednesday.

On Sunday, Dr. Foster appeared at the First Baptist Church Capitol Hill and asked the congregation for prayers, "to fight the latest attack from the white right-wing extremists that are using my nomination to achieve their radical goals."

Mr. McCurry said today that Dr. Foster did not mean to include the word "white" in the speech. The experiment, formally called "The Tuskegee Study of Untreated Syphilis in the Negro Male," was begun in 1932 by the United States Public Health Service. It involved approximately 400 black men, almost all sharecroppers from around Tuskegee and Macon Counties in Alabama, who were denied treatment so doctors could observe how the disease progressed.

Senator Nancy Landon Kassebaum, a Kansas Republican who is chairwoman of the Senate Labor and Human Resources Committee, which will consider the Foster nomination, has said that the Tuskegee experiment was, "one of the most tragic episodes in the history of the Public Health Service." She said she had instructed her staff to investigate "what role, if any, Dr. Foster played in this experiment."

Dr. McRae, who now practices obstetrics and gynecology in Mt. Vernon, Ga., said he was astonished that Dr. Foster had been at the meeting. Dr. McRae said he recalled

the event in much detail because it was not held at the normal meeting place at Tuskegee University but instead at a restaurant a few miles outside Tuskegee. He said that Dr. Foster, who was the society's vice-president, sat two or three chairs to his left.

Dr. Foster railed against the experiment publicly when it was disclosed by press reports in 1972 and was instrumental in seeing that the subjects received immediate treatment.

Dr. McRae said that he was baffled in 1972 when Hank acted

An issue that Republicans say raises additional questions of credibility.

quote, outraged, unquote, about this because he had been at the meeting himself when we learned of it three years before."

Dr. McRae said that Dr. Foster should have admitted being at the 1969 meeting and just said that he behaved like everyone else. "That would have been a better way to handle it," he said. Dr. McRae said that he often used Dr. Foster to consult on difficult cases and has always regarded him as a fine person and doctor who would make an excellent surgeon general.

Another physician who was at the

meeting, Dr. Howard Settler, an ophthalmologist, said he was unable to say whether Dr. Foster was present. Dr. Settler said that no one objected to the Tuskegee experiment because the officials portrayed it in vague terms and did not ask for anyone's approval. "It was just like getting a report from a state health agency, kind of update," he said.

Dr. John Hume, a surgeon who was an officer in the medical society, said he too could not recall if Dr. Foster was at the meeting.

The issue of whether Dr. Foster attended the 1969 meeting may be crucial in shaping the confirmation debate. Republican opponents of the nomination like Senator Don Nickles of Oklahoma said it further cast doubt on Dr. Foster's credibility. Dr. Foster had previously given varying answers as to how many abortions he had performed over his career.

Republican opponents are hoping the battle will be waged on the issue of credibility while White House strategists would rather it be directly on abortion.

White House officials have said that such an approach would put the Foster opponents in the position of objecting to the performance of legal abortions, a position they say is acceptable to most Americans.

According to the book "Barbed Wire Blood" by James H. Jones (Free Press, 1981), the Public Health Service began to worry in 1969 that the long-running experiment could be portrayed as inhumane. The minutes of one meeting, Mr. Jones said, showed that the service's senior officials thought that obtaining the approval of the local medical society would help buffer them from criticism.

NATION

Doctor disputes Foster claim on study

Double standard
in media seen
over Foster gaffe

By Rod Dreher
THE WASHINGTON TIMES

When is an unintentional slur news?

It depends on the race and politics of the slurrer and the slurred, say conservative media critics, who assert that Surgeon General nominee Dr. Henry Foster is benefiting from a media double standard.

In January, when House Majority Leader Richard Armey referred to his Democratic colleague Barney Frank as "Barney Fag," he called it a slip of the tongue and promptly apologized.

It was major news on the evening newscasts and in the major print media. Syndicated columnists chewed over the gaffe for days, and The New York Times editorial page even called for his ouster from his leadership post over the flap.

On Sunday, Dr. Henry Foster, speaking before a black church audience in Nashville, departed from his text and attacked "white right-wing extremists" for trying to stop his nomination.

The next day, White House spokesman Mike McCurry said Dr. Foster "misspoke" by adding the word "white" to his prepared remarks. "It was a slip of the tongue," Mr. McCurry explained.

The Washington Times gave the gaffe front-page play, but it did not get major attention in the media. The Washington Post and USA Today ran a short item inside. There was no mention in the New York Times.

Some conservatives consider the Foster remark incendiary because it drags race into the vitriolic fight over his nomination and implies that the Nashville obstetrician's opponents are driven by racist motives.

"They have been treated differently. I don't think that is unusual," said John Sheehan of the Center for Media and Public Affairs.

Mr. Sheehan said liberal black public figures can get away with remarks that would not be tolerated by the media if uttered by others. He noted recent statements by the Rev. Jesse Jackson and Rep. Charles Rangel, New York Democrat, likening their political opponents to Nazis.

"Jesse Jackson has been known to make comments that if



Dr. Henry Foster

others had said them, would be considered anti-Semitic and racist. Yet his remarks are treated differently," he said.

Tim Graham of the Media Research Center said many reporters and editors grant blacks more leeway in attacking whites because whites are not a historically oppressed minority.

It's also likely, said Mr. Graham, that most reporters have a positive impression of Dr. Foster, a black physician who has been associated with Planned Parenthood and other favored liberal causes, and a negative one of Mr. Armey, a deeply conservative Texas Republican who is white.

"There's a feeling that Foster is basically a good guy, but Armey is a white Republican from Texas, so he must be a homophobe," said Mr. Graham.

Mr. Graham said the Jan. 27 episode of CNN's "Crossfire" shows what he's talking about. According to a transcript of the program, liberal Newsweek correspondent Eleanor Clift said the Armey slip "feeds into a larger impression about Congressman Armey, and that is that he gives neo-speeches a bad name."

Another guest, U.S. News & World Report's Michael Barone, said if House Democratic leader Richard Gephardt had made a similar remark, chances are the reporter he said it to would have pocketed the tape and not made it public, as the reporter who interviewed Mr. Armey did.

"If somebody pocketed the tape with Dick Gephardt, it wouldn't be because they were protecting Dick Gephardt," said Miss Clift. "It would be because they could not imagine him talking this kind of poison."

Says nominee had no objection to not treating syphilis patients

By Joyce Price
THE WASHINGTON TIMES

A former head of an Alabama medical board yesterday disputed Dr. Henry W. Foster Jr.'s claim that he learned of a federal study in which hundreds of syphilis patients were left untreated only after the study ended in 1972.

Dr. Luther C. McRae Jr., now a family physician in Mount Vernon, Ga., said Dr. Foster, President Clinton's embattled surgeon general nominee, attended a Macon County Medical Society meeting on May 19, 1969, in which federal health officials discussed the controversial Tuskegee Syphilis Study and expressed their interest in getting permission to continue it.

Dr. Foster "voiced no objection to the continuation of the study," Dr. McRae said in a letter released yesterday.

Dr. McRae's disclosures could pose yet another roadblock for the Foster nomination, which the White House sent to the Senate yesterday.

White House spokesman John Podesta said, "We have nothing against Dr. McRae... but his recollections about how the meeting was set up, the nature of the study and Dr. Foster's role following disclosure of the study are all inconsistent with documentary evidence."

In a statement Friday, Dr. Foster said he was "outraged" when he "first learned" of the study in 1972. He was president of the county medical society at that time.

"I was concerned and shocked to read in the papers in 1972 that how outraged Hank [Foster] was when he was asked about the study by members of the press... I was wondering why he was getting so upset then, when he was at the meeting three years before" where details of the study were disclosed, Dr. McRae, 61, said in a telephone interview.

In the study, conducted by the U.S. Public Health Service from 1932 to 1972, about 400 black sharecroppers with syphilis were denied medical treatment. They remained untreated even after penicillin became widely available because researchers wanted to see how the venereal disease progressed.

Dr. McRae recalled what went on in the 1969 meeting in a letter sent yesterday to Jerry Horn, reporter for the American Life League's pro-life magazine, *Celebrate Life*.

"At this meeting, we were ap-

prised, myself and everyone there included, of the ongoing syphilis study that began in 1932 and (that) was to run over a 40-year period," Dr. McRae wrote. "This study consisted of a double blind study of treated and untreated male syphilis patients."

The Public Health Service officials who made the presentation were "very upfront" about the research, Dr. McRae said in a phone interview. "We were very deeply shocked... since no one (in the medical society) previously knew about this study."

The Georgia doctor's recollections confirmed information about the 1969 medical society meeting contained in a 1972 article in the *Montgomery Advertiser*, an Alabama newspaper, and a 1981 book, "Bad Blood," by Texas historian James H. Jones.

According to the book, two PHS officials, Dr. William J. Brown and Dr. Alfonso H. Holman, informed members of the medical society about the study and their full approval to continue with it.

As the book indicated, Dr. McRae said the federal officials provided a list of patients still remaining in the study and directed the doctors not to treat them for syphilis.

Dr. McRae said five of the persons on the list were his patients. He said he had personally treated three of them for syphilis during prior hospitalizations.

By 1992, 28 men in the study had died of the disease.

The New York Times and National Public Radio were first to report Dr. McRae's comments. The Times said it had reached two other members of the medical society — Dr. Howard Sontag, an ophthalmologist, and Dr. John Hume, a surgeon — but they were not able to say whether Dr. Foster attended the meeting in question.

Dr. McRae said he was one of only two whites in the Macon County Medical Society in 1969.

The White House has suggested that Republicans attack on Dr. Foster, a black, are driven by racism. Dr. Foster characterized opponents of his nomination as "white right-wing extremists" in a speech at his church in Nashville Sunday.

But Dr. McRae said Dr. Foster knows "I'm not a racist." He pointed out that he "ungrudgingly" joined the Macon Medical Society and reeled off a long list of other organizations and activities in which he was the first white member or participant.

Wash. Post A20 3-1-95

Dr. Foster and the Syphilis Study

THE WHITE HOUSE last night formally sent the nomination of Henry W. Foster Jr. for the surgeon general's post to the Senate. In the short time since he was announced as President Clinton's choice, Dr. Foster has been subjected to a torrent of criticism, not only because he has performed abortions in the past but also for the clumsy way in which he and the White House made known the activity. The episode did little to boost either Dr. Foster's or the administration's credibility. Still, despite our own misgivings about the significance of the office, we have encountered little about Dr. Foster's 38-year career as a physician, academic administrator and pioneer in teen pregnancy-prevention programs that would weigh decisively against his confirmation.

Recently, however, Dr. Foster's name has become linked to the infamous 40-year Tuskegee experiment in which hundreds of black men with syphilis were deliberately left untreated in the name of medical research. At issue is what and when Dr. Foster knew about the study before it was publicly exposed in 1972. We hope the answer is, as Dr. Foster and the White House maintain, that he was not informed about the study until the story broke. To have known earlier and not insisted on proper treatment for the innocent patients would disqualify any candidate for the surgeon general's post.

The Tuskegee syphilis study, conducted by the U.S. Public Health Service in Macon County, Ala., was a terrible case of cruelty in science. Hundreds of black men with syphilis were misled by the government into thinking they were being treated for the disease, when in fact help was being withheld so

researchers could study the disease's progress. After penicillin was introduced in the 1940s and accepted as an effective treatment for syphilis 10 years later, the Public Health Service should have urged treatment on the syphilitic men. Instead, in the name of science, researchers allowed the suffering to go on until the men died.

From the day the study was launched in 1932, it was morally indefensible. Researchers who had no qualms then certainly were entertaining doubts in the 1960s. Unfortunately, the doubts were not enough to stop them. Instead, in May 1969, the Public Health Service sought to bring the local Macon County medical society into the picture on the study as a shield against criticism. Dr. Foster was vice president of the society at the time. Following a meeting with the medical society, the federal researchers left thinking they had the society's endorsement to keep the study going. Dr. Foster unequivocally states that he was not in attendance, that he was not informed until 1972 through news accounts, at which time he demanded the study be halted and the patients treated. His recollection, however, is at odds with that of Luther C. McRae, president of the medical society in 1969, who maintains that Dr. Foster was in fact present at the 1969 meeting and knew that curative treatment was being withheld.

Memories of some participants have dimmed or are inconclusive. Other participants have died, and minutes have been lost. No doubt this is a difficult matter to resolve. But it is crucial to pin down when Dr. Foster learned about the study. The question of his fitness for the job hangs on it.

Doctor attacking Foster willing to testify

A former colleague of Dr. Henry Foster Jr. said yesterday he would testify under oath that the surgeon general nominee knew about a government study that left black men with syphilis untreated. The White House said the man's remarks "are all inconsistent with the facts."

Dr. Luther McRae, who lives in Mount Vernon, Ga., was the president of the Macon County (Ala.) Medical Society when it was briefed on the U.S. Public Health Service's Tuskegee project on May 19, 1969. Dr. Foster was then the vice president of that society.

No records have been found of the meeting. Dr. Foster, who was on Capitol Hill visiting senators yesterday, has said he was not there and that he only learned of the experiment when it became public in 1972.

Dr. McRae said Dr. Foster offered no comment or criticism when Dr. Bill Brown of the Public Health Service described the experiment, which had been going since 1932 and was supposed to last 40 years — until 1972.

The doctors endorsed continuation of the study by consensus, Dr. McRae said.

Wash. Times 3-2-95 A7

"An authentic/exquisitely detailed case study of the
consequences of racism in American life."
The New York Times Book Review

BAD BLOOD

The Tuskegee Syphilis Experiment



The modern classic
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Experiment's legacy
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The New York Times Book Review

"This is a valuable, superbly researched, fair-minded, profoundly troubling and clearly written book."

The Washington Post Book World

"Bad Blood is an important book, an authentic and appalling study of how the educated deliberately deceived and betrayed the uneducated in our own times through a government agency."

DAVID WOODWARD

Author of *The Strange Career of Jim Crow*

"Bad Blood is a shocking and bold report of scientific cruelty and moral mediocrity. The moral and ethical questions this book raises come into sharp focus and are compelling."

BENJAMIN L. HOOKS

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"By eschewing sensationalism, Jones offers a compelling narrative that enhances our understanding of race relations in the twentieth-century South, of professionalism in medicine, and of American literature. Bad Blood deserves to win a prize."

JAMES T. PATTERSON

Author of *The Dread Disease*

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Shadow of the Plantation, 1934

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About the Author

James H. Jones is associate professor of history at the University of Houston. He lives in Houston, Texas. He received his Ph.D. in history from Indiana University and has held a Kennedy Fellowship in Bioethics at Harvard University, served as a senior research fellow at the Kennedy Institute of Ethics at Georgetown University, and recently held senior fellowships from both the National Endowment for the Humanities and the Rockefeller Foundation. He published the first edition of *Bad Blood* in 1981 to critical acclaim. It was a Main Selection of the History Book Club and a *New York Times* Best Books of 1981 and has inspired a play, a PBS *Nova* special, and a motion picture.

CHAPTER 12

"Nothing Learned Will Prevent, Find, or Cure a Single Case"

BARRING public disclosure, the only pressure that might have forced PHS officials to end the Tuskegee Study voluntarily would have been the adoption of federal guidelines on human experimentation. Discussions by PHS and NIH officials about the need to regulate human experimentation in extramural research programs dated from 1945. Little came of these early deliberations. The Nazi experiments had practically no effect on them because American officials tended to dismiss the German studies as the isolated acts of deranged scientists—sheer madness that would never again be repeated.

Low-key discussions on human experimentation continued within the PHS and NIH into the 1950s and 1960s, largely because officials thought that the government agencies that promoted scientific research should encourage academic and private industry investigators to adopt guidelines creating a system of self-regulation for scientists. The civil rights movement no doubt added to the pressure for reform during the 1960s by calling attention to the plight of minority groups, as did the consumers' rights movement by demanding better service and more public accountability from the professions. The first federal law that explicitly imposed controls on human experimentation came in response to the thalidomide tragedy.

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The Pure Food and Drug Act was passed to protect the public when they were buying food and drugs.

Additional impetus came from the international community. The World Health Organization, an American government agency, had developed international medical device regulations. The subjects of scientific inquiry were not as scientific as the Nazi experiments. The ethics of human experimentation were all of the leading medical journals. The code contained especially stringent provisions for human experimentation.

An NIH report was issued in 1966. The result was a new code within the American medical community. The code accepted code of ethics for studies involving human subjects and wide variation in experimentation. The exposure of the Tuskegee study led to the exposure of a number of their own reports. The code learned of an ongoing study in the United States had been addressed by this review. The apparent void, governing flexible guidelines for research to a minimum of restrictive action.

On February 8, 1967, the Policy and Procedure Committee issued its first guidelines on human experimentation. The guidelines established a standing panel of experts. Members of the committee reviewed all proposals from investigators for assurance of compliance with the guidelines.

Critics accused the committee of the investigators of being too lenient.

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The Pure Food and Drug Act Amendments of 1962 sought to protect the public by ordering doctors to inform their patients when they were being given drugs experimentally.

Additional impetus for government regulation came from the international front. The Declaration of Helsinki, issued by the World Health Organization in 1964, served notice that American government agencies were out of step with international medical developments in failing to take action to protect the subjects of scientific experiments. The Declaration of Helsinki announced a series of guidelines that were much less legalistic than the Nuremberg Code and far more concerned with the ethics of human experimentation. Endorsed by practically all of the leading medical organizations in the United States, the code contained provisions on informed consent that were especially stringent.

An NIH report in 1964 further strengthened the case for action. The result of years of inquiry, the paper revealed that within the American medical profession there were no generally accepted codes on clinical research. The legal status of studies involving human subjects remained ambiguous at best, and wide variations existed in official attitudes toward human experimentation. The potential for abuse became clear with the exposure of a shocking experiment. During the review of their own report on human experimentation, NIH officials learned of an ongoing study in which medical scientists in the United States had injected live cancer cells into patients. Distressed by this revelation and mindful of the need to fill an apparent void, government health officials began work drafting flexible guidelines that would keep federal control of research to a minimum, while creating the appearance of decisive action.¹

On February 8, 1966, the surgeon general's office issued Policy and Procedure Order Number 129, outlining the PHS's first guidelines on clinical research and training grants. The guidelines established a system of peer review exercised by a standing panel of colleagues at an investigator's institution. Members of the committee had the responsibility of reviewing all proposals from their institution and submitting an "assurance of compliance" to the PHS.²

Critics accused the review panels of being weighted in favor of the investigators, and the PHS responded by revising the

guidelines in 1969. Henceforth, the panels had to include members with nonscientific backgrounds. In 1971, the surgeon general attempted to clarify the policy again, requiring review panels to include people who were capable of judging projects by community standards. In practice, however, the 1969 and 1971 revisions had little effect. The heart of the regulations remained peer review, and the government made no attempt to apply rigid rules to diverse research proposals. Instead of drafting a substantive moral or ethical code, health officials preferred to rely upon procedural guidelines to be applied by a system of decentralized review committees.³

Significantly, none of the guidelines contained provisions that applied to the PHS's own research programs. Nothing in the guidelines, except, of course, their spirit, obliged the PHS to meet the same standards as its grantees. Thus, none of the health officers connected with the Tuskegee Study expressed any ethical concern until critics started asking questions.

In June 1965, Dr. Irwin J. Schatz, a staff member of the Henry Ford Hospital in Detroit, became the first member of the medical profession to object to the Tuskegee Study. After reading one of the published reports on the experiment, he wrote the primary author of an article published in 1964:

I am utterly astounded by the fact that physicians allow patients with a potentially fatal disease to remain untreated when effective therapy is available. I assume you feel that the information which is extracted from observations of this untreated group is worth their sacrifice. If this is the case, then I suggest that the United States Public Health Service and those physicians associated with it need to reevaluate their moral judgments in this regard.

Dr. Schatz never received a reply. His letter was tucked away in the files of the Center for Disease Control with a note stapled to it by Dr. Anne Q. Yobs (coauthor of the report that had prompted his attack) containing this explanation: "This is the first letter of this type we have received. I do not plan to answer this letter."⁴

Peter Buxtun was not so easily dismissed. Born in Prague, Czechoslovakia, in September 1937, Buxtun was brought to the United States as an infant on the eve of World War II by his Jewish father and Catholic mother who fled Europe to escape

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the Nazis. He was reared on a ranch in Oregon, later graduating from the University of Oregon with a major in political science. Following a hitch in the army where he received training as a psychiatric social worker, Buxtun was hired in December 1965 as a venereal disease interviewer and investigator by the PHS in San Francisco.

Soon after going to work at the Hunt Street Clinic, Buxtun heard the Tuskegee Study discussed by coworkers one day at lunch. He had difficulty believing the stories. "It didn't sound like what a PHS institution should be doing," he stated. Since he was required as part of his job to write a short paper on venereal disease or epidemiology every two months, Buxtun decided to do his next assignment on the Tuskegee Study and asked the Center for Disease Control for reprints of articles that had been published on the experiment. When the copies arrived, he recalled, "I went through them and was even more disturbed." He found the discussions of syphilitic heart disease especially troublesome, and the more he read the more it became obvious that the subjects did not have much medical knowledge and did not know what was being done to them. "That was what really stuck in my craw," he declared.⁵

In early November 1966, Buxtun sent Dr. William J. Brown, the director of the Division of Venereal Diseases, a letter (registered mail) expressing grave moral concerns about the experiment. He asked whether the purpose of the experiment was to obtain information "on the syphilitic damage which these men were being allowed to endure." He also inquired if any of the men had been treated properly and whether any had been told the nature of the study. And finally, he asked, "are untreated syphilitics still being followed for autopsy?"⁶

Weeks passed and nothing broke the silence from the CDC. Dr. Brown drafted a two-page reply but never mailed it. Instead, he asked a colleague from the CDC who happened to be going to San Francisco over the Christmas holidays to drop by the Hunt Street Clinic and discuss the experiment with Buxtun. The two men met and Buxtun tried to explain his moral objections, all the while feeling that the visitor thought that he was a bit crazy. "He was still somewhat puzzled but said he would take my views back to Dr. Brown," Buxtun recalled.⁷

A few months later Buxtun was invited to attend at government expense a conference on syphilis research at CDC. Once

he arrived, however, it became clear that no provisions had been made for him to attend the sessions and that the real reason he had been brought to Atlanta was to discuss the Tuskegee Study. Late in the afternoon he was introduced to Dr. Brown, who escorted him to an executive conference room with a big mahogany table surrounded by a dozen or so chairs. The room was large and very dignified in decor, displaying an American flag and the PHS flag at one end. In addition to Dr. Brown, Buxtun encountered the emissary who had talked with him in San Francisco and Dr. John Cutler, a health officer with intimate knowledge of the study.

According to Buxtun, Dr. Cutler began to harangue him the moment they were seated. "He was infuriated," stated Buxtun. "He had obviously read my material, thought of me as some form of a lunatic who needed immediate chastisement and he proceeded to administer it." Dr. Cutler then launched an impassioned defense of the experiment, stressing, in particular, how it would benefit physicians who were treating syphilitic blacks.⁸

Buxtun was neither intimidated nor impressed. The men were not volunteers, Buxtun insisted, "they were nothing more than dupes and were being used as human substitutes for guinea pigs." He stated that the PHS had a duty to consider the moral implications of the study and suggested that legal advice be sought. Moreover, Buxtun warned that if the story fell into the hands of a yellow journalist, it could be used to damage the entire PHS, including its worthwhile programs.⁹

Buxtun left the meeting with "a very inconclusive feeling," he stated, "as though I had dropped a bomb into their laps and nobody knew quite what to do about it." He returned to San Francisco, expecting to be fired. When he was not, Buxtun settled back into his work. He did not anticipate hearing from Atlanta immediately. Instead, he thought the health officers would take care of things "in their own professional and bureaucratic way." Months passed and nothing happened.¹⁰

In November 1967, Buxtun resigned voluntarily from the PHS. The next fall he enrolled in law school at Hastings. Still troubled by the experiment, he wrote Dr. Brown a second letter in November 1968. Two years had passed since his first inquiry. During the interlude several American cities had exploded into race riots, and Buxtun had grown more alarmed

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and pessimistic about the racial implications of the experiment. "The group is 100 percent Negro," he declared. "This in itself is political dynamite and subject to wild journalistic misinterpretations." The racial composition of the study group also supported "the thinking of Negro militants that Negroes have long been used for 'medical experiments' and 'teaching cases' in the emergency wards of county hospitals." Denying that the subjects were volunteers, he characterized them as "uneducated, unsophisticated, and quite ignorant of the effects of untreated syphilis." The excuses and justifications that might have been offered for starting the study in 1932 were no longer relevant. "Today it would be morally unethical to begin such a study with such a group," he declared. "Probably not even the suasion of belonging to the 'Nurse Rivers Burial Society' would be sufficient inducement." Buxtun closed by expressing the hope that the subjects had been treated or would be soon."

This time Buxtun got results. Dr. Brown showed the letter to his boss, Dr. David Sencer, the director of CDC, and for the first time in the history of the experiment health officials realized that they had a problem on their hands. They did not think that they were doing anything wrong, but they were worried that people who did not understand medical research might make trouble if the press became involved. They saw the experiment as a public relations problem that could have severe political repercussions.

On February 6, 1969, Drs. Sencer and Brown convened a blue-ribbon panel to discuss the Tuskegee Study. The conference was held at CDC, in the same conference room where health officials had met with Buxtun two years earlier. This time the participants were all physicians. The committee consisted of three medical professors, the state health officer of Alabama, and a senior officer from the Milbank Memorial Fund. In addition to Drs. Sencer and Brown, the PHS had several high-ranking officers in attendance. Dr. Olansky, who had left the PHS by this time and was employed by the Emory University Clinic, was called in as a special resource person to discuss the early years of the experiment. No one with training in medical ethics was invited to the meeting, none of the participants was black, and at no point during the discussions that followed did anyone mention the PHS's own guidelines on human experimentation or those of other federal agencies.



Following the introduction of panelists, Dr. Sencer delivered a brief description of the Tuskegee Study and then told the group that the PHS needed their help in deciding whether to terminate or continue it. When the study began, he explained, there was no concern about racial discrimination and withholding treatment from the men did not pose any problems. In recent years, however, questions had been raised and the study had become a political liability. "We want your advice in making a decision," he told the panelists. "We are here to discuss this problem."¹²

Dr. Brown then took over the meeting, focusing attention on the study as it was organized in 1932; the fate of the participants down through the years; and the current condition of the survivors. The original study group had been composed of 412 black men with syphilis and 204 black male controls, he told the panelists. According to the most recent figures, 56 syphilitic subjects and 36 controls were still living, a total of 373 men in both groups were known to be dead, and the remaining subjects could not be accounted for. Dr. Brown stated that 83 of the syphilitic subjects had shown evidence of the disease at time of death, but stressed that he personally believed that syphilis had been the primary cause of death in only 7 of the men. The ages of the survivors, he revealed, ranged from 59 to 85, with one subject claiming to be 102.¹³

Once the meeting was opened for discussion, Dr. J. Lawton Smith, associate professor of ophthalmology at the University of Miami, quickly emerged as the leading proponent of continuing the study. That was hardly surprising. He had a personal interest in seeing the experiment go forward. Not only had he known about the study for years, he had actually been to Tuskegee to examine the subjects in connection with his own research. Describing the eye examinations he had performed on the men in 1967, Dr. Smith stated that he had taken fundus (the part of the eye opposite the pupil) pictures, boasting that "20 years from now, when these patients are gone, we can show their pictures."¹⁴

Dr. Smith thought that the time had come to change the study's emphasis. "First, stress pathology, get away from serology," he urged his colleagues. "You will never have another study like this; take advantage of it." He even volunteered to return to Tuskegee, to go to the subjects' homes, explain the

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experiment to them, and examine them again. "This is a golden moment," Dr. Smith declared. "Turn this Study into pathology studies."¹⁵

Dr. Gene Stollerman, in contrast, cared more for the survivors than the experiment's scientific potential. He was chairman of the Department of Medicine at the University of Tennessee and the only member of the panel who did not have previous knowledge of the Tuskegee Study before being asked to review it. It quickly became apparent that he was also the only panelist who saw the subjects as patients and thought that they had a right to be treated.

Dr. Stollerman sought repeatedly to shift the discussions to the PHS's moral obligation to treat the men. He rebelled against the scientific focus of the meeting. For him the experiment raised moral questions, and he was troubled by the committee's insistence on discussing the survivors as a group of subjects rather than individual patients. He urged his colleagues to establish criteria for treatment, to give the men complete examinations, and to decide whether or not to treat each patient on a case-by-case basis. Unless the men were treated, he warned prophetically, there were certain to be criticisms of the study.¹⁶

Dr. Stollerman's recommendations found little support among his colleagues. Instead of addressing his moral concerns, they turned the meeting into a medical debate on whether treatment would do more harm than good. No one attempted to gauge the degree of risk on a case-by-case basis or even suggested that this might be a good idea. Instead, the physicians lumped the men together and cited the severe complications that could result from penicillin therapy (Herxheimer reactions, fibrillations, etc.) as absolute dangers. Dr. Olansky, whose name appeared as the principal author and coauthor of more publications on the study than any other investigator, was especially forceful in voicing his concern over the damage treatment might inflict on the men.¹⁷

The ad hoc committee also heard testimony that treatment probably would not help the men. Citing a recent study by Dr. Smith, Dr. Brown noted that although penicillin could cure syphilitic lesions it often failed to kill the spirochetes that were encased in certain tissues of the body. "I doubt if you could cure them," Dr. Smith observed gravely. Dr. Myers further dis-



counted treatment by suggesting (without a word of explanation) that the subjects probably would not accept therapy even if it were offered. "I haven't seen this group," he admitted, "but I don't think they would submit to treatment."¹⁸

In the end, the ad hoc committee overrode Dr. Stollerman and recommended against treatment—at least not for the present. Predictably, that decision ended debate on the Tuskegee Study's future: It would continue. The physicians had approached the experiment as a medical affair, and once a medical judgment had been made against treatment, they saw no point in stopping the study. Except for Dr. Stollerman, they perceived no conflict between their own scientific interest in the experiment and attempting to decide what was best for their subjects. The doctors thought that the Tuskegee Study had scientific importance and that much remained to be learned. Since they had convinced themselves that the men could not benefit from treatment, it followed in their minds that science should be permitted to learn all it could.

With the experiment's future settled, the ad hoc committee turned its attention to protecting the PHS. Having the men give their "informed consent" in writing would have been ideal, but that would have required explaining the experiment to them in language they could understand, with special emphasis on the risks to which they had been exposed. No one brought up the possibility that the men might listen and understand all too well. Instead, most of the committee argued at the outset that it was impossible to obtain "informed consent" from men of such limited education and low social status. In their judgment, the men were incapable of understanding the facts of the experiment and forming their own conclusions.

The other possibility was to seek the approval of the Macon County Medical Society, obtaining, as it were, a type of "surrogate informed consent" from local doctors. Dr. Myers warned that the society's racial composition had completely changed in recent years, transforming it from an all-white organization into a nearly all-black one. Still, he had found them very reasonable to work with. Dr. Myers admitted, adding that the fears of real trouble-making had not come to pass. He recommended bringing the local doctors up to date on the experiment so that in the future federal and state health authorities could "work very closely with them and keep them informed of

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everything we do." Seconding the idea, Dr. Smith suggested sending someone to explain the experiment to the society's members. "They might think the same [as we do]," he declared. "If the local physicians agree there is no need for treating these patients, this would be good public relations."¹⁹

Reinvolving the Macon County Medical Society was indeed critical to protecting the PHS. Over the years, relations with the local doctors had been neglected, for once Nurse Rivers's network was firmly established they had become relatively unimportant to the experiment. The physicians with whom Drs. Vonderlehr and Heller had collaborated were either dead or retired, and a new generation had replaced them, one that had little knowledge of the experiment.

Dr. Sencer soundly endorsed reestablishing contact so that the PHS could benefit from a time-honored principle of the medical profession: namely, that "good medicine" in any community is defined by the physicians who practice there. If the PHS succeeded in establishing rapport with the Macon County Medical Society, he told his colleagues, there would be no need to answer criticisms. Thus, without being aware of what they had done, the ad hoc committee and the health officials brought the Tuskegee Study full circle. Like the experiment's organizers, they saw local doctors as crucial allies without whose help the study could not go forward. Ironically, Dr. Sencer and his colleagues were as hopeful of winning the support of black physicians in 1969 as the experiment's organizers had been of white physicians in 1932.²⁰

Dr. Myers suggested that before any overtures were made to the local medical society it would be wise to discuss the experiment with the county health officer, Dr. Ruth R. Berrey, a former missionary to Nigeria whom he described as "very competent." Cautioning that Dr. Berrey might lean toward treatment, he told the group: "She loves the people in the area. She's very good to them." Still, trying to win her over was worth a try, he thought, because she was "very interested in research" and enjoyed good relations with the local doctors. Dr. Myers left no doubt that her support might help persuade them to sanction the study.²¹

Virtually everyone agreed that the study needed to be upgraded scientifically. Greater efforts needed to be expended to locate subjects who had been lost to the study, and the PHS

had to be prepared to devote more money and more personnel to the experiment's final years. There was even talk of providing some free medical care for men who were in need of treatment. Dr. Sencer stated that Nurse Rivers would have to be replaced with someone younger so that follow-up work could be resumed and the men who showed signs of active syphilis could be treated. The others were to remain untreated.²²

Early in the discussions Dr. Myers had warned that no new actions could be taken on the experiment without the whole program folding, but as the meeting drew to an end the group became more optimistic. Before adjourning, Dr. Sencer asked Dr. Kiser, the Milbank Fund's representative, to comment on the racial and political overtones of pushing forward. "This is not a Study that would be repeated now. The public conscience would not accept it," Dr. Kiser replied. "If you combined treatment with the present study, I am impressed with the plan—but I don't know whether the Fund would up the ante." Dr. Sencer closed by assuring everyone that the PHS would be guided by their recommendations and that he, personally, planned to "lean heavily on Ira [Myers]."²³

A few weeks later Dr. Myers discussed the Atlanta meeting with his colleagues on the Alabama State Board of Health. They listened carefully and then voted unanimously to refer the entire matter to the Macon County Medical Society. He then spoke with Dr. Berrey. According to Dr. Myers, she had heard no criticisms of the experiment and had doubts if the local medical society even knew it existed, but she hoped the doctors would be sympathetic. With the local ground work completed, Dr. Myers forwarded the names of the officers of the society to the CDC, suggesting that Dr. Brown contact them directly to arrange an audience.²⁴

The 1969 meeting with the Macon County Medical Society ended in total victory for the PHS. Dr. Sencer dispatched Dr. Brown and two other federal officers. Drs. Leslie Norins and Alfonso H. Holguin, to Tuskegee, and Dr. Holguin, who was spokesman for the PHS delegation, explained the experiment in detail to the society's members. According to Dr. Brown, the directors listened attentively and immediately "volunteered cooperation and approval and support." Indeed, just as their white predecessors had done nearly four decades earlier, Ma-

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con County's black physicians promised to assist the PHS. "They actually agreed," Dr. Brown continued, "if they had a list of the individuals that they would not knowingly give them antibiotics . . . but would refer them locally to the health department and to Nurse Rivers." Needless to add, each of the local doctors was given a list.²⁴

Apparently, no one thought to question the morality of withholding treatment that was not specifically limited to syphilis. Antibiotics, it must be stressed, are given for a wide variety of infections.

The PHS also reestablished something of its former working relationship with medical personnel at John A. Andrew Hospital, thus restoring another element of biracial support for the experiment. Following the retirement of Dr. Dibble, none of the staff there had been involved directly with the study, though the Tuskegee Institute had continued to serve as fiscal agent for the Milbank Fund's burial stipends. In April 1970, Dr. Joseph G. Caldwell, the health officer in charge of the annual roundup that year, met with both the administrator and the medical director of Andrew Hospital and contracted to have the men's X-rays done in the hospital's new three-story building. Mr. Luis A. Rabb, the administrator of the hospital, not only agreed to cooperate but insisted on giving Dr. Caldwell and Nurse Rivers Laurie a personally guided tour of the new building. No doubt the men who were examined there a few weeks later found the hospital impressive. They must have had a sense of déjà vu upon returning to the campus of the Tuskegee Institute.²⁵

In September 1970, Mrs. Elizabeth M. Kennebrew, a black woman, went on the PHS payroll as the nurse assigned to the Tuskegee Study. Realizing that she was being asked to fill some rather large shoes, one of her supervisors later wrote to her reassuringly: "The excellent rapport which Mrs. Laurie had with these patients cannot be achieved overnight, but I believe a regular system of visitation will aid you in doing this." Toward that end, he instructed her to "make personal contact with every patient being followed in the Tuskegee area at least once every 2 months," adding that "patients who are hospitalized for any reason should be followed daily with visits." Nurse Kennebrew settled easily into the routine and

reported to her superiors in Atlanta: "Most of the patients seem to look forward to my visits because they get either pain pills and/or tonic."²⁷

Armed with the approval of the local doctors, a revitalized working relationship with the Tuskegee Institute, and a new nurse, the PHS entered the 1970s determined to continue the experiment until the last subject had died. Despite the ad hoc committee's discussions, none of the men was treated for syphilis and the experiment's focus remained the same—following the men to their graves to trace the effects of untreated syphilis. All that changed was the zeal with which the PHS pursued the men.

Not since the early 1950s had health officials expended so much energy searching for subjects who had been lost to the experiment. They outdid themselves in devising schemes for finding the men. One health official persuaded the assistant postmaster in Tuskegee to help with the search, while another officer turned to private enterprise for assistance: He paid a retail credit association thirty dollars a man to track down the more difficult cases. Amid the flurry of activities, there was even talk of employing a full-time person at CDC to supervise and coordinate the study's final years, including editing a monograph that would report all the findings in a single volume, with various chapters contracted to experts not affiliated with the PHS.²⁸

Moreover, reports from the field indicated that the Tuskegee Study had lost none of its power to fascinate young clinicians. Echoes of Dr. Vonderlehr's enthusiastic letters could be heard in 1970 in the words of Dr. Caldwell, who uncovered a man, long missing from the study, with "classic aortic insufficiency and syphilitic heart disease." According to Dr. Caldwell, the man "even had deMusset's sign and capillary pulsations which none of the other patients with AI [aortic insufficiency] have had." (In deMusset's sign, the valve of the left ventricle to the patient's heart is badly eroded and will not close properly. Thus, when the heart contracts, the valve leaks, causing the blood to rush back through the artery to the head with such force that the patient's head snaps back.) "It is unfortunate that it took us all of 29 years, however, to locate and examine him again," wrote Dr. Caldwell. "This has destroyed much of

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the potential of being a complication of syphilis."

In addition to the reports were filled with the experiment's organ shocked by what the local conditions were waiting a subject who miles from the near two miles had died front of his "hut," a not been able to dis amining room (his "and two mice white to the local color." her husband, the man outside in a field, their remaining in Caldwell took the health officer stated for both of them.²⁹

Despite the similarities made by the studies earlier, the health study in the same line had been replaced by a "work as usual" conception that things come to the conclusion wrong. Rather, they became known public searchers could ignore of human subjects.

Thus, the PHS offensive about disclosure inquired about recent climate in recent years volunteers as well as wide publicity of the candid in confessing

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In addition to descriptions of syphilitic pathologies, the re-
ports were filled with comments on social conditions. Like the
experiment's organizers, the health officers of the 1970s were
shocked by what they saw in Macon County. To Dr. Caldwell
local conditions were "unbelievably primitive." He told of vis-
iting a subject who "had not even electricity and lived 2-3
miles from the nearest dirt road or neighbor." One of the man's
two mules had died within the past month just over the rise in
front of his "hut," and due to his old age and disabilities he had
not been able to dispose of the carcass. "The stench of our ex-
amining room (his hut) was unbelievable," wrote Dr. Caldwell.
"and two mice which kept scampering about the room added
to the local color." While the "government doctors" examined
her husband, the man's wife, who was in her late sixties, stayed
outside in a field, plowing a few acres for watermelons with
their remaining mule. To complete the examination, Dr.
Caldwell took the man and his wife to Tuskegee, a trip the
health officer stated was "without doubt the delight of the year
for both of them."²¹

Despite the similarity between these reports and the com-
ments made by the experiment's organizers nearly four dec-
ades earlier, the health officers of the 1970s did not view the
study in the same light. The self-confidence of the predecessors
had been replaced by self-consciousness. For beneath the fa-
çade of "work as usual" there was a growing uneasiness, a per-
ception that things had changed. The health officers had not
come to the conclusion that the Tuskegee Study was morally
wrong. Rather, they feared the consequences if the experiment
became known publicly. The day had passed when medical re-
searchers could ignore the public's concern over the protection
of human subjects, and they knew it.

Thus, the PHS officials became more and more apprehen-
sive about disclosure and felt restrained. When an old friend
inquired about recent publications, Dr. Brown replied: "The
climate in recent years (disfavor of research involving human
volunteers as well as racial tension) has not been conducive to
wide publicity of the Tuskegee findings." He was even more
candid in confessing his reluctance to sanction new articles to

the Milbank Fund, explaining, "We feel that the analysis of the data assembled to date should await a more favorable national climate."³¹

Apprehension gave rise in one instance to a modicum of critical thinking. Late in 1970 Dr. James B. Lucas, the assistant chief of the Venereal Disease Branch, finally said what no other PHS officer had uttered: The Tuskegee Study was incongruous with the goals of the PHS. Worse yet, the experiment was "bad science" because it had been contaminated by treatment. "Nothing learned will prevent, find, or cure a single case of infectious syphilis or bring us closer to our basic mission of controlling venereal disease in the United States," Dr. Lucas declared. Moreover, the experiment's value had been undermined, he explained, "because effective and undocumented treatment has been given to the vast majority of the patients in the syphilitic group" for most had received penicillin "in the 'happenstance' manner while under treatment for other conditions."³²

Dr. Lucas stated that the impact of this inadvertent treatment would be almost impossible to assess "but without question the course of untreated syphilis (which the study was supposed to have delineated) has been radically altered." As a result, he concluded: "Probably the greatest contribution that the Tuskegee Study has made and can continue to provide has been documented sera for study in our laboratory," the sole use for which was "evaluating new serologic tests." Thus, Dr. Lucas admitted that the Tuskegee Study's principal contribution to medical science has been keeping laboratories supplied with blood samples for evaluating new blood tests for syphilis, such as precipitation tests like the Hinton, which had replaced the Wassermann. The benefit seems small when one remembers that some of the blood donors later died from syphilis.³³

Like his predecessors, however, Dr. Lucas opposed ending the experiment. The PHS had "both an implied and expressed obligation" not to abandon "the remaining syphilitic patients." Stressing that the "long continued assignment of Mrs. Laurie and now Mrs. Kennebrew to Tuskegee demonstrates our good faith and sincerity," Dr. Lucas insisted that the PHS was obligated to preserve its "present level of observation as long as a significant number of patients remain alive." He therefore recommended that the experiment "be continued

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along its present line serologic surveillance might "prefer not to its sensitive nature, could not continue to officers."³⁴

In the end it was stopped the Tuskegee his second letter until then informed Buxton professionals draw viewed all aspects of treating the men, a of medical judgment offset against the risk made no attempt to ity, freely conceding early death has been treatment of the subjects the experiment, that the state that they longer exercise the control of syphilis." Urging Dr. Buxton issues at stake as well "What is the ethical Compensate the families await the quiet death the matter?"³⁵

Buxton was not answered. He had not really expecting a haunted him all through the study with friends. They were syphilitic that anything could have been done had expired in died. One professor American Civil Liberties articles and copies neglected to do the work with law work at the

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ucas opposed ending plied and expressed ining syphilitic pa-assignment of Mrs. kegee demonstrates sisted that the PHS el of observation as remain alive." He nent "be continued

along its present lines with periodic clinical observation and serologic surveillance." Conceding that "outside experts" might "prefer not to be associated with this study because of its sensitive nature," Dr. Lucas saw no reason why the PHS could not continue to publish reports by using its own medical officers.³⁴

In the end it was Peter Buxtun (aided by the press) who stopped the Tuskegee Study. Dr. Brown had delayed answering his second letter until after the ad hoc committee had met. He then informed Buxtun that a committee of highly competent professionals drawn from outside the government had reviewed all aspects of the experiment and had decided against treating the men, a decision Dr. Brown insisted was "a matter of medical judgment since the benefits of such therapy must be offset against the risks to the individual." In response, Buxtun made no attempt to challenge the committee's medical authority, freely conceding that "most of the physical damage and early death has been suffered, and advanced age prevents treatment of the survivors." Instead, he reviewed the facts of the experiment, tracing step by step how the men had reached the state that they could no longer be helped and could "no longer exercise the choice of ending their days free from syphilis." Urging Dr. Brown to see that there were legal and moral issues at stake as well as medical ones, he concluded by asking: "What is the ethical thing to do? Compensate the survivors? Compensate the families of all the subjects? Or should NCDC await the quiet demise of the survivors and hope that will end the matter?"³⁵

Buxtun was not surprised when his questions went unanswered. He had written to vent his anger and frustration, not really expecting a reply. Yet, concern over the experiment haunted him all through law school. In addition to discussing the study with friends, he told his story to several law professors. They were sympathetic but offered little encouragement that anything could be done, stating that the statute of limitations had expired in the vast majority of cases of men who had died. One professor did suggest sending a long letter to the American Civil Liberties Union, complete with reprints of the articles and copies of the correspondence. "I regret to say that I neglected to do that because I was up to my rear in alligators with law work at that time," Buxtun recalled.³⁶

Early in July 1972 Buxtun finally told his tale to someone who was willing to do more than listen politely—Edith Lederer, a longtime friend who worked as an international affairs reporter with the Associated Press in San Francisco. He had mentioned the experiment once before, but she had not seemed to grasp what he was saying. This time, however, she hung on every word, devouring the letters and articles that Buxtun produced as proof.

Lederer showed copies of the materials to her superiors at the Associated Press and asked to be assigned to the story. To her disappointment, she was told that the Tuskegee Study would have to be turned over to an investigative reporter in the East, someone who would be closer to the sources and had experience with government agencies. She immediately thought of her friend, Jean Heller, a highly regarded young reporter who worked for the research bureau of the Associated Press in Washington, D.C. She sent the materials on the Tuskegee Study to Heller and, in effect, dropped the story in her lap, tied with a pretty bow.

Heller could not begin her investigation immediately because she had to cover the Democratic National Convention in Miami. Once George McGovern was nominated, however, she returned to Washington and went to work filling in the gaps that existed in Buxtun's materials. A little digging uncovered additional medical articles on the experiment, but her best source of information proved to be officials at the CDC. While she did not go to Atlanta, Heller received straightforward, matter-of-fact answers to her questions—however sensitive or ostensibly damaging to the PHS. Spokesmen there even provided estimates of the number of men who had died from the various complications of late syphilis. In short, the health officials acted like men who had nothing to hide.²⁷

True to their goal of pursuing the subjects until the last one had died, PHS officers were still conducting the experiment when Heller broke the story on July 25, 1972, in the *Washington Star*. Ironically, another ghost out of a public servant's medical past appeared simultaneously. The Tuskegee Study had to compete for headlines with the sensational disclosure that Senator Thomas Eagleton of Missouri, Senator McGovern's running mate, had a medical history of bouts with

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depression requiring hospitalization and shock therapy. A high-ranking official in the Department of Health, Education, and Welfare confessed privately to Heller that he was relieved when the Tuskegee Study and the Eagleton affair hit the front pages of the nation's newspapers on the same day. "He kept us beneath the fold," the official sighed.³⁸

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Problems to be Considered. Olansky was pleased with Dr. O. C. Wenger," he has a moral obligation for previous investigators, the group who has borne the sky to Cutler, November for Tuskegee Study."

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ment began had a 17 percent shorter life expectancy than controls in the same age group. Including the forty-five to fifty year age group presumably lowered the shortening of life expectancy from 20 percent to 17 percent. See Shafer et al., "Untreated Syphilis," p. 689. The health officials also stated that the men in the syphilitic group, in addition to having their lives shortened, were in poor health more generally than men in the control group, a discovery that led researchers to warn that the untreated syphilitic "runs a considerable risk of having his life span shortened by other fatal conditions. In addition, he can expect to experience more manifestations of ill health of all kinds than do uninfected persons." See Deibert and Bruyere, "Untreated Syphilis," p. 313.

35. Shafer et al., "Untreated Syphilis," p. 689; Jesse J. Peters et al., "Untreated Syphilis in the Male Negro: Pathologic Findings in Syphilitic and Nonsyphilitic Patients," *Journal of Chronic Diseases* 1 (1955): 129; Rockwell et al., "The Tuskegee Study," p. 795.
36. Peters et al., "Untreated Syphilis," p. 129.
37. Author's Interview, Sidney Olansky, November 10, 1976; Author's Interview, William J. Brown, April 6, 1977.
38. Olansky Interview.
39. Rivers to Brown, April 11, 1960, TF-CDC.
40. Memorandum from Joseph G. Caldwell to Brown entitled "Fifth (final) Report, Tuskegee Study, 1970," June 11, 1970, TF-CDC. The rights of subjects are more likely to be violated when they come from a different background than the investigator. See Hans Jonas, "Philosophical Reflections on Experimentation," *Daedalus* 98 (1969): 234-37.

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1. Mark Frankel, "The Politics of Human Experimentation," unpublished manuscript, pp. 150-54.
2. Ibid., pp. 155-59. For an influential article that contributed to the pressure for reform by showing that unethical experiments were widespread in American science, see Henry K. Beecher, "Ethics and Clinical Research," *New England Journal of Medicine* 274 (1966): 1354-60.
3. Frankel, "Politics," pp. 154-59, 355.
4. Irwin J. Schatz to Donald H. Rockwell, June 11, 1965, Tuskegee File, Center for Disease Control, Atlanta, Georgia [hereafter TF-CDC]. Yobs's note is attached to Schatz's letter.
5. Author's Interview, Peter Buxton, May 23, 1979.

6. So that there would be no doubts about his views, Buxtun enclosed a copy of the paper he had written in which he compared the Tuskegee Study indirectly to the Nazi experiments. Buxtun to Brown, November 6, 1966, TF-CDC.
7. Buxtun Interview; Dr. Brown's draft was dated December 7, 1966. In this response, Dr. Brown insisted that all the men were volunteers and were "completely free to leave the study at any time." He also stated that the men had received all types of accepted therapy over the years and declared: "The participants have been entirely free to seek treatment at any time." Furthermore, he maintained that the men in the study had gotten a great deal of medical care that they would not have received otherwise. Brown to Buxtun, draft, December 7, 1966, TF-CDC.
8. Buxtun Interview.
9. Ibid.
10. Ibid.
11. Buxtun to Brown, November 24, 1968, TF-CDC.
12. Ad Hoc Committee Minutes, undated, TF-CDC.
13. Ibid. Dr. Kiser told the group about a study of executives on the East Coast to learn the incidence of heart disease mortality. Though they received the best medical attention, he stated, most died of the disease. Dr. Kiser expressed amazement at the survival rate in the Tuskegee Study.
14. Ibid.
15. Ibid.
16. Ibid.
17. Ibid.
18. Ibid.
19. Ibid.
20. Author's Interview, David Sencer, November 10, 1976; Author's Interview, Sidney Olansky, November 10, 1976; Author's Interview, William J. Brown, April 6, 1977.
21. Ad Hoc Committee Minutes.
22. Ibid.
23. Ibid.
24. "Minutes of the State Board of Censors," February 19, 1969, TF-CDC; Myers to Brown, March 13, 1969, TF-CDC.
25. Brown Interview. See also Sencer Interview; Brown to Dr. Alexander Robertson, executive director, the Milbank Fund, November 19, 1969, TF-CDC.
26. Memorandum from Dr. Joseph G. Caldwell to Dr. Arnold L. Schroeter, April 9, 1970, TF-CDC; and Memorandum from Caldwell "Third Tuskegee Report," May 8, 1970, TF-CDC.

27. When Nurse Kenne Berrey kindly arranged a week in September, Kendrick, August 2, 1972, April 27, 1972, 24, 1971, TF-CDC. A train her successor, during the first auto-nized Nurse Kennebr.
28. Memorandum from 1970 survey, Tuskegee Telephone Call, J. Caldwell, TF-CDC; Schroeter to Brown, that success in local. "We are now selecting somehow managed. "We will include the syphilis, and those ever will most likely orandum from Caldwell Study, 1970." May
29. Memorandum from Report, 1970, May had found "five living significant syphilitic committee's discussion who had syphilitic apy, recommending attempt to record t and apex abnormal medicine to do the
30. Memorandum from 1970 survey, Tuske
31. Brown to Harold J. Health, University of Brown to Robertson permit a paper on the American Venereal Atlantic City, New Jersey, and, ironically, gested that "specific beneficial." In star

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27. When Nurse Kennebrew's PHS appointment was delayed, Dr. Berrey kindly arranged to pay her at the federal rate for more than a week in September out of state funds. See Berrey to E. C. Kendrick, August 21, 1971, TF-CDC; Don W. Printz to Kennebrew, April 27, 1972, TF-CDC; and Kennebrew to Schroeter, April 24, 1971, TF-CDC. Nurse Rivers came out of retirement to help train her successor. She showed Nurse Kennebrew what to do during the first autopsy in which she participated and accompanied Nurse Kennebrew on her first roundup.
28. Memorandum from Caldwell to Brown, "Report of second week, 1970 survey, Tuskegee Study," May 4, 1970, TF-CDC; "Report of Telephone Call, June 1, 1970," from Andrew Theodore to Caldwell, TF-CDC; and Memorandum, "Tuskegee Study," from Schroeter to Brown, August 5, 1970, TF-CDC. Dr. Caldwell feared that success in locating missing subjects might skew the study. "We are now selecting those patients who were fortunate and somehow managed to live in harmony with syphilis," he wrote. "We will include these as being relatively healthy despite their syphilis, and those 61 [on] whom we have no information whatever will most likely never be allowed to tell their stories." Memorandum from Caldwell to Brown, "Fourth Report, Tuskegee Study, 1970," May 18, 1970, TF-CDC.
29. Memorandum from Caldwell to Brown et al., "Third Tuskegee Report, 1970, May 8, 1970, TF-CDC. Caldwell reported that he had found "five living patients in Macon County who still have significant syphilitic cardiovascular disease." Despite the ad hoc committee's discussion just the previous year of treating subjects who had syphilitic heart disease, Caldwell said nothing of therapy, recommending study instead: "It behooves us, I think, to attempt to record their murmurs as well as their pulse pressure and apex abnormalities now that we are sophisticated enough in medicine to do these measurements."
30. Memorandum from Caldwell to Brown, "Report of second week, 1970 survey, Tuskegee Study," May 4, 1970, TF-CDC.
31. Brown to Harold J. Magnuson, associate dean, School of Public Health, University of Michigan, February 16, 1970, TF-CDC; and Brown to Robertson, November 16, 1969, TF-CDC. The PHS did permit a paper on the Tuskegee Study to be delivered in 1971 at the American Venereal Disease Association's annual meeting in Atlantic City, New Jersey. The paper focused on aortic regurgitation, and, ironically, the authors reported that their research suggested that "specific antimicrobial therapy of late disease may be beneficial." In stark contradiction to the ad hoc committee of

1969, they also asserted that "withholding penicillin treatment from such patients probably cannot be justified by the argument that repair of already existing destruction would be minimal compared to the risk of Jarisch-Herxheimer reactions of fever, angina, or rupture of aneurysms." While admitting that other authorities might disagree, they recommended treatment! See Joseph G. Caldwell et al., "Aortic Regurgitation in a Study of Aged Males with Previous Syphilis," presented, in part, on June 22, 1971, p. 7. The paper was later published under the title, "Aortic Regurgitation in the Tuskegee Study of Untreated Syphilis," *Journal of Chronic Diseases* 26 (1973): 187-94. While the first version of the paper omitted any reference to the Tuskegee Study in its title, the published version (which appeared one year after the experiment was made public and abandoned) contained a specific citation. Obviously, the need for caution had passed, but ethicists will no doubt wish to debate the propriety of the decision by the editor of the *Journal* to print the paper, thus rewarding the authors with a publication for their work on the experiment.

32. Memorandum from Lucas to Brown, "An analysis of the current status of the Tuskegee Study," September 10, 1970, TF-CDC.
33. Ibid.
34. Ibid.
35. Brown to Buxtun, February 27, 1969, TF-CDC; and Buxtun to Brown, March 29, 1969, TF-CDC.
36. Buxtun Interview.
37. Author's Interview, Jean Heller, June 5, 1979.
38. Ibid.

Chapter 13. "I Ain't Never Understood the Study"

1. *Atlanta Constitution*, July 27, 1972, p. 30A.
2. Ibid.
3. Ibid., July 26, 1972, p. 1A.
4. *Atlanta Daily World*, August 3, 1972, p. 1.
5. Ibid., and *Birmingham News*, July 27, 1972, p. 4.
6. *Birmingham News*, July 27, 1972, p. 4.
7. Ibid.
8. *Montgomery Advertiser*, July 30, 1972, p. 1.
9. Ibid.
10. Ibid. Settler's statement was made a few days after Foster's announcement; however, both statements were released in the same news story.

11. "New Release Tuskegee File [hereafter TF-ald H. Brown Dr. Jean L. H. Association Fc of Venereal Di Professor Jay l ner, Princeton from Harrisbu the Alabama Sinkford (D.D of Dentistry, l
12. *Medical Work* eral discussio gust 18, 1972.
13. "News Relea DHEW, TF-CI
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15. Seward Hiltz Country. Nove of the Tuskege 25, 1972, p. 2
16. "HEW News. The actual dis assistant sec try of giving by the genera memorandum ge Study); A of the Study. TF-CDC.

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35. Brown to Buxton, February 27, 1969, TF-CDC; and Buxton to Brown, March 29, 1969, TF-CDC.
36. Buxton Interview.
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38. Ibid.

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9. Ibid.
10. Ibid. Settler's statement was made a few days after Foster's announcement; however, both statements were released in the same news story.

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11. "New Release Tuskegee File [hereafter TF-CDC] H. Brown, Dr. Jean L. Ha Association For Venereal Dis Professor Jay K. ner, Princeton T from Harrisburg the Alabama La Sinkford (D.D.S of Dentistry, Ho
12. *Medical World N* eral discussion o gust 18, 1972, pp
13. "News Release," DHEW, TF-CDC.
14. One panelist obj uons. See J. Kat Charge 1," in "Flx Hoc Advisory Par Welfare (Washingt 14-15. For a discu panel, see Allan M. the Tuskegee Stud 27. For a polemic l little but racism in "Racism and Huz (February 1974): 46
15. Seward Hiltner, "T Country, November of the Tuskegee Sypl 25, 1972, p. 2, TF-C
16. "HEW News," Offic The actual directive assistant secretary & ility of giving treatme by the general couns memorandum "USPI gee Study); Authorit of the Study," from TF-CDC.

ing penicillin treatment justified by the argument that the reaction would be minimal. Other reactions of fever, chills, and other symptoms were admitted. See "The Tuskegee Study of Untreated Syphilis in the Negro Male" (1973): 187-94. While the reference to the Tuskegee study (which appeared one public and abandoned) is, the need for caution is clear. The *Journal* to print the study in a publication for their

an analysis of the current study, October 10, 1970, TF-CDC.

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11. "New Release," August 24, 1972, Office of the Secretary, DHEW, Tuskegee File, Center for Disease Control, Atlanta, Georgia [hereafter TF-CDC]. The other members of the panel were Ronald H. Brown, general counsel of the National Urban League; Dr. Jean L. Harris, executive director of the National Medical Association Foundation, Inc.; Dr. Vernal Cave, director, Bureau of Venereal Disease Control, New York City Health Department; Professor Jay Katz, Yale Law School; the Reverend Seward Hiltner, Princeton Theological Seminary; Fred Speaker, an attorney from Harrisburg, Pennsylvania; Barney H. Weeks, president of the Alabama Labor Council of the AFL-CIO; and Dr. Jeanne C. Sinkford (D.D.S.), associate dean for Graduate Affairs, College of Dentistry, Howard University.
12. *Medical World News*, September 14, 1973, p. 58; for a good general discussion of the experiment, see *Medical World News*, August 18, 1972, pp. 15-17.
13. "News Release," August 24, 1972, Office of the Secretary, DHEW, TF-CDC.
14. One panelist objected publicly to the constraints of the questions. See J. Katz, "Reservations about the Panel Report on Charge 1," in "Final Report of the Tuskegee Syphilis Study Ad Hoc Advisory Panel," Department of Health, Education, and Welfare (Washington, D.C., 1973) [hereafter "Final Report"], pp. 14-15. For a discussion of the limited charges given the ad hoc panel, see Allan M. Brandt, "Racism and Research: The Case of the Tuskegee Study," *Hastings Report* 8 (December 1978): 26-27. For a polemic from a historian who seems intent on seeing little but racism in the Tuskegee Study, see Herbert Aptheker, "Racism and Human Experimentation," *Political Affairs* 53 (February 1974): 46-59.
15. Seward Hiltner, "The Tuskegee Study Under Review," *Christian Century*, November 28, 1973, p. 1175; "Initial Recommendations of the Tuskegee Syphilis Study Ad Hoc Advisory Panel," October 25, 1972, p. 2, TF-CDC.
16. "HEW News," Office of the Secretary, March 5, 1973, TF-CDC. The actual directive came on March 3. See Weinberger to acting assistant secretary for health, March 8, 1973, TF-CDC. The legality of giving treatment as part of the experiment was certified by the general counsel of DHEW, Wilmut R. Hastings. See the memorandum "USPHS Study of Untreated Syphilis (the Tuskegee Study); Authority to Treat Participants Upon Termination of the Study," from Hastings to the secretary, March 5, 1973, TF-CDC.

17. "Final Report," pp. 7, 23-24. Disagreements within the ad hoc panel had developed early in their deliberations. Dr. Butler, whom several members on the panel suspected of being too sympathetic to the government's defense of the study, angered his colleagues by refusing to open their meetings to the press. Their differences erupted into open warfare when Dr. Butler without warning or advance discussions refused to endorse the panel's final report. In response to this refusal, several panelists held a press conference to defend the report and denounce the chairman. See Hiltner, "Tuskegee Study," p. 1176; and "Report on HEW's Tuskegee Report," *Medical World News*, September 14, 1973, pp. 57-58. For a ringing denunciation of the final report from a medical defender of the experiment, see R. H. Kampmeier, "Final Report on the 'Tuskegee Syphilis Study,'" *Southern Medical Journal* 67 (1974): 1344-53.
18. For an interesting editorial in support of the payment bill, see *Afro-American*, August 19, 1972, p. 4.
19. *Quality of Health Care: Human Experimentation*, 1973, Hearings Before the Subcommittee on Health of the Committee on Labor and Public Welfare, Ninety-third Congress (Washington, D.C., 1973), III:1041.
20. *Ibid.*, p. 1035.
21. *Ibid.*, p. 1042.
22. Mark Frankel, "The Politics of Human Experimentation," unpublished manuscript, pp. 150-59, 355. The national debate over human experimentation led to a special commission to formulate new guidelines. The commission's proceedings may be followed in *National Commission for the Protection of Human Subjects of Biomedical and Behavior Research* (Washington, D.C., 1976).
23. The "Guidelines for Medical Care" were mailed to physicians chosen by the subjects, along with a cover letter. See Donald R. Hopkins to "Dear Doctor," April 13, 1973, TF-CDC. The instructions explicitly recommended treatment for syphilis with penicillin unless the physician "feels there is reasonable suspicion of penicillin allergy or documented proof of prior adequate . . . antibiotic treatment."
24. The CDC began debating whether to treat the wives and children in 1973. A memo written in that year said: "The possibilities are that wives may have contracted the disease directly and that children may suffer from congenital conditions." See Charles M. Gozonsky to William C. Watson, "CDC-Tuskegee Study—

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26. Charles W. Poll Action No. 412 bama, District
27. Charles W. Poll Action No. 412 bama, District tlement," pp. 1
28. For a critical "The \$10-Mill p. 23.
29. *Ibid.*, p. 24.
30. *Ibid.*
31. *Ibid.*
32. Author's Inter
33. Author's Inter view, Carte

Chapter 14. "AIDS"

1. *New York Times*
2. *Ibid.*
3. *New York Times*
4. *Atlanta Constitution* et al. v. United Northern Div. of the United
5. Alan Brandt,
6. *Ibid.*
7. Alan Brandt,
8. Elizabeth Fee

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"I Ain't Never Understood the Study"

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Indeed, officials presented no evidence that the pros and cons of treatment were ever discussed by the experiment's organizers. Similarly, current expressions of shock and indignation had the effect of putting distance between present officials and the generation of health officers who had initiated the study, yet said nothing about the responsibility modern officials had to bear for continuing the experiment. Finally, the promised review put the government in the position of investigating itself. As an instrument for preempting public action, a government investigation might have had some value, but could health officials truly be trusted to pass judgment on themselves?

Following the lead of federal officials, the Tuskegee Institute issued a press release stating that it was "deeply concerned" about the experiment. The Institute acknowledged that its medical facilities and personnel had been used in the study, but emphasized that cooperation had been limited to the 1930s when the surgeon general of the United States had personally requested the Institute's participation in the experiment as part of a larger treatment program. Referring to the subjects as "voluntary participants" in an experiment that was designed "to develop new and more effective treatment programs," the Institute maintained that the study "was acceptable under the clinical conditions prevailing 40 years ago, when the drugs available for treatment . . . were dangerous and their long-term effectiveness had not been established."⁴

The Institute claimed it had lost contact with the experiment by the time penicillin became available in the 1940s. Both the treatment program and the study of untreated syphilis had been removed from Andrew Hospital and "were fully based in the Macon County Health Department" by 1946. From that date to the present, the Institute declared, "there has been no active medical program at Tuskegee Institute's John A. Andrew Hospital connected with this USPHS study." While technically true, that statement ignored the fact that the Institute had given its tacit approval to the experiment by permitting its facilities and medical personnel to be used repeatedly over the years. Indeed, a few days before the Institute released a formal statement, the administrator of Andrew Hospital, Luis Rabb, told reporters that the subjects had been X-rayed at the hospital two years earlier, but denied that this constituted direct involvement because the hospital's X-ray facilities were available to anyone.⁵

The Veterans' Administration Hospital in Tuskegee, whose pathologist, Dr. Peters, had performed some of the autopsies until his retirement in 1963, also tried to distance itself from the study. Dr. Robert S. Wilson, the hospital's director, denied that his institution had been directly involved, though he could not rule out the possibility of indirect participation at some past date since some the subjects may have been veterans. "The Veterans' Administration would not condone or approve of such as this," Dr. Wilson told reporters.⁶

The other collaborating agencies staked out similar posi-

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tions. Dr. Ira L. Myers, the state health officer of Alabama, told reporters that his department had simply helped the PHS observe and evaluate the subjects. He repeated the familiar argument that the study had been started when "there was not much in the way of treatment for syphilis." The subjects had participated "on a volunteer basis," he explained, and he insisted that the men had been "followed pretty carefully to be sure that no one had been denied care." In his view the flap was totally unjustified. "Somebody is trying to make a mountain out of a molehill," Dr. Myers declared.⁷

Yet Dr. Myers neglected to mention that the state board of health had refused to commit itself three years earlier when the PHS had sought advice about whether to stop or continue the experiment. Dr. Myers was not available for comment when the *Montgomery Advertiser* announced that it had uncovered records of the February 1969 meeting in which the board had voted unanimously to refer the Tuskegee Study without comment to the Macon County Health Department.⁸

The Macon County Medical Society responded to the experiment's disclosure with expressions of concern and pledges of help. Dr. H. W. Foster, the society's president, told reporters that he was under the impression that the PHS would stop the experiment immediately. For its part, the society had voted unanimously "to identify the remaining living members of this study and make available forthwith appropriate therapy."⁹

A few days after that statement was released, however, the *Montgomery Advertiser*, pursuing its story on the state board of health, contacted spokesmen for the society and asked whether it had in fact approved the experiment back in 1969. Dr. S. H. Settler, the society's secretary, acknowledged that they had met with representatives of the PHS in 1969 and admitted agreeing to the study's continuation. He denied, however, that they had been informed about the withholding of treatment, a claim the PHS spokesmen who had talked with the group promptly challenged. Dr. Alfonso H. Holguin and Dr. William J. Brown told the *Advertiser* that the local doctors had been apprised of the nature of the experiment and had agreed that the men should not be treated.¹⁰

While its partners retreated into official silence following their initial statements, the federal government moved forward with an investigation. Bowing to public opposition

against its promised internal review, the government reversed itself and appointed a nine-member citizens panel, five of whom were black, to investigate the experiment. Dr. Duval announced on August 24, 1972, that the Tuskegee Syphilis Study Ad Hoc Panel would be headed by the distinguished black educator, Broadus Nathaniel Butler, president of Dillard University in New Orleans.¹¹

The racial composition of the ad hoc advisory panel was designed to allay fears of a whitewash. "I wanted a panel that would be sympathetic to the public point of view rather than the scientific or factual point of view, so I loaded it with angry blacks," Dr. Duval insisted a year after forming the panel. "My purpose was an exercise in self-flagellation if you will," he added. "I knew we were going to pay a penalty for Tuskegee, and I figured we should take the whole penalty—that way there could be no criticism."¹²

Despite his eagerness to "take the whole penalty," Dr. Duval severely restricted the scope of the inquiry. Had he desired a comprehensive investigation, he would have permitted the panel to frame its own questions. Instead, he directed the panel to:

1. Determine whether the study was justified and whether it should have been continued when penicillin became generally available.
2. Recommend whether the study should be continued at this point in time, and if not, how it should be terminated in a way consistent with the rights and health needs of its remaining participants.
3. Determine whether existing policies to protect the rights of patients participating in health research conducted or supported by the Department of Health, Education, and Welfare are adequate and effective and to recommend improvements in these policies if needed.¹³

Dr. Duval clearly wanted the panel to concentrate on the issue of informed consent and the decision to withhold penicillin from the men. He made no mention of the initial decision to withhold salvarsan and bismuth, and he did not confront the issue of racism by charging the panel to explain why the experiment was limited to blacks. Dr. Duval was sensitive to the need to proceed expeditiously, however. He ordered the panel

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to conclude its investigation and issue a final report by Decem-
ber 31, 1972, unless he personally approved an extension. (Act-
ing upon a subsequent request from the panel, he did in fact
grant an extension through the end of March.)¹⁴

Working in separate teams to attack each of its three
charges, the ad hoc panel held a dozen meetings, collected
scores of affidavits, interviewed numerous witnesses, visited
Tuskegee, and reviewed a pile of documents that one panelist
put at "just short of three feet high." A decision on the second
charge came quickly. Late in October, the panel notified Dr.
Duval that the experiment "should be terminated immedi-
ately," with the men receiving "the care now required to treat
any disabilities resulting from their participation."¹⁵

While Dr. Duval promised to implement these recommen-
dations "as rapidly as possible," months of delay ensued as fed-
eral health officials and lawyers debated whether the govern-
ment had the authority to provide comprehensive health care
for the men. The ad hoc panel, on the verge of releasing its final
report, finally broke the impasse by appealing directly to Cas-
par Weinberger, the secretary of HEW. Secretary Weinberger
announced on March 3, 1973, that he had instructed the PHS to
provide all necessary medical care for the survivors of the
study. Ironically, the only legal way he could authorize treat-
ment was to reopen the experiment so that the men could re-
ceive health care as part of the official study.¹⁶

The ad hoc panel's first report, issued in late April 1973,
was highly critical of the entire study. While acknowledging
that "scientific justification for a short-term demonstration
study in 1932 cannot be ruled out," the panel judged that the
experiment was "ethically unjustified in 1932." That decision
rested on the government's failure to obtain the informed con-
sent of the participants in a study of a disease with a known
risk to human life. The panel stated unequivocally that "peni-
cillin therapy should have been made available to the partici-
pants . . . as of 1953 when penicillin became generally availa-
ble" and strongly implied that treatment with arsenicals and
mercury should have been administered earlier. Finally, to the
surprise of no one, the panel argued that existing protections
for the human subjects of experiments were not effective. The
panel offered procedural and substantive recommendations for
safeguarding subjects, the most important of which was the

creation by Congress of a permanent body to regulate all federally sponsored research on human subjects.¹⁷

Though useful as a public forum, the ad hoc panel had no legal standing. An advisory body with a limited investigative mandate, it did not address itself to any of the legal questions arising from the experiment. Scores of men had died from a disease that could have been cured. Some had gone blind, others insane. Had any laws been broken? Were physicians and scientists who had conducted the study in any way liable for their actions? For their omissions? Were the subjects entitled to compensation?

Shortly after word of the experiment broke, Governor George Wallace's office announced it would seek to determine whether any of Alabama's state laws requiring treatment for communicable diseases had been broken. No legal action followed this announcement, though the experiment clearly violated state health laws passed in 1927, 1943, 1957, and 1969. Without attempting to assign legal responsibility to any individuals, Alabama's senators, James B. Allen and John D. Sparkman, coauthored a bill to authorize federal payments up to \$25,000 for each participant in the Tuskegee Study. In their view, the federal government had an ethical responsibility to compensate the survivors and their families.¹⁸

There were strong indications that the men would sue if the government did not volunteer compensation. Shortly after the story broke, Charles Pollard, one of the survivors, approached Fred Gray for legal advice concerning the experiment. Pollard turned to him only in part because Gray had done some routine legal work for him in the past. Along with everyone else in Macon County, he knew that Gray was Tuskegee's most prominent black lawyer and one of Alabama's leading civil rights activists.

Gray had first won national recognition in 1955 by defending Rosa Parks for refusing to relinquish her bus seat to a white man in Montgomery. An ordained minister of the Church of Christ, as well as a lawyer, he represented Martin Luther King in the Montgomery bus boycott case that followed. Over the next quarter of a century, he helped build one of the most successful black law firms in Alabama and argued several important cases before the United States Supreme Court. Personally unassuming and soft-spoken, Gray managed to combine civil

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rights activities and a profitable legal practice. In 1970, he was elected to the Alabama State House of Representatives, the first black Democrat to join white legislators in Montgomery since Reconstruction.

Gray delayed bringing suit for nearly a year, hoping the government would volunteer compensation and medical care. During the interlude, Senator Edward M. Kennedy offered the Alabama lawyer a public forum from which to present his case. Long recognized as one of the Senate's leading authorities on health care, Kennedy had expressed his outrage over the experiment when the story first broke. In February and March of 1973, he held a series of hearings on human experimentation before the subcommittee on health of the committee of labor and public welfare. Testimonies were received from top-ranking government bureaucrats, leading scientists, high-powered academics, and concerned citizens on topics ranging from psychosurgery to involuntary sterilization. More than any other case, however, the Tuskegee Study dominated the hearings.

All sides got to tell their stories. Peter Buxtun recounted his efforts to persuade the PHS to stop the experiment voluntarily; Dr. David Sencer, the director of the Center for Disease Control, served as spokesman for the PHS; and Dr. Jay Katz, a professor in the Yale University School of Law and a member of the Tuskegee Syphilis Ad Hoc Advisory Panel, argued persuasively against the ability of the current system of institution-based peer review panels to provide adequate protection for human subjects in experiments.

The most poignant testimonies, however, came from two survivors of the Tuskegee Study, Charles Pollard and Lester Scott. It was the first chance any of the subjects had been given to tell their stories to any agency or branch of government, and the two men did so with dignity and candor.

Pollard and Scott unfolded a forty-year saga of lies and deceit, of unlettered men who had trusted and been betrayed by educated men. Each, in turn, related how he had answered the PHS's call for blood tests; how he had been told his blood was bad; and how he had cooperated for forty years with doctors who said they were treating him. Both emphasized they wanted nothing more to do with the PHS or any of its doctors. When asked by Senator Kennedy what the government should do for them now, Scott replied: "They ought to give us compen-

sation or something like that, where we can see other doctors and continue our health."¹⁹

Gray was adamant on this point. The men did not want to be placed back in the hands of an agency that had repeatedly "refused to treat them," he declared in his testimony before the committee. "They have no faith, trust, nor confidence that the Public Health Service will properly examine them and give them proper treatment." PHS physicians could not be trusted to make unbiased medical decisions, Gray charged, because their primary concern "would be to cover up their unlawful conduct during the past forty years." The only solution was for the government to give the men adequate compensation, enough to permit them to "select their own physicians, hospitals, and medical technicians who will give them medical attention."²⁰

Senator Kennedy was clearly angered by what he heard. He called the Tuskegee Study "an outrageous and intolerable situation which this Government never should have been involved in." The tragedy was compounded by the government's failure to provide health care to the men immediately after the study was disclosed, an injustice that had been left standing for eight months despite the ad hoc panel's recommendation that health care be made available and despite Dr. Duval's assurances that it would be. Kennedy noted with approval Secretary Weinberger's announcement (issued just a few days before witnesses on the Tuskegee Study began testifying) pledging comprehensive health care for the men without further delay, but warned that his subcommittee would be watching to see if the promises were kept. "We are going to stay after it," he told the survivors and their attorney.²¹

The Kennedy hearings presaged a national review of federal guidelines on human experimentation, a review in which opponents of existing regulations used the Tuskegee Study as a rallying cry for reform. The result was a complete revamping of HEW regulations on human experimentation. The new guidelines established specific criteria for research projects involving human subjects and mandated a larger role for humanists on institutional review panels. More than any other experiment in American history, the Tuskegee Study convinced legislators and bureaucrats alike that tough new regulations had to be adopted if human subjects were to be protected.²²

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ous and intolerable situ-
ould have been involved
he government's failure
mediately after the study
en left standing for eight
mendation that health

al's assurances that
roval Secretary Wein-
w days before witnesses
(g) pledging comprehen-
urther delay, but warned
hing to see if the prom-
iter it," he told the survi-

ational review of federal
a review in which oppo-
Tuskegee Study as a ral-
complete revamping of
entation. The new guide-
research projects involv-
arger role for humanists
than any other experi-
ce Study convinced legis-
h new regulations had to
be protected.²²

For the men in the Tuskegee Study, of course, the new regu-
lations came too late. Uppermost in their minds were treat-
ment and compensation. In the wake of Senator Kennedy's
hearings, the government moved rapidly to provide complete
health care to all the men—both those who had syphilis and
those who did not. Beginning in April 1973, the CDC undertook
the mammoth job of tracking down the survivors to inform
them in person and in writing that the government would pay
all of their medical expenses for the remainder of their lives.
Field representatives urged the men to obtain comprehensive
medical examinations at once by physicians of their choice and
to proceed immediately with appropriate medical care. To
help the attending physicians, the CDC provided a checklist of
tests and procedures recommended by a panel of distinguished
physicians with no previous contact with the experiment.²³

The CDC also restored old services. Henceforth, the govern-
ment (not the Milbank Fund) would pay burial stipends, a key
benefit under the experiment. Significantly, no mention was
made of the autopsies. Instead, they were quietly dropped as a
condition. And, as a final irony, the CDC reappointed Nurse
Kennebrew to look after the survivors who lived in and around
Macon County. Her assignment, as in bygone days, was to visit
the men periodically and make certain they were receiving
proper medical care for all their ailments. Not until two years
after medical services were supplied for the men were provi-
sions made for their families. In 1975 the government extended
treatment to the subjects' wives who had contracted syphilis
and their children with congenital syphilis.²⁴

A few of the men were suspicious and categorically refused
to take advantage of their new health program, but most did so
eagerly. Armed with special identification cards instructing
physicians and druggists to send all bills directly to the CDC
for payment, the men selected their own physicians, had them-
selves examined, and began enjoying the luxury of total health
care. That included vigorous therapy for tertiary syphilis. De-
spite the PHS's long-standing argument that treatment might
prove harmful, no cases of drug reactions or any other complica-
tions were reported among the syphilitic survivors who were
given penicillin.²⁵

The government's failure to offer a cash settlement as part
of its health plan made a lawsuit inevitable. Attorney Gray rec-

ROSTER



Includes Telephone Numbers
In Alphabetical Directory

1969

The Medical Association of the State of Alabama

ROSTER OF THE ASSOCIATION BY COUNTIES

LIMESTONE (Continued)

Karrh, Bruce Wakefield, b 36, mc Ala.
62, sb 63, Route 10, Athens 35611.
GP.

Nethery, Sidney Johnson, b 05, mc U. Col.
34, sb 35, Belle Mina 35615. GP.

Norwood, Eston Gibbons, b 28, mc S. C.
53, recip. S. C. 60, Sanders St., Athens
35611. I.

Pendleton, Henry Harwood, Jr., b 24, mc
Hahneemann 52, recip. NBME 58, W.
Market St., Athens 35611. S.

Pennington, William Scott, b 27, mc Tenn.
49, recip. Tenn. 53, W. Market St.,
Athens 35611. GP.

Springer, Jack Stricklin, b 23, mc Ark.
48, recip. Ark. 58, W. Market St.,
Athens 35611. GP.

Tourney, Robert Lyman, b 18, mc Ill. 44,
recip. Ill. 53, Athens-Limestone Hosp.
Athens 35611. R.

Waddell, John R., Jr., b 29, mc Temple
54, sb 55, Sanders St., Athens 35611.
GP-S.

LOWNDES COUNTY

Members 3; Nonmembers 1

President W. L. Staggers
Vice-President . . . H. H. Meadows, Jr.
Sec.-Treas. R. P. Griffin
Health Officer J. B. Dismukes

Censors - W. L. Staggers, Chairman,
H. H. Meadows, Jr., R. P. Griffin.

NAME OF MEMBERS WITH THEIR COLLEGE
AND POST OFFICES

Griffin, Robert Palmer, b 28, mc Ala.
54, recip. Miss. 60, P. O. Drawer N.,
Ft. Deposit 36032. GP.

Meadows, Henry Howard, Jr., b 12, mc
Wash. 36, recip. Mo. 38, P. O. Box
236, Hayneville 36040. I.

Staggers, William Llewellyn, b 90, mc
Ala. 16, sb 20, Benton 36785. ALR-GP.

Physicians not Members

Coleman, Henry Neal, b 78, ng, sb 01, Ft.
Deposit 36032.

MACON COUNTY

Members 10; Nonmembers 4

President L. C. McRae, Jr.
Vice-President H. W. Foster
Sec.-Treas. S. H. Settler, Jr.
Health Officer Ruth R. Barrey

Censors - C. R. Dowe, Chairman, G. C.
Hester, Jr., L. C. McRae, Jr., J. F.
Hume, S. H. Settler, Jr.

NAME OF MEMBERS WITH THEIR COLLEGE
AND POST OFFICES

Campbell, Thomas Monroe, Jr., b 12, mc
Meharry 41, recip. Tenn. 46, 404 Bibb
St., Tuskegee Inst. 36088. Pd.

Dowe, Calvin Ray, b 25, mc Meharry 58,
sb 56, 108 Reed Ave., Tuskegee Inst.
36088.

Foster, Henry Wendell, b 33, mc Ark. 58,
recip. Ark. 65, John A. Andrew Hosp.,
Tuskegee Inst. 36088. ObG.

Giles, Julian Wheatley, b 21, mc Howard
46, recip. Mo. 51, Drawer G, VA Hosp.,
Tuskegee 35083. ALR.

Hester, George Carl, Jr., b 28, mc Ala.
59, sb 59, 209 E. Northside St., Tuske-
gee 36088. GP.

Hume, John Franklin, b 18, mc Howard
40, recip. Ohio 49, 314 Bibb St., Tuske-
gee Inst. 35088. Or.

Kemney, Howard Washington, b 17, mc
Meharry 44, recip. Tenn. 53, John
Andrew Hosp., Tuskegee Inst. 36088.
I.

McRae, Luther Curtis, Jr., b 30, mc Fla.
60, recip. Ga. 65, 104 S. Maple St.,
Tuskegee 35083. GP.

Settler, Sheridan Howard, Jr., b 23, mc
Meharry 59, recip. Ga. 63, John An-
drew Hosp., Tuskegee Inst. 36088.
Oph.

Williams, Joshua Warner, b 99, mc
Howard 32, recip. Ga. 36, P. O. Box
145, Tuskegee Inst. 36088.

Physicians not Members

Blassingille, Benjamin, b 11, mc Meharry
50, recip. Tenn. 53, Tuskegee 36088.

Lattimore, Reuben Mallory, b 29, mc
Howard 62, recip. Va. 67, Tuskegee
VA Hospital, Tuskegee 35083.

Taylor, Elmer Augustine, b 12, mc How-
ard 46, recip. Mo. 50, Tuskegee 36088.

ROSTER OF THE ASSOCIATION BY COUNTIES

MACON (Continued)

Thompson, Daniel Joseph, b 19, mc Meharry 46, recip. Tenn. 52, Tuskegee 36083.

MADISON COUNTY

Members 134; Nonmembers 4

President C. L. Butler
Vice-President R. L. Lester, Jr.
President-Elect H. M. Pewitt, Jr.
Sec.-Treas. O. F. Gay
Health Officer O. F. Gay

Censors - B. B. Jordan, Chairman, A. L. Watson, E. E. Camp, I. D. Thompson.

MEMBERS OF MEMBERS WITH THEIR COLLEGE
AND POST OFFICES

Akin, Tony Joe, b 37, mc Tenn. 60, recip. Tenn. 66, 401 Lowell Dr., S.E., Huntsville 35801. S.

Alison, William Evans, b 33, mc Tulane 58, sb 59, 806 Gallatin St., Huntsville 35801. ObG.

Anderson, Henry Luther, b 11, mc Tulane 39, sb 39, 410 Lowell Dr., Huntsville 35801. GP-Ob.

Anderson, Henry Luther, Jr., b 25, mc Tulane 60, recip. La. 62, Huntsville Clinic, Huntsville 35801. L

Arrington, Thomas Howell, b 30, mc Harvard 56, recip. Miss. 58, 2357 Whitesburg Dr., Huntsville 35801. L

Baker, Grady Levoy, b 24, mc Louisville 49, recip. Ky. 52, 930 Franklin St., Huntsville 35801. GP-S.

Bell, William Hugh, III, b 34, mc Tenn. 60, recip. Tenn. 68, 401 Lowell Dr., Huntsville 35801. NS.

Belle, James Major, Jr., b 30, mc Meharry 61, recip. Cal. 62, 217 Church St., Huntsville 35801. GP.

Berg, Ernestine Halliard, b 22, mc Louisville 53, recip. Ky. 56, 714 Owens Dr., Huntsville 35801. Anes.

Bibb, Robert Chambers, b 16, mc Tulane 40, recip. La. 46, Med. Arts Bldg., Huntsville 35801. GP.

Binger, Richard William, b 33, mc Tenn. 59, recip. Tenn. 54, 205 St. Clair, Huntsville 35801. ALR.

80

Boon, Robert Horace, b 21, mc Ark. 51, recip. Ark. 56, 410 Lowell Dr. S. E., Huntsville 35801. Pul.

Bordenca, Anna, b 39, mc Ala. 63, sb 63, 2358 Whitesburg Dr., Huntsville 35801. Pd.

Bramm, Horace George, Jr., b 28, mc Tenn. 51, recip. Tenn. 57, 401 Lowell Dr., Suite 13, Huntsville 35801. ObG.

Browning, Russell Leslie, b 35, mc Tenn. 60, recip. Tenn. 65, Brock Bridge Manor, Apt. 525, Fort Meade Road, Laurel, Md. 20810. Anes.

Broyles, John Alfred, III, b 34, mc Tenn. 60, recip. Tenn. 64, 5807 H. Paquette St., Ft. Knox, Ky. 40121. D.

Bryan, Albert Coleman, Jr., b 23, mc Tenn. 51, recip. Miss. 64, 401 Lowell Dr. #2, Huntsville 35801. Ob-G.

Bryson, Roscoe Eugene, b 18, mc Tenn. 51, recip. Miss. 58, 905 Madison St., Huntsville 35801. R.

Butler, Charles Leavitt, b 20, mc Md. 45, recip. Md. 57, Huntsville Hosp., Huntsville 35801. Path.

Cameron, William Brooks, b 26, mc Tenn. 52, recip. Tenn. 59, 930 Franklin St., Huntsville 35801. ObG.

Camp, Ephriam Elias, b 09, mc Tenn. 36, recip. Tenn. 49, 905 Madison St., Huntsville 35801. R.

Campbell, James Edward, b 35, mc Tenn. 59, recip. Tenn. 63, 905 Madison St., Huntsville 35801. R.

Carlisle, Bob Byron, b 32, mc Vanderbilt 57, recip. Tenn. 66, Med. Arts Bldg., Huntsville 35801. ThS.

Carpenter, James Lauer, b 09, mc Vanderbilt 35, sb 35, New Hope 26708. GP-I.

Clanton, Jerry Ned, b 33, mc Vanderbilt 58, recip. Tenn. 65, Huntsville Hosp., Huntsville 35801. Path.

Corley, William Sim, b 35, mc Ga. 60, recip. Ga. 65, 1330 Toney Dr., Huntsville 35802. GP-Ind.

Cosby, Joseph Conway, b 28, mc Ala. 61, sb 62, 930 Franklin St., S.E., Suite 108, Huntsville 35801. GP.

Cotter, Clement Patrick, b 28, mc Texas U. 55, recip. Texas 65, 711 Franklin St., Huntsville 35801. S.

PRISON. One (A) - ~~James~~ robbery and burglary.
in ~~1934~~ ~~1935~~ ~~1936~~ ~~1937~~ ~~1938~~ ~~1939~~ ~~1940~~ ~~1941~~ ~~1942~~ ~~1943~~ ~~1944~~ ~~1945~~ ~~1946~~ ~~1947~~ ~~1948~~ ~~1949~~ ~~1950~~ ~~1951~~ ~~1952~~ ~~1953~~ ~~1954~~ ~~1955~~ ~~1956~~ ~~1957~~ ~~1958~~ ~~1959~~ ~~1960~~ ~~1961~~ ~~1962~~ ~~1963~~ ~~1964~~ ~~1965~~ ~~1966~~ ~~1967~~ ~~1968~~ ~~1969~~ ~~1970~~ ~~1971~~ ~~1972~~ ~~1973~~ ~~1974~~ ~~1975~~ ~~1976~~ ~~1977~~ ~~1978~~ ~~1979~~ ~~1980~~ ~~1981~~ ~~1982~~ ~~1983~~ ~~1984~~ ~~1985~~ ~~1986~~ ~~1987~~ ~~1988~~ ~~1989~~ ~~1990~~ ~~1991~~ ~~1992~~ ~~1993~~ ~~1994~~ ~~1995~~ ~~1996~~ ~~1997~~ ~~1998~~ ~~1999~~ ~~2000~~ ~~2001~~ ~~2002~~ ~~2003~~ ~~2004~~ ~~2005~~ ~~2006~~ ~~2007~~ ~~2008~~ ~~2009~~ ~~2010~~ ~~2011~~ ~~2012~~ ~~2013~~ ~~2014~~ ~~2015~~ ~~2016~~ ~~2017~~ ~~2018~~ ~~2019~~ ~~2020~~ ~~2021~~ ~~2022~~ ~~2023~~ ~~2024~~ ~~2025~~ ~~2026~~ ~~2027~~ ~~2028~~ ~~2029~~ ~~2030~~ ~~2031~~ ~~2032~~ ~~2033~~ ~~2034~~ ~~2035~~ ~~2036~~ ~~2037~~ ~~2038~~ ~~2039~~ ~~2040~~ ~~2041~~ ~~2042~~ ~~2043~~ ~~2044~~ ~~2045~~ ~~2046~~ ~~2047~~ ~~2048~~ ~~2049~~ ~~2050~~ ~~2051~~ ~~2052~~ ~~2053~~ ~~2054~~ ~~2055~~ ~~2056~~ ~~2057~~ ~~2058~~ ~~2059~~ ~~2060~~ ~~2061~~ ~~2062~~ ~~2063~~ ~~2064~~ ~~2065~~ ~~2066~~ ~~2067~~ ~~2068~~ ~~2069~~ ~~2070~~ ~~2071~~ ~~2072~~ ~~2073~~ ~~2074~~ ~~2075~~ ~~2076~~ ~~2077~~ ~~2078~~ ~~2079~~ ~~2080~~ ~~2081~~ ~~2082~~ ~~2083~~ ~~2084~~ ~~2085~~ ~~2086~~ ~~2087~~ ~~2088~~ ~~2089~~ ~~2090~~ ~~2091~~ ~~2092~~ ~~2093~~ ~~2094~~ ~~2095~~ ~~2096~~ ~~2097~~ ~~2098~~ ~~2099~~ ~~2100~~ ~~2101~~ ~~2102~~ ~~2103~~ ~~2104~~ ~~2105~~ ~~2106~~ ~~2107~~ ~~2108~~ ~~2109~~ ~~2110~~ ~~2111~~ ~~2112~~ ~~2113~~ ~~2114~~ ~~2115~~ ~~2116~~ ~~2117~~ ~~2118~~ ~~2119~~ ~~2120~~ ~~2121~~ ~~2122~~ ~~2123~~ ~~2124~~ ~~2125~~ ~~2126~~ ~~2127~~ ~~2128~~ ~~2129~~ ~~2130~~ ~~2131~~ ~~2132~~ ~~2133~~ ~~2134~~ ~~2135~~ ~~2136~~ ~~2137~~ ~~2138~~ ~~2139~~ ~~2140~~ ~~2141~~ ~~2142~~ ~~2143~~ ~~2144~~ ~~2145~~ ~~2146~~ ~~2147~~ ~~2148~~ ~~2149~~ ~~2150~~ ~~2151~~ ~~2152~~ ~~2153~~ ~~2154~~ ~~2155~~ ~~2156~~ ~~2157~~ ~~2158~~ ~~2159~~ ~~2160~~ ~~2161~~ ~~2162~~ ~~2163~~ ~~2164~~ ~~2165~~ ~~2166~~ ~~2167~~ ~~2168~~ ~~2169~~ ~~2170~~ ~~2171~~ ~~2172~~ ~~2173~~ ~~2174~~ ~~2175~~ ~~2176~~ ~~2177~~ ~~2178~~ ~~2179~~ ~~2180~~ ~~2181~~ ~~2182~~ ~~2183~~ ~~2184~~ ~~2185~~ ~~2186~~ ~~2187~~ ~~2188~~ ~~2189~~ ~~2190~~ ~~2191~~ ~~2192~~ ~~2193~~ ~~2194~~ ~~2195~~ ~~2196~~ ~~2197~~ ~~2198~~ ~~2199~~ ~~2200~~ ~~2201~~ ~~2202~~ ~~2203~~ ~~2204~~ ~~2205~~ ~~2206~~ ~~2207~~ ~~2208~~ ~~2209~~ ~~2210~~ ~~2211~~ ~~2212~~ ~~2213~~ ~~2214~~ ~~2215~~ ~~2216~~ ~~2217~~ ~~2218~~ ~~2219~~ ~~2220~~ ~~2221~~ ~~2222~~ ~~2223~~ ~~2224~~ ~~2225~~ ~~2226~~ ~~2227~~ ~~2228~~ ~~2229~~ ~~2230~~ ~~2231~~ ~~2232~~ ~~2233~~ ~~2234~~ ~~2235~~ ~~2236~~ ~~2237~~ ~~2238~~ ~~2239~~ ~~2240~~ ~~2241~~ ~~2242~~ ~~2243~~ ~~2244~~ ~~2245~~ ~~2246~~ ~~2247~~ ~~2248~~ ~~2249~~ ~~2250~~ ~~2251~~ ~~2252~~ ~~2253~~ ~~2254~~ ~~2255~~ ~~2256~~ ~~2257~~ ~~2258~~ ~~2259~~ ~~2260~~ ~~2261~~ ~~2262~~ ~~2263~~ ~~2264~~ ~~2265~~ ~~2266~~ ~~2267~~ ~~2268~~ ~~2269~~ ~~2270~~ ~~2271~~ ~~2272~~ ~~2273~~ ~~2274~~ ~~2275~~ ~~2276~~ ~~2277~~ ~~2278~~ ~~2279~~ ~~2280~~ ~~2281~~ ~~2282~~ ~~2283~~ ~~2284~~ ~~2285~~ ~~2286~~ ~~2287~~ ~~2288~~ ~~2289~~ ~~2290~~ ~~2291~~ ~~2292~~ ~~2293~~ ~~2294~~ ~~2295~~ ~~2296~~ ~~2297~~ ~~2298~~ ~~2299~~ ~~2300~~ ~~2301~~ ~~2302~~ ~~2303~~ ~~2304~~ ~~2305~~ ~~2306~~ ~~2307~~ ~~2308~~ ~~2309~~ ~~2310~~ ~~2311~~ ~~2312~~ ~~2313~~ ~~2314~~ ~~2315~~ ~~2316~~ ~~2317~~ ~~2318~~ ~~2319~~ ~~2320~~ ~~2321~~ ~~2322~~ ~~2323~~ ~~2324~~ ~~2325~~ ~~2326~~ ~~2327~~ ~~2328~~ ~~2329~~ ~~2330~~ ~~2331~~ ~~2332~~ ~~2333~~ ~~2334~~ ~~2335~~ ~~2336~~ ~~2337~~ ~~2338~~ ~~2339~~ ~~2340~~

FEDERAL JUDGE JAMES E. HUGHES sentenced Norman R. Gross, 29, of Montpelier, Ind., to three years in prison for obstructing the life of President Nixon in a letter mailed to the White House.

John Morrison, brother-in-law of the kidnapped woman, told newsmen later that Mrs. Piper and her husband had a "heated" argument.

"The man found in a vehicle was once charged to a train," Stevens said. "The man was charged to a lot of and on for two days and nights." He said the record will reveal where man had been kept hostage, and he returned to answer questions about the abductions.

Mrs. Pappas is here," he said. "She is positively healthy, but she is very tired. Her doctor did look her over briefly and said she is in fine shape."

Lord I thank You for the precious gift of children and love and care for. Let them keep us ever mindful of You in the joys they bring to our life. Amen.



Richard Gorman, right, is shown on the training wire at the Wallenda water house in Sarnow, Fla., in 1971. With Gorman are Karl Wallenda, left, and Gorman's wife

Carl, who also is Karl Walenda's daughter Gunnen fell to his death before a circus crowd Friday night in Wheeling, W. Va., adding another tragedy for the Walenda family. Three other members of the family have died in plunges from the high wire within 10 years.

By W. P. VERMONT
and W. P. VERMONT

[illegible]

...to the ...
...the ...
...the ...
...the ...

By 8:00 a.m. on 1/10/68, the...
...Georgia Department of...
...in telephone to...
By 8:00 a.m. on 1/10/68, the...
...there might have been...
...memorandum over...
...a details of the program...
...of with Home Court...
...the state in 1968 but there...
...in mind on his or his...
...part to control the...
......has been...

of the Yodas Society, the
the man clearly agreed to direct
the. The remaining 32 members
of this group and the 10
available for health approval
that group.

• The Podgoric system is
main point that very large drives
have proved a more necessary
with the German

no members of the 1980s
but health board meeting
that the Public Health Ser-
vice had expressed concern about

The city people who were members of the federal experiment were found by the department to be serving more than 40 years of sentence for a variety of crimes, but when it was reported that

to an effort of the state Bureau of Preventive Diseases, several Bureau Division, and Friday that the Alabama Department of Health awarded the Public Health Service in its annual phase of recognition of health units by providing

The formal action of a de-
Board of Health meeting Fri-
th, and suggesting that local
public health officials draw
plans for getting the people
out of the Chicago Stock
the Haven County Medical
city, was discussed Friday.
The Advertiser is a regular
being meeting people and
back to Hill.

[illegible]

Dr. Hargrave said there have been some indications during the morning that some of the resistance in the government and provincial treatment to a phenomenon of the postwar period. The discussion was that there is a state as it would not be

In H.W. Faxon, president of the "Health" committee, Faxon, he is under impression that the Department of Health Service will discuss the problem immediately.

The county draft a statement of a meeting at Vardø Thursday night which will discuss the plan of the

"The New South Africa
- Organized by the Public
Server," the minister
said, "is a country of the people
and not a country of the state."
He said the new government
will be a government of the
people.

[illegible]

The official said that state public health representatives were charged to the "Harris County" and asked to locate the patients and transported them to the county health department for treatment.

The state health department began the beginning of the outbreak in 1981 to the present time to add.

Meharry

FOR IMMEDIATE RELEASE:
February 22, 1995

CONTACT: Kristi S. Hamrick
or Kristin Hansen for radio

FOSTER FABLE: MEHARRY "MAINTAINED" WELL

FOSTER FACT: MEHARRY RANKED LOWEST IN THE NATION TWICE, HAD \$\$ PROBLEMS DURING FOSTER'S SERVICE

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

Foster officially headed the school of medicine beginning in 1990, following his chairmanship of the ob/gyn department beginning in 1973. However, in his 2/8/95 Nightline interview, Foster said, "I maintained an accredited residence program for 17 years."

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

FOSTER FACTS:

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

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

FAMILY
RESEARCH
COUNCIL

Gary L. Bauer
President

700
Twentieth St., NW
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Washington, DC
20005
(202) 393-2100
FAX (202) 393-2134

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

- * The use of federal funds for non-federal projects.*
 - * Poor collection procedures on student loans.*
 - * Failure to reconcile the general fund bank accounts for more than a year.*
 - * Weak controls on expenditures, accounting for about 25 percent of Meharry's annual deficit.*
 - * Insufficient accounting staff.*
 - * 'Incomplete and inaccurate records' and an 'inadequate accounting system.'*
- The records for fiscal 1978 were in such bad shape they couldn't be completely audited, the auditors said."*

Nashville Banner, 4/17/79

** "Meharry Medical College, which for years has been the beneficiary of millions of dollars in federal subsidies, is learning to cope with a different experience — paying Uncle Sam. The U.S. Department of Health and Human Services has required the school to repay between \$2.7 and \$3.8 million — the total amount is still in dispute — in federal funds that the federal officials said were used for unauthorized purposes."*

Nashville Banner, 3/3/81

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

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

- END -