But the legacy of debt for the 12 year period 1980-92 will not go away quickly and can be seen in three aspects of fiscal and budget policy.

First, net interest on the increase in the publicly held debt—accumulated during the 12 year period 1980-1992—is about $180 billion or roughly the size of the annual deficit. Second, even without a balanced budget amendment fiscal policy remains paralyzed—as long as we are running deficits of $200 billion, for whatever reason, it is difficult to deliberate on the problem of the deficit as an anti-inflationary measure. The public will just not accept that. Second, the legacy of annual deficits of almost $300 billion must be reduced gradually, so as not to depress the economy. Consequently, we will continue to add to the debt. By the end of the century the gross Federal debt will approach $7 trillion.

But it can be done. Note once more. Spending on Government programs is less than the first time since the 1960s. If we keep at it, do more, the deficit could start declining in 5 years surely. The decline accelerates as smaller debt leads to lesser borrowing for interest which leads to smaller debt. But can we do this on our own? Will I say to senators that it won't happen otherwise. The Courts, to which all disputes under government, thereby swelling up the taxes; on the several departments of the State Government, thereby swelling up the government, thereby swelling up the taxes, thereby swelling up the government, thereby swelling up the taxes.

Some 40 years ago, Guthrie Birkhead, professor, late dean of the Maxwell School of Citizenship and Government at Syracuse University, remarked that Americans are gadget-minded about government. The proposed balanced budget amendment is nothing if not a gadget. Allow me to offer a cautionary budget amendment is nothing if not a gadget. Allow me to offer a cautionary budget amendment is nothing if not a gadget. Allow me to offer a cautionary budget amendment is nothing if not a gadget. Allow me to offer a cautionary budget amendment is nothing if not a gadget.

Mr. NICKLES. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded. The FOSTER NOMINATION OBJECTION. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded. The FOSTER NOMINATION OBJECTION. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

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The undersigned, citizens of the State, would respectfully represent: That owing to the great falling off of the Canal revenue, as well as the increasing drafts upon the State Treasuries, and large expenses of carrying on the several departments of the State Government, thereby swelling up the taxes; therefore the deficit of reliefing the people from the large amount now unnecessarily expended to sustain the Executive and Legislative Departments, and to secure the honest and better administration thereof: your petitioners respectfully ask that your Honorable body pass an act for calling a Convention to alter the Constitution as to abolish both the Executive and Legislative Departments, as they now exist, and to vest the powers and duties thereof on the President, Vice President, and Directors of the New York Central railroad company.

The Times special correspondent, an early advocacy journalist, explained that the proposal, while intended as a joke, nonetheless conveyed a bitter satire, a satire which is deserved and just, such were the depredations of the ruling Democrats. The time would come, he concluded, when “after long suffering” the people would rise and “retaliated.” They almost did and not long there after. Joke or not, the proposal passed the legislature, went on the ballot the next fall, and failed by only 6,360 votes.

The amendment failed, but retaliation was another story. The New York Democrats scarcely held office for the rest of the century. But retaliation has pursued us into the twentieth century, even to this time. The New York Democrats have controlled the New York State legislature for a total of 4 years it is because in the twentieth century so far. Let Republicans beware. This amendment could pass.

Mr. HATCH. Mr. President, I see the distinguished Senator from Oklahoma is here. I am hoping that after he speaks, we will be able to close out the Senate for the day.

Mr. NICKLES. Mr. President, I suggest the absence of a quorum. The FOSTER NOMINATION OBJECTION. The clerk will call the roll.

Mr. NICKLES. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded. The FOSTER NOMINATION OBJECTION. Without objection, it is so ordered. Mr. NICKLES. I ask unanimous consent to proceed as if in morning business.

The FOSTER NOMINATION OBJECTION. Without objection, it is so ordered.

Mr. NICKLES. Mr. President, over the last 9 days, a firestorm has erupted over President Clinton’s announcement that he intends to nominate Dr. Henry W. Foster as the Surgeon General of the United States.

I believe that the President erred when he chose Dr. Foster as Surgeon General, and I believe the President should withdraw his nomination. I would also recommend to Dr. Foster that he withdraw his name from consideration.

Mr. President, much has been made about the fact that Dr. Foster, by his own admission, has performed abortions. President Clinton said yesterday why he chose Dr. Foster. He was unaware that the only people who are fighting this nomination are people who oppose abortion. I believe the President is wrong.

Mr. President, I might mention that I do oppose abortion, I do not make any qualms about that. I do believe it is the deliberate taking of a human life, and I think it is a mistake to have as our Surgeon General a person who routinely performs abortions. To be named as Surgeon General, you are named as the Nation’s No. 1 public health officer.

Some people say, should a person be totally disqualified because of that? I would not vote for him, but that does not mean that this body would not. Likewise, I could not help but think of the reaction of many people in this body and what they would say if the medical researcher for American Tobacco Institute was appointed as Surgeon General. Smoking, like abortion, is legal, but I expect that there would be significant opposition because that is the reason we have a Surgeon General to have as the Surgeon General.

Mr. President, my reason for speaking today and my reason for saying that the President should withdraw the nomination, is not just because Dr. Foster has performed a lot of abortions. It is because in the last 9 days, there has been a real lack of candor from Dr. Foster. There has been a real misleading of the American people and the American Congress to the facts. I think that alone disqualifies him for this office.

The office of Surgeon General has been referred to as a bully pulpit, and it is. It is an office which gives the Surgeon General the ability to educate and to lead. And it is an office that, if one is going to educate and to lead by example, one has credibility. I think Dr. Foster has lost that credibility.

Mr. President, this morning’s New York Times, in the lead editorial, calls upon President Clinton to withdraw the Foster nomination. The editorial states:

Although Dr. Foster is a highly respected obstetrician, his lack of candor about his abortion record disqualifies him from serious consideration. Misleading statements by candidates for high position cannot be condoned.

The editorial concludes:

President Clinton promises to fight for his nominee and Dr. Foster pledges to stay the course. But this is a fight that neither the White House nor Congress really wants over a crippled candidacy. It is time to withdraw the nomination.

Mr. President, I ask unanimous consent to have the New York Times editorial printed in the RECORD at this point.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

[From the New York Times, Feb. 10, 1995]

THE TAINTED FOSTER NOMINATION

The nomination of Dr. Henry Foster J. r. to be surgeon general has been so badly bungled, by the White House and by Dr. Foster himself, that there is little choice but to hope it dies quickly. Although Dr. Foster is a highly respected obstetrician, his lack of candor about his abortion record disqualifies him from serious consideration. Misleading statements by candidates for high position simply cannot be condoned.

The chief blame for this debacle lies with the White House, which once again put forth in a nominee without adequately vetting the person’s background or knowing the answers to potentially explosive questions. As a result, the Administration put out false information on the number of abortions performed by Dr. Foster. In this as in earlier episodes, White House bungling makes it difficult for President Clinton’s natural allies to support him fully. The situation moves from difficult to impossible for...
pro-choice Republicans like Senator Nancy Kassebaum of Kansas, who cannot reason-ably be expected to take a political gamble amid such swirling incompetence.

That is a shame because Dr. Foster, based on his record, is a good choice. I sup-port Dr. J. Joycelyn Elders, who was pushed from the job after her repeated intemperate language made her a target for conservative attacks. Dr. Foster, the acting director of Meharry Medical College in Tennessee, is deeply committed to delaying child-bearing among adolescents, one of the most pressing social problems confronting the nation. He de-veloped a highly successful program, called "I Have a Future," in Nashville that was honored by President Bush as one of his "points of light."

During a 30-year practice Dr. Foster, like many obstetricians, performed a number of abortions. In doing so, he was providing a legal, constitutionally protected medical service. If the latest numbers put forth are correct, he performed 39 surgical abortions during his 38-year medical career, a once-a-year rate that seems modest for a very busy practitioner serving a needy population. He was also the titular head of a federally sanctioned test of a potential abortion supposi-tory.

This record would in any case have prob-ably inflamed America's anti-choice minor-ity, who are well organized and have good friends in Congress. But since most Americans believe that women should retain the right to choose, Dr. Foster's nomination might not have been an issue pushed through the Senate had his record been forthrightly pre-sented. Instead both he and the Administra-tion made it look as if there accounts were unreliable or designed to mask a more trou-bling history.

President Clinton promises to fight for his nominee, for he knows he has to stay the course. But this is a fight that neither the White House nor Congress really wants over a crippled candidacy. It is time to withdraw the nomination.

Mr. NICKLES. Mr. President, I do not agree with the New York Times editorial page, but I think this editorial is correct. President Clinton should withdraw this nomination immediately because Dr. Foster has seri-ous credibility problems.

The New York Times editorial says Dr. Foster is guilty of lack of candor in making misleading statements about his abortion record. They are correct.

In less than a week, he has given three different estimates on the number of abortions he has performed. Ini-tially, he told the administration official he had performed just one abor-tion. Then, last Friday, he issued a statement that said:

"As a practicing physician, I be-lieved that I performed fewer than a dozen pregnancy terminations."

Mr. President, I ask unanimous con-sent to have printed in the RECORD the article I just referred to.

Again, we are talking about credibil-ity. They indicate that Dr. Foster mis-represented his abortion record three times in the last week, and we still do not know, despite three different esti-mates supplied by the nominee, how many abortions Dr. Foster has performed.
Mr. President, there is a record that was made on Friday, November 10, 1978, at the Federal Building in Seattle, WA, before the Department of Health, Education, and Welfare, Office of the Secretary, an ethics advisory board.

A list of participants included: Henry W. Foster, M.D., professor and chairman, Department of Obstetrics and Gynecology, Meharry Medical College, Nashville, TN.

Mr. President, on page 180 of this record, under Dr. Foster’s name, it says: “I have done a lot of amniocentesis and therapeutic abortions, probably near 700. There is a lot in this transcript, Mr. President. There is a lot in this transcript, but this one line, Dr. Foster’s words, “probably near 700.” Initially from the White House we heard maybe the transcript was a forgery. Then we heard it probably was not this Dr. Foster, maybe it was a different Dr. Foster; maybe he was not there. I think they have recanted those statements and they said this probably is a legitimate transcript and it probably is the same person they nominated to be Surgeon General, but he did not say what the official transcript of the meeting says he said.

Again, credibility. Was it 1 or was it 12 or was it 39 or was it a lot more before 1973? So we do not know how many.

And, oh, yes, in his original comments he forgot that he was chief investigator of a drug, a suppository that would prevent abortion that they gave to 60 people that he has written a report on, and I will include that for the RECORD as well. Out of the 60 pregnant women who participated in the study, 55 had their pregnancies aborted by the drug, and those abortions were not medically necessary. I think 58 of those who participated in the study were black women, ages 15 to 32; in 55 of the 60 cases, the drug successfully induced abortion; in 4 other cases, they had to go ahead with a surgical abortion procedure; and in one case, the mother changed her mind and carried the baby to term.

There are other things in this report. I am going to include this for the RECORD, not the entire report but I will include about 40 pages. This transcript includes a discussion about research, trying to do research to determine whether the fetus has a disease called sickle cell anemia and whether or not they can detect that disease prenatally or find out whether the fetus is affected in time so there could be a therapeutic abortion; in other words, abort a fetus because it happens to have sickle cell anemia so it would be in time to find out if the mother, I guess, would like to have an abortion, a therapeutic abortion. Not very therapeutic for the fetus, I might mention.

It even goes on further, and I do not even like talking about this. It talks about research on human ova fertilized in a laboratory setting. Dr. Foster is saying, “Well, if we have spares that are not going to be used for medicine, they could be used for research.”

It happens to be against the law right now, but he was advocating they would use fertilized ovum for research. That bothers me. This is a report, this is a transcript of a hearing. Maybe a lot of us who have spoken we are recorded. I do not know. But these are statements.

Mr. President, I would like to keep the CONGRESSIONAL RECORD very short, but this is a very controversial nominee and I think people are entitled to find out what the facts are. So I ask unanimous consent this portion of a copy of the ethics advisory board meeting dated November 10, 1978, be printed in the RECORD.

There being no objection, the transcript was ordered to be printed in the RECORD, as follows:

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, OFFICE OF THE SECRETARY, ETHICS ADVISORY BOARD, MEETING V, NOVEMBER 1978

MEMBERS OF THE ETHICS ADVISORY BOARD

Gaither, James C., J.D., Chairman, Cooley, Godward, Castro, Huddleston and Tatam, San Francisco, California.

Hamburg, David A., M.D., Vice Chairman, President, Institute of Medicine, Washington, D.C.

Conway, Jack T., Senior Vice President, Government and Labor Movement Relations, United Way of America, Washington, D.C.

Foster, Henry W., M.D., Professor and Chairman, Department of Obstetrics and Gynecology, Meharry Medical College, Nashville, Tennessee.

Henderson, Donald A., M.D., Dean, The Johns Hopkins School of Hygiene and Public Health, Baltimore, Maryland.

Lazarus, Maurice, Chairman, Finance Committee, Federated Department Stores, Inc., Boston, Massachusetts.


Spellman, Mitchell W., M.D., Dean for Medical Services and Professor or Surgery, Harvard Medical School, Boston, Massachusetts.

Williams, Agnes N., LL.B., Potomac, Maryland.

Zwieback, Eugene M., M.D., Surgeon, Omaha, Nebraska.

STAFF MEMBERS

Dr. Charles McCarthy, Staff Director, EAB.

Ms. Barbara Mishkin, Deputy Staff Director, EAB.

Ms. Roberta Garfinke, Assistant to EAB.

Mr. William Dommel, Special Assistant to Staff Director, EAB.

Mr. Philip Galpern, Special Counsel to Chairman, EAB.

EXCERPTS FROM HEARING

. . . given the risk benefit ratio and whatever—it would not be ethical and moral for the government to pay for that process.

Mr. LEIMAN. So long as we are leaving the conceptus out of the discussion, I think so.

Mr. GAITHER. Dr. Henderson, one last question.

Dr. HENDERSON. Just an observation. I wonder if we are really looking at proceeding on the assumption that there is no additional risk. As one looks at the whole field of medicine, almost any drug one takes, there is some minimal additional risk. Acceptable minimal additional risk I think is the way we are really looking at this and I think this and probably no additional risk I think is probably not the way we can look at this. I think we must say minimally acceptable additional risk.

Mr. GAITHER. I think the acceptability is still at issue. But I think that the point is well taken.

Rabbi Leiman, thank you very much. We appreciate it.

Let’s take a short break and figure out how we can get back to our schedule.

(Brief recess.)

Mr. GAITHER. Needless to say, we have fallen a bit behind schedule, and I would suggest that we postpone for the time being the legal discussion regarding in vitro fertilization, and proceed at this time to a consideration of the research application involving fetoscopy, submitted by the Charles Drew Postgraduate Medical School.

I would like to note at the outset that Dr. Spanier, formerly Dean that medical school has asked that he be excused from the deliberation on this issue. I hope that you will stay with us and listen to it, but I understand your reluctance to become involved, and we will now address you. We will not be involved in either the discussion or the decision on this issue.

Dr. HAMBURG. However, as a point of personal privilege, you may respond to insulting remarks. (Laughter.)

Mr. GAITHER. Mrs. Mishkin, we will let you describe the issue before us, and I would ask that you start by describing why the application is before us and what we are expected to do with it.

Ms. MISHKIN. The HEW regulations governing a proposal involving the human fetus lay down certain conditions which must be met in order for an institutional review board to approve that research. If the institutional review board is not able to determine that all of the conditions has been met, and it considers that the research nevertheless is important, it may refer that research proposal to this Board for review. And if the Board determines that the proposal should go on, it may recommend to the Secretary that he waive those parts of the regulations that the research proposal cannot meet.

Now, the proposal before the Board at this point is a proposal to perform fetoscopy on mothers who have elected to have abortions for reasons totally unrelated to the research, in order to discover and to document what the risk to mothers and fetuses might be from the procedure of fetoscopy. The purpose of developing the fetoscopy is to be able to diagnose prenatally certain conditions for which the parents are at risk. In this particular research proposal the focus is primarily on prenatal diagnosis of sickle cell disease.

The reason that this proposal is before the Board is that it cannot meet or at least cannot clearly meet provisions of the HEW regulations set forth in sections 46.504(a) and 46.508(a) when taken together, require that the activities in the research proposal be designed to meet the health needs of either the mother or the particular fetus involved, or, if that is not the case, the proposal there is no more than minimal risk to the fetus.
Now, the problem in this proposal is that it is not designed, as written, to provide ther-
apy for the mother, nor is it designed to pro-
vide therapy for the fetus, because the pur-
pose is to assess safety of a technique and to do it under conditions in which the fetus has already
undergo abortion. So there is no question as
to whether or not it is or not so-called thera-
petic research. It clearly is not. Therefore, it
does not meet that first condition.
It does not seem to meet the second con-
dition because the risks, I think, must be con-
sidered undetermined. Although the HEW
regulations list minimal risk, it is not possible to go and look behind those regu-
lations to the Commission's discussion of what
they intended, because the regulations were an
afterthought for the Department's purpose. It
implies the Commission's recommendations
on research involving the fetus.
So I am going to offer to you for your guid-
ance what the Commission's intentions were
when they made their recommendations to
the Secretary. That does not mean that you
must follow the Commission's intentions; it
is only to elucidate for you somewhat what
the Commission had in mind, because the
regulations themselves give this Board no
guidance. The only guidance in the regula-
tions is to the institutional review boards.

Mr. GAITHER. Let me interrupt for just one
second, because I think it is important that
we understand the context in which those
provisions would apply. I gather what you are saying is that
this particular application is not therapeutic and not clearly
within the category or at least so determined by the institu-
tional review board, as involving no more than
minimal risk.
Ms. MISHKIN. That is correct.
Mr. GAITHER. Therefore, it can only be
funded if this Board determines that it is
ethically acceptable? Is that the standard?
Ms. MISHKIN. Yes.
Mr. GAITHER. And you are giving us
the particular conditions that those provi-
sions that we just mentioned be-
ommend to the Secretary that he waive
the conditions.
Ms. MISHKIN. And what the Commission
/coped with when it discussed the problem of
research on fetuses to be aborted, and what
standard might be appropriate in considering
the importance of the knowledge to be
obtained. It is one issue whether the abor-
ted or whose mothers intend to go through
with an abortion. It was a very, very dif-
cult problem for the Commission. Any of
the risks, I think, must be consid-
ered. Certainly if the research is done on
fetuses prior to birth. The point of the research is to do
the research of Dr. Kaback's understanding of what
a viable product of abortion is an
additional risk.
Mr. HALPERN. Mr. Gaither, if I could be of
help, if you look at subpart 5 under Tab I in
our book, the regulations why the Commission
46.211 provides some guidance as to the
standard, at least which will guide the Sec-
retary in his decision to accept our
recommendations.
Ms. MISHKIN. At Tab I of your book, we
have reproduced the applicable provisions
of 45 CFR 46, and it simply says if this Board feels
that the risk is justified by the sum of
the benefit to the subject, which is not in
question here, or the importance of the
knowledge to be gained.
Mr. GAITHER. And are we referring to
46.211?
Ms. MISHKIN. Yes.
Mr. HALPERN. In fact, it doesn't say that
the Board should be guided by the risk ben-
efit analysis, it says that the Board should
consider whether waiver, which is what we are
talking about in this particular instance.

Mr. GAITHER. But it seems to me that it is
important that 46.211 say that the
Secretary can only waive, unlike the
other situation before us, with our approval.
So that is the question, whether we would
approve a modification or waiver of these
regulations to permit this research to con-
tinue. And basically there are no specific
standards imposed upon us. Is that correct?
Ms. MISHKIN. That is correct.
Mr. GAITHER. And what you are giving us is
the particular conditions that the
Commission suggested that a body such as ours be involved in
the deliberations.
Ms. MISHKIN. And what the Commission
/coped with when it discussed the problem of
research on fetuses to be aborted, and what
standard might be appropriate in considering
the importance of the knowledge to be
obtained. It is one issue whether the abor-
ted or whose mothers intend to go through
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cult problem for the Commission. Any of
the risks, I think, must be consid-
ered. Certainly if the research is done on
fetuses prior to birth. The point of the research is to do

Now, there was one problem that we had in
reviewing this particular proposal, and that
is the fact that the proposal, because we had conflicting state-
ments—the site visit review said one thing,
and the proposal said something else—as to
whether this disease is not diagnosable by amnio-
centesis. Fecoscopy has been the only possible way to
diagnose sickle cell disease through
amenioentesis, thus avoiding the necessity
go to fetoscopy in order to diagnose sickle
cell disease. These findings are supposed to be
disclosed in the most recent issue of the
journal Lancet. We were unable to find what-
ever issue that was. It must not be out yet.
If it is out it is not available in any of the li-
braries we had available.
We tried very hard to call the investigator
at the University of California at San Fran-
cisco, and we were unable to reach him. We
tried very hard to call Dr. Michael Kabad,
who is Assistant Professor of Pediatrics and Medical Genetics at the
University of California at San Francisco.
Dr. Michael Kabad has done fetoscopy
themselves to diagnose sickle cell disease through
amenioentesis, thus avoiding the necessity
go to fetoscopy in order to diagnose sickle
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disclosed in the most recent issue of the
journal Lancet. We were unable to find what-
ever issue that was. It must not be out yet.
If it is out it is not available in any of the li-
bibliographic databases.

Now, let me break that out for you. What
they have to do is they have to identify the
parents, then the child and then the
child through DNA testing. They then
look for the presence of the
DNA. The presence of the
DNA is the disease.

Ms. MISHKIN. That is correct.
Mr. GAITHER. And what you are giving us is
the particular conditions that the
Commission suggested that a body such as ours be involved in
the deliberations.
Ms. MISHKIN. And what the Commission
/coped with when it discussed the problem of
research on fetuses to be aborted, and what
standard might be appropriate in considering
the importance of the knowledge to be
obtained. It is one issue whether the abor-
ted or whose mothers intend to go through
with an abortion. It was a very, very dif-
cult problem for the Commission. Any of
the risks, I think, must be consid-
ered. Certainly if the research is done on
fetuses prior to birth. The point of the research is to do

who have that polymorphism, then it is possible to perform amniocentesis—yes?

Dr. Foster. I should clarify something at this point. You are using a medical term, and I am not sure—you are saying "carriers," do you mean sickle cell carriers, or do you mean sickle cell disease?

Ms. Mishkin. No, I mean carriers.

Dr. Foster. That is not a person with sickle cell disease.

Ms. Mishkin. That is correct.

Dr. Foster. Okay.

Ms. Mishkin. But again, this is my understanding through Dr. Kaback. That is the best we can give you.

Dr. Foster. Go ahead and let me hear you out, then.

Ms. Mishkin. My understanding is this is carriers.

Dr. Foster. Okay, I will hear you out.

Ms. Mishkin. So if both parents are carriers, either with or without the disease—

Dr. Foster. It is the previous I am concerned about.

Ms. Mishkin. Right. If both parents are carriers and have this trait of the polymorphism, and it is possible to be a 15 percent of carriers do not show this trait. If they are among the 85 percent of carriers who show this trait, then through amniocentesis they can look for the segments showing the polymorphism, that is a child with sickle cell disease. If the fetus has one segment that is a carrier. If the fetus has no segments, that is a normal child.

Now, I went back and asked again whether that child could be one of the 15 percent that do not show the polymorphism, and the answer was that Dr. Alexander believes not. The answer is if they have done this whole procedure and the child does not carry that polymorphism, that child is not a carrier or a diseased child with respect to sickle cell.

Now, if either parent is not polymorphic, does not have this additional clump, is within in that 15 percent of parents who are carriers but do not have this change of the DNA, then it is impossible to diagnose the sickle cell disease in the fetus through this amniocentesis procedure, and that would mean that for those parents the only way to diagnose the sickle cell disease in the fetus would be through fetoscopy, which brings us back to the Drew application.

Now, what all this means is there has been a shift in the risk benefit analysis that all of the research on the Drew application, because when they looked at the Drew application fetoscopy was the only method for diagnosing sickle cell disease prenatal diagnosis, although they did not have the documentation to give you, that it is possible in 85 percent of sickle cell carrier parents to diagnose the presence or absence of sickle cell disease by amniocentesis unless both parents show the polymorphism.

Dr. Foster. Now, the next question I have—Ms. Mishkin, I will make my comments—now, I read the research proposal, and I missed this delay. That bothers me a little bit, first. I have got to really clear that in my mind.

I have done a lot of amniocentesis and therapeutic abortions, probably near 700. As I read the protocol, the patient would be brought in the hospital, and that would be in in 24 hour delay, which was not inordinate, based on the information that we have. It is very reasonable. But the clinical part, catheter in beyond this point.

Ms. Mishkin. My understanding is that it is not going to be a reliable test through amniocentesis unless both parents show the polymorphism.

Dr. Foster. I think that is something that needs to be addressed in terms of the details of the research.

Ms. Mishkin. I am frankly bothered by anything coming as far as to the Ethics Advisory Board to make some strong statement about wanting to be clear on what the procedures proposed are here.

Mr. Lazarus. I wasn't clear on either the consent processes.

Dr. Foster. That doesn't come through. But the one thing I do want to say, and then I will get to the other points I want to make about what all of the implications of fetoscopy are as I see it. I do think a longer observation period would be an acceptable re-

search modality provided safeguards are there. We have already talked about extend-

ing beyond the 20 weeks. That can be consid-

ered so fairly well validated by work that Kan has been doing for establishing fetal age, and a few other things. But I think you might want to con-

sider the observation period without the catheter in place. I don't think amniocentesis has proven to be relatively safe in terms—the danger is in leaving a con-

duct for bacterial migration.

Now, what I am really saying is I can see the investigators making a justification for an observation period of longer than 24 hours, but I find it a little difficult at this point to see that a 7 day catheter makes a justification in beyond this point.

And now I think the things we need to be concerned about irrespective of what we ultimately recommend in terms of going back or whatever. There was very, very strong community support for this proposal. Anyone who read the type of support, and the rather incisive and critical questions, I thought, that the community asked in regard to many of the social and medical implications. I think it is keen that we remember that there have been so many charges of disregard for the ethic makeup of our research, genocide and all the issues, if this is an indigenous deci-

sion by a community, I think we need to give that due respect, that justification for us to say this is a decision that you made. If we say to the community no, we shouldn't do this, the community in a sense may want to say to us to impose certain things on us externally that we feel are an abridgment, but here we see something clearly directing us, you deny it. So that is something that has to be consid-

ered strongly in terms of sociology.
is a basic need. Now, I am going to go slowly and really try to make this point.

Kan’s approach right now is the acceptable one. It is a reaction. It is an after-the-fact approach. It gives us an option simply to abort. Basic research will afford us a much broader and brighter horizon, might I add. And that is the possibility of diagnosing the defective fetus and then allowing the development of sickle cell disease in that fetus.

Now, I will try and paint a picture. In utero, for all of us normally, there is a difference of protein in two of the chains of our hemoglobin in early fetal life. The normal hemoglobin molecule has four chains, two upper alpha chains, which are proteins in a set sequence, and two lower, somewhat larger, beta chains in a set sequence.

The only difference between one who has sickle cell hemoglobin and a normal person is out of 184 amino acids in one of those chains, and that is in set sequence, there is an exchange of valine for glutamic acid, in the sixth position from the end. One of 184 chains. That is the only difference. But because of this change in the chain, certain physical and chemical defects, as you may call them, are imparted into the hemoglobin. It makes it, its ability to carry and release oxygen is affected. The stability of the red cell membrane is affected. It changes its pattern of migration in an electrical, you might say, and that now do our hemoglobin electrophoresis.

Back to in utero, none of us has these beta chains when we are developing. We have another four gamma chains in the way we are developing. The gamma chain is provided for through a mechanism which we yet do not fully understand, and this is where our basic research should be continued. There are repressor and activator genes. Rarely, through chance, some people who were destined to have sickle cell disease never develop it. But they continue to have the gamma chains which make fetal hemoglobin throughout life, even in the postnatal period. And these people have absolutely no trouble. That is the ideal situation for the sickle cell person, to be able to find that mechanism that will prevent the turning on of the activator genes from going from gamma chains to defective beta chains. So there is a clear need for this kind of research in spite of the work by Kahn and his associates.

It is at this basic step where not only will we be able to diagnose the child destined to have sickle cell disease, but indeed, to prevent it. So I think that alone justifies continued basic research approach.

Ms. Mishkin. No, I am asking whether one would endorse the Drew application today on the basis of the need to develop the prenatal therapy, or are we not yet there with respect to the therapy, with the animal work and so forth?

Dr. Foster. I think the animal work has been done. I think that has been satisfied.

Ms. Mishkin. There is one other thing I forgot to know the Public, and that is the concern about using fetuses to be aborted. There is not much direction in the HEW regulations on this matter, but there is a statement in the preamble to the regulations that pos- may or may not be useful for you, but I think it has some merit. That is, they felt that it was ethically acceptable to perform procedures on the fetus if we felt that we would feel ready to perform those procedures on a fetus intended to go to term.

In other words, if one had done all of the animal work, including primate work, which they have done in this case, and if they were unable to do it on fetuses to be aborted to further assess the risk, if they would be willing then to go forward therapeutically with it on fetuses going to term. That condition has been met in this case, because there are apparently several groups who are performing this kind of research in spite of the work by Kahn and his associates.


Mr. Gaiter. I think the issue is Dr. Foster’s judgment.

Ms. Mishkin. I mean the condition of its being performed on fetuses going to term has been met, and the question is whether or not we feel that there is any risk that those individuals, those embryos, would feel ready to perform those on fetuses intended to go to term.


Mr. Gaiter. I think the issue is Dr. Foster’s judgment.

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given very little guidance from the Department as to how to assess and categorize that risk.

Mr. LAZARUS. It would seem to me, though, that a patient's consent is very important with respect to the risks, which is undefined. It should be very carefully spelled out.

Mr. GAITHER. Particularly when one is conducting research for the purpose of finding out how risky the procedure is.

Mr. LAZARUS. Right.

Ms. MISHKIN. Underlining the illogic of the whole process, where you are saying we don't know what it means, well, the problem is it is in our HEW regulations, and if in fact the risk is minimal as the patient is told, it doesn't matter.

Ms. MISHKIN. That is right. It would not be before this Board if the risk were minimal. Then we would have approved the project by themselves, although there is another provision that would need a waiver, so it probably would come here anyway. That is, the regulations currently provide that there be no change in timing or procedure of an abortion for research purposes that would add any additional risk, and that provision does not say, "that would add more than minimal risk," but that "would add any additional risk." So it might have had to come here even so.

Dr. MCCARTHY. But the determination, the very point that Mr. Lazarus made, was picked up in the Office for Protection from Research Risks, which refused to—even though it had been reviewed by all of the subsidiary bodies—refused to go ahead and fund until and unless it has been approved by this Board.

So it is that very point: If you are doing research to assess risk, it does not seem possible then to prejudge the outcome by calling it minimal, which might turn out to be minimal, but there is no justification for the research if you already know it is minimal.

Mr. LAZARUS. And you are getting your consent under a false clause.

Dr. MCCARTHY. Yes, and I think the Office for Protection from Research Risks was correct in making the judgment that it should come before this Board to comply with HEW regs.

Mr. GAITHER. Yes, Dr. Henderson?

Mr. HENDERSON. Let me just carry that a little further. One of the important criteria here is whether the technique could be offered, and I think that is important and justified. I think this is what is indicated. Clearly we have got investigators who are very much interested in people and they have obviously proceeded step by step in reaching the point they have.

I guess there are a couple of things in my own mind that are rather unclear. There are two centers where the work is being done now, Toronto and New Haven, where the risks now appear to be rather small. I think this is perhaps where the statement is that it is probably a minimal risk, that experienced people following along with two other centers, and doing what I interpret or what I understand the procedure to be that they are doing in New Haven and Toronto.

The question I guess I have, then is it necessary to fund yet a third center? Should HEW or the President or whoever be doing this? What are the advantages?

The initial point here, as they say, initially it is limited to an assessment of the safety of the procedure. Initially one is doing a study to assess the safety. But then I ask what is the ultimate objective, because we want research which is important. What is the endpoint to this? Obviously there is an objective here.

I believe, as I interpret it, that they would hope to be defining sickle cell disease. Now, I think in talking with you earlier, the question is can you identify either the sickle cell trait or the sickle cell disease before 30 weeks? Can you define it at this point in time?

I think we are talking about, as you mentioned earlier, longer term basic research, which is used, is it enough to say that it is important that we do longer term basic research employing this technique without defining what is that basic research? And that is at the present now to approve of this sort of application which is based on safety, for some sort of ill-defined subsequent future, when in fact what we are referring to is the point that the research is important and justified.

Now, it is obvious that there are a lot of very good people who have looked at this, but I think there is a point here that I would say is out of ignorance, because I found some contradictions here which I am having trouble with.

Father McCARTHY. Do you want to respond to that, because I have got a different point I want to raise.

Dr. FOSTER. Well, yes, I tried to make some of them and I will try again. I think there are quite a number of justifications, Don, for continuing. One of the biggest reasons—I think the assumption is not completely correct that this work is being done at the other centers. I don't think there is anywhere the proportionate interest in sickle cell disease, either.

Even if Kan's work proves to be what it is purported to be, based on what Ms. Mishkin has said, we are still left with 15 percent of a large population that is at greatest risk. As you are probably aware, about 8 percent of the blacks in this country harbor the sickle cell trait, and that is 2.5 million people, and 15 percent of that is a large part of the population.

So I think there is still in our current state of the art to continue to try and be able to diagnose sickle hemoglobinopathies prior to the 30th week. This is what is concerning me at the moment. And if it isn't identifiable before the 30th week, because you may have fetal heme, I am not quite sure where this technique leads. I think this is information which we do have a reasonable body of knowledge on, do we not?

Mr. NICKLES. Mr. President, we...
difficult job. I maintained an accredited residency program for 17 years. But as today's Washington Times reports, the obstetrics residency program at Meharry Medical College lost accreditation in May 1990 when Dr. Foster was department chairman.

I watched a tape of that program, and I know he maintained that accreditation for 17 years. He kind of forgot to say that it lost accreditation when he was department chairman. Maybe he just forgot to say that. I do not know why it lost accreditation. I have a record when surgeons general are not even mentioned that. I am not even faulting him for that. I am just saying his record before the public is misleading because he lost accreditation in that program. As a matter of fact, that accreditation, according to this article, has not been recovered meaning Meharry Medical College cannot place students in hospital residency programs in obstetrics.

I ask unanimous consent to print the Washington Times article in the RECORD.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

[From the Washington Times, Feb. 10, 1995]

MEDICAL SCHOOL FACES CRISIS WITH FOSTER AT HELM

(By Paul Bedard)

The obstetrics and gynecology residency program at Meharry Medical College in Nashville, Tenn., permanently lost its accreditation when Surgeon General Dr. Michael McCurry said: "No, we're not satisfied with Dr. Foster's answer that he had performed 1,500 abortions since 1973, but he didn't address his story training hospital is jeopardizing the tough case: the school itself.

For 115 years, Meharry Medical College has been the nation's only major medical school for African Americans. But now Meharry's doctors are facing their toughest case: the school itself.

Lack of patients at Meharry's modern, 12-story teaching hospital is jeopardizing the tough case: the school itself.

On the same "Nightline" show Wednesday night, the 61-year-old former Planned Parenthood board director said he had done 39 abortions since 1973, but he didn't address his eight-year stint as chief of obstetrics and gynecology at John A. Andrew Memorial Hospital at Tuskegee University in Alabama.

"I ask unanimous consent to print the USA Today article in the RECORD. There being no objection, the article was ordered to be printed in the RECORD, as follows:

[From USA Today, JUne 26, 1991]

PROGNOSIS: POOR—MED SCHOOL'S CRITICAL ROLE IS IN PERIL

(By Mark Mayfield)

For 115 years, Meharry Medical College has trained more black doctors than any other school in the nation, earning a reputation for excellence.

But now Meharry's doctors are facing their toughest case: the school itself.

Lack of patients at Meharry's modern, 12-story teaching hospital is jeopardizing the tough case: the school itself.

And that means trouble for the national health-care system because Meharry is a top provider of doctors for low-income rural areas and medically starved inner cities.

"If the Meharrys and other minority medical schools slide into a crisis situation, it will have a serious long-term impact on health care in low-income areas around the country," says Thomas W. Chapman, president of Greater Southeast Community Hospital in Washington, D.C.

"The president also joined with Dr. Elders in bashing Dr. Foster's opponents as ardent anti-abortion radicals.

"Mr. Nickles, Mr. President, Dr. Foster became dean of Meharry Medical College later in 1990. The following year, according to the June 26, 1991, edition of USA Today, two other residency programs at Meharry also lost accreditation—pediatrics and surgery. So while he was dean of the medical school, they lost pediatrics and surgery accreditation.

I ask unanimous consent to print the USA Today article in the RECORD.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

[From USA Today, JUne 26, 1991]

PROGNOSIS: POOR—MED SCHOOL'S CRITICAL ROLE IS IN PERIL

(By Mark Mayfield)
The same problem cost Meharry its surgical training program. "When you don't have enough patients, you don't have enough cases and not enough experience for your residents," says Dr. Washing Hay Hill, Meharry's chairman of obstetrics and gynecology.

Loss of the school's teaching hospital programs could limit its ability to attract minorities to medical students. "When Meharry has a serious problem, that obviously has an impact on the opportunity of black students to go to medical school," says Dr. Fred Denton of the Southern Regional Education Board, which has just completed a study of minority medical student education.

"In absolute terms, if you don't have residency programs in pediatrics or obstetrics-gynecology, two primary health-care fields, it affects the whole teaching atmosphere of a medical school," says Denton.

But Denton says the school's overall quality isn't a problem. "People shouldn't confuse the residency problems with the quality of teaching at Meharry. It has been very effective in getting its graduates licensed," he says.

Nearly 40% of the nation's practicing black doctors and dentists are Meharry graduates. Most of them work where doctors are needed the most—poor urban areas and under-served rural towns.

"Our graduates are working in inner cities, in New York, in downtown Detroit, here in downtown Nashville," Hill says. "Nobody wants to practice in inner cities. But our graduates do."

Meharry has also produced four of every 10 black faculty members in the nation's 126 medical schools.

Until the 1970s, Meharry and Howard University School of Medicine in Washington, D.C., trained nearly 80% of the nation's black doctors. But with desegregation of what were once all-white schools, just 20% of the nation's black doctors now graduate from any one of the four black medical schools.

Nevertheless, under 7% of all first-year medical students nationally are black, so educators say Meharry gives opportunity to those who would not otherwise have it. More than 50 of the 80 first-year students enrolled at Meharry this year were accepted nowhere else.

"We take kids knowing they bring (academic) baggage," says Dr. Henry Foster, Meharry's medical school dean. "We know they may never make it. It's not how they come; it's how they exit. We'll put our graduates up against anybody."

Administrators say students cite a "cultural sensitivity" that graduates may not get elsewhere, based partly on the school being located in a poor, mostly black section of north Nashville.

"Being here is like being in the giant arms of a loving mother," says fourth-year student Andi Coleman, 28, of Greenville, Miss. "Meharry has students who've been taken care of the poor, of the homeless. There is a warmth here you don't find in other programs."

Says Dr. David Satcher, Meharry's president: "African-Americans face a chronic health problem when you look at life-expectancy rates, infant mortality, death rates from treatable health problems. Meharry is not just a black institution. It's the leading hospital for the care of the poor and indigent. In all of our history, we have been involved with people who are disproportionately poor."

Meharry's patient shortage stems from a combination of politics, tough competition for patients in one of the nation's best medically served cities and financial woes inherited from its predecessors. Nashville, with 510,000 residents, has one of the highest per-capita number of hospital beds: 6,000 in 17 hospitals. It is home to the largest private hospital corporation in the nation, HCA, and Vanderbilt University Medical Center, which employs 10,000 people.

To solve Meharry's residency problem, administrators are proposing merging two hospitals—Meharry-Hubbard, where most patients are black, and Metro General, a dilapidated downtown hospital where most patients are white.

Meharry-Hubbard, with 235 beds, rarely has more than 100 patients at a time. "We have a relatively modern, empty plant," says Dr. Rupert Francis, chairman of family and preventive medicine. "We have to get patients back."

The 200-bed Metro General also rarely has more than half its beds filled. A merger "will benefit people who are using a very antiquated facility, and it will provide more patients in which to train medical students," Hill says.

Among those supporting the merge is Vanderbilt, which now provides most of the doctors at Metro General.

But Nashville's Metro Board of Hospitals, in a 4-2 vote, rejected the merger in February, citing economic reasons.

"Some of us call (the vote) racism. The more dignified way is to call it Southern politics," Francis says.

Meharry administrators are confident they'll win the merger and re-establish accreditation for residency programs.

"Every hospital located in a low-income community is having a problem," Satcher says. "If you're in that business, you take a beating. You're punished for your commitment. We'll struggle to hold on, until one's ability to perform is seen as a public service."

Says Dr. Tim Holcomb, a white Meharry resident in family medicine: "We have an emphasis on care for the poor. If I went to a big-city type of residency, I'd see sniffs and colds. Here, I see people who haven't seen a doctor in 20 years. I have absolutely no regrets coming here."

Mr. NICKLES. Mr. President, in my opinion, this raises further questions concerning Dr. Foster's credibility. On "Nightline," he presented himself as someone who had maintained accreditation at Meharry obstetrics residency programs. But Denton has mentioned that he was department chairman when that accreditation was lost.

In my opinion, this nomination should not go forward. Some people say, "Let's wait until we have a hearing and get all the facts out." But these are statements that came from Dr. Foster himself. This statement came from Dr. Foster himself before a committee. It directly contradicts the statement he made on "Nightline." The "Nightline" statement directly contradicts a statement that he made and gave to the press, which I inserted in the RECORD, that he gave a week ago. Dr. Foster's statements are totally inconsistent. They have been leading.

A statement about the accreditation of Meharry was misleading.

So, Mr. President, I do reluctantly—I do not do this often—but reluctantly, I urge Dr. Foster to withdraw his name from consideration or urge the President to withdraw his name from consideration to be the next U.S. Surgeon General.

Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. DASCHLE. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

SENATOR WILLIAM FULBRIGHT Mr. DASCHLE. Mr. President, the British poet John Donne said that "every person's death diminishes us." That is certainly true, and it is especially true today, for yesterday America and, indeed, the world said goodbye to a man whose death diminishes us all, Senator William Fulbright.

He served in the Senate for 30 years. He served with distinction. Some in this Chamber had the privilege of working with him. But whether or not you served with Senator Fulbright personally, we were all touched by him. Our Nation and our world are better for him having passed through it.

Senator Fulbright understood that the most powerful deterrent to war is not bombs, not some mysterious shield we might try in vain to erect, but simply understanding.

The cornerstone of his legacy, the Fulbright scholars program, has created more than 200,000 ambassadors for peace and for progress throughout the world. These are bright young men and women who have traveled from America to study in 130 nations as well as men and women from around the globe who have come here to our Nation to learn. Our world is safer for the work of these Fulbright scholars and for the vision of the man who made their studies possible.

He was a son of Arkansas, but his influence was felt throughout the world, and it will be, I suspect, for generations to come.

Today, as we remember Senator Fulbright, it is easy to feel diminished by his passing. But let us also remember how enlarged we are by his life. As we struggle to find America's place in the post-cold war world, let us remember the lesson Senator Fulbright taught us about the formidable power of understanding. Let us also remember that America has a responsibility to be not only a military leader in this world, but a moral leader as well. And we must never shrink from either role.

William Fulbright, the "Chairman," as he was fondly known, was a diplomat, an idealist with a strong heart, an uncommon vision, a dogged fighter for what he believed was right. He was unfraid to stand against public opinion when his conscience told him he must.