

**Conference: The Call To Action On Sexual Health: Science
And Belief Seeking Common Ground:
Sexual Health and the Training of Service Professionals:
Health, Social Sciences and Religion/Theology
May 24, 2004**

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MR. WILLIAMS: Thank you so much for being here today. We have a very distinguished panel and we're going to talk about sexual health and the training of service professionals. Health, social services, religion and theology. We have a very distinguished panel. We've put a great deal into bringing you just an array of ideas on this topic. Let me introduce our first panelist here today. We're just waiting on a young lady to take her seat. I'm not going to read the entire bio, because I know we're dealing with a room of people who can read. So you can always go to the bio to complete what I've started. Could you have a seat please? You, ma'am. Just have a seat. Take any seat.

William R. Stayton is a Professor and Director of a graduate human sexuality program in the Center for Education, School of Human Service Professor Sessions at Widner University in Chester, Pennsylvania. He's a founding board member of the Center for Sexuality and Religion, an organization dedicated to facilitating dialogue between the field of sexology and various religious systems. While Mr. Stayton is going; are you going to go to the podium, sir?

Let me just tell you what the ground rules are. Each panelist will literally have 10 minutes. Ten minutes. And so that will allow 30 minutes for our distinguished panel and then

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30 minutes for the audience. You can only ask one question. You're to direct it to one panelist. You ask the question, not make a statement. If you want to make a statement, you should stay in your seat. This is a panel for questions, not for people to get on a soapbox. And we intend to respect that hear today. Okay? Ladies and gentlemen, let's give a round of Applause for our first panelist. Thank you.

DR. WILLIAM STAYTON: This is usually the sleepy time of the day. I do have pictures, so at least keep one eye open. Over my past 35 years of being in the field, it has been mostly in training professionals in the healthcare professions. I have been through a number of seminaries teaching, as well as medical schools, schools of psychology, schools of social work, schools of nursing. And in doing that, one of the things I find is that you're dealing with a broad scope of diversity in terms of cultural background, religious background and ethnic/racial background. And trying to find a methodology for training has probably the biggest part of my career. So I would like to present just very briefly within my next nine minutes, some ideas about this.

One was that it was a great addition to the field when the call to action came out. And to blend what I do with the call to action, I've developed a vision statement. To implement the call to action, to [inaudible] sexual health and

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responsible sexual behavior, the healthcare provider will have a comfort level with understanding of, and a sex positive attitude towards human sexuality, including the respect for diversity. I think this is really important and it's the guts of what I'm going to be talking about.

Part of the difficulty in coming into this area is that sexuality is a very emotional laden subject. And what we have is a lot of anxiety in our culture. You cannot get through our culture without anxiety around sexuality. Sometimes it's conscious, unconscious, pre-conscious, post-conscious, whatever. But it's there. And what's really been interesting to me, and this is anecdotal, but that some of the people who I have worked with and have the easiest experienced with, have been the most conservative people.

Because in our work they know where they're coming from. And some of the people who have had the most difficulty have been liberal people who didn't know what caught them when we went through our training program. And so I just think it's really interesting because our goal is how do we reduce anxiety, wherever it comes from. Whether it comes from our messages or whatever, our experiences; how the real key issue in education is how do we lower anxiety so that a person is not only comfortable, but educable. And so I'd like to go through.

Part of it is that we have to deal with the barriers to

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sexual health and responsible sexual behavior. And the first barrier is sexual ignorance. I love this picture because that's me. I've always been curious. The little girl is Janet. She was the daughter of my parents' close friends. But I was always curious about sex. But had very little information. My school had no sex education. My church had no sex education except don't. And I asked my parents once about sex and all I remember is that my dad got up and left the room and my mother turned to me and said, Bill, you'll know. God will tell you. So I became a minister. I went to theological school. And there I learned that sex was sinful.

So I decided to become a psychologist, and I went through graduate school and got my doctorate in psychology. And there I learned that sex was sick. So I had the double whammy. I was both sick and sinful. So I decided to become a sexologist, and my sins have been forgiven and washed away down the drain. And so my point here is that we're in a culture that values ignorance around sex. And that has been a terrible blight on our people. We don't talk about it and we don't education about it except with some fear notions usually, or with negative messages or just wait, or God will tell you, or whatever it is. But we are beset with a culture that is sexually ignorant and values that ignorance.

The second thing is that we're sexually secretive.

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Because we value ignorance, we value secretiveness around sex. So that we don't talk about it at a very deep level ever, within our families, with partners, with our children. We just; we can't talk about deepest hopes, fears, anxieties, fantasies, experiences because of the value on secretiveness. So that we bring up a generation that really cannot talk about sex at a very significant level.

The third thing is that then we're all sexually traumatized. We're traumatized by the messages we get about sex. We're traumatized by maybe religious concepts that we've been given. We're traumatized by the kind of education that we've had, even graduate education. And that we really don't talk about the issues that we live out and that we feel in our lives very easily. We don't work this through. And then if you add child abuse or rape or violations of any kind, you only compound the kind of trauma that all people get. I don't identify, by the way, with this picture. I just chose it out of, you know hundreds of pictures that I could have chosen. So I must identify with it in some way. I'll talk to my therapist about that.

So the issue comes then what are the components of training? Once we can break through sexual ignorance, secretiveness and trauma; and how do we do that? How do we break through these? Well, we've developed over the years, I

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think a concept that is an educational methodology that is reliable, valid and really works. One of the objectives in training healthcare professionals is to get them to be comfortable and educable. And a method we've been using for over 35 years is what we call a sexual attitude reassessment program or a SAR. It's an opportunity to reassess our ideas, our attitudes about sex. There is no desire in this to change anybody. The only desire in this is to get people to really look at what they feel, where they're coming from and what they can do about it. We have now developed a; we use explicit films often in this, historically. We also have developed, both at; when I was at the University of Pennsylvania and at the University of Minnesota, we had developed non-explicit SARs and found them as effective, as long as we promised the students that they'd get to see the films afterwards. But we have found very efficient and helpful ways of helping people go through this process if they are not within a value system that they would like to go through a film program.

The second thing is once we can reach that level of educability and comfortability, we can then begin to build knowledge. Before this, knowledge is merely a head trick. It's when you can get down into the soul of a person, into the core of a person, that you can really begin to make knowledge come alive and meaningful. And so we go through the second

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erotic experience of knowledge building, to help us to really think through these issues. And then finally we come to the area of skill development. Once we've reached that area of educability and comfortability and we've gotten some knowledge about what we're doing, then how do we help people to become better teachers and better clinicians? And how then can they help their clients or their students to be better lovers? To be able to communicate at a deeper, more intimate level. By the way, I wanted to read these versus here. And the first one, which was with; back with the angels; I love that. Two angels. Which the verse said let us never forget the power of love, the strength in unity and the joy of expressing our true natures. This one says your love is like the night mist. In the morning my pedals drip with desire. It's an African proverb.

But that's our goal, is to help our healthcare providers to be comfortable, knowledgeable and to be skilled in being able to help people to develop intimate, wonderful, sexual intimate lives. Whether they're single, married, partnered, however, with themselves. And not only that, but how can we help them to become better lovers, better parents and better friends. I have just one illustration of all of this. And that is you're going to be hearing from Dr. McJunkin in a few minutes, who heads up the Philadelphia Baptist

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Association. In the Philadelphia Baptist Association we have a Commission on the Ministry, whose job it is to develop guidelines for looking at clergy sexual misconduct. To develop guidelines to help churches deal with some of these really nitty gritty sexuality issues. To help our churches to develop guidelines for ordaining clergy and for being able to come into the fellowship of our churches.

And in order to do that, the commission had never had any training in sexuality. So Dr. McJunkin had me lead them in a SAR, explicit SAR. And it was an amazing experience where we dealt with value systems, coming from very, very disparate value systems. And I think it was successful and profoundly helpful.

MR. WILLIAMS: Well, that was entertaining. It had me a little uptight there for a few moments, but that's okay. I'll get over it. It's good to be made to feel uncomfortable. That's the good thing about life. I'm here to grow too. Thank you, Dr. Stayton, you knew exactly what you were doing. Jim; thank you. You're quite entertaining man. I've got to give it to you. There's a place for you in Hollywood.

Jim Baggot is a medical doctor who finished his OB/Gyn; I'm a little more at home now, you know; I was a little uptight in the beginning; his residency at Mt. Sinai Hospital in 1992. He completed a maternal/fetal medicine fellowship, and a

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medical genetic fellowship, before becoming a certified family planning medical consultant from the Pope Paul VI Institute in 1997. If his presentation is anything like our first, we are really in for a treat. Doctor, you're up next. You're on. Dr. Baggot. Let's give him a round of applause.

DR. PADDY JIM BAGGOT: The problem. What we've been hearing today is that we have numerous sexually transmitted diseases in our society and sex. Twenty-five percent of college age females have one single sexually transmitted disease, that being HPD or human papilloma virus. One-half of pregnancies are unintended. One-third of pregnancies are aborted. And you know, how many abortions are wanted? Respect for women is falling. We have exploitive and coercive sex is increasing.

Conventional solutions. We have for sexually transmitted diseases, condoms and antibiotics have been promoted and proliferated. For unintended pregnancies, contraception and abortion. For exploitive and coercive sex, legal punishment. Solutions like these have been exhaustively promoted in sex education, school based clinics, doctors clinics, billboards, media. All of these solutions have been scientifically validated. All these solutions are so good and so scientifically validated that; they should be so effective that we should have never met anyone in the last 10 years with

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any of these problems. But that's not where we're at, otherwise we wouldn't be here.

Why are we here? Since 1960, the problems have increased steadily and dramatically. Since 1960, the solutions have increased steadily and dramatically. It doesn't seem to be working. Are we missing something important? Could we be trying to drown fire with gasoline?

Why it doesn't work. Let's say some examples from many peoples' personal experience. Attraction between a young man and a woman could develop. They engage in casual sex. Unbeknownst to them, this could extinguish the love they feel for each other. Then they would feel unfilled and work into a pattern of serial monogamy, constantly seeking a new partner that will have true lasting love for them. But the truth is they're extinguishing it themselves. This results in broken hearts, lost innocence, feelings of being exploited, and they're unable to find true love.

Or we might have an ongoing relationship, and one of the partners wants to know is this true love or he just using me for sex. We could test this with a pregnancy. The results might be keep the baby and have a shotgun marriage with increased divorce rate, or an out of wedlock birth, or abort the baby, abort the love, resulting in psychological damage and a cycle of replacement pregnancies and repeat abortions.

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Something has been missed. Was this crisis predicted and by whom? And does that person have a recommendation for the solution we need? The prophecies of Pope Paul VI in 1968 in a widely denounced, one of the most widely denounced documents in modern history [inaudible]. He said that if contraception became widespread, then what we would see is an increase in adultery, men would lose respect for women, men would treat their bodies as machines, governments would control population coercively and we would see a broad and general decline in societal morality. Can anyone doubt that he was right? Thank you.

But he would not have been alone if we had consulters that consulted others. They would have agreed with him. Luther, Calvin, Wesley and Knox all major protestant theologians before 1900, all popes, Moses himself and even Mahaut Mugandi [ph?], would have all agreed with Pope Paul VI as what would happen if we had widespread conception.

So let's go back to the ancient, deeply held religious principles founding our society and see if we can learn something. The Orthodox Church practice what's called Neid [ph?] or family purity in most of the Old Testament, recommended that married couples should abstain from intercourse for the first 10 to 14 days of the menstrual cycle. And that's a lot of abstinence. The results would be

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abstinence would make the heart grow fonder. The spouses would have increased attraction for each other. In the beginning of each month they would have a perpetual courtship, followed by a perpetual honeymoon each month, which is increased happiness at reunification. This resulted in increased respect of men for women. And the wife is no longer a sexual convenience.

Natural family planning is in modern Christianity, somewhat different in purpose, but reestablishes periodic abstinence as a benefit to either marriage, in permanent abstinence, even the single life. It can be used to achieve pregnancy or to avoid it. Results in increased spousal respect, love and communication. The things that Dr. Stayton was saying that couples ought to be able to discuss with each other. And that's what family planning; couples, they do discuss with each other and they communicate very well, as reviewed in the extensive book of Dr. Mary Shivanandan in Crossing the Threshold of Love.

This has also been integrated into modern gynecology, at the request of Pope Paul VI himself. And it has a lot of beneficial effects. We can compare either birth control pills or our general population on the left side, with natural family planning on the right side. If used correctly, both are highly effective to prevent pregnancies, if that's your goal, 99.5%. But on the right side, the abortion rate in couples using

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natural family planning is less than 1% and yet in the general population it's; you know, pick your number, 20%, 30%, 40%. The divorce rate, as we've heard today, whatever it is, it's very high. But among natural family planning couples 1% to 2%, this is; there's now three studies demonstrating that. In my personal anecdotal experience, couples using hormonal contraceptives of any sort have high rates of sexually transmitted diseases. Among couples using natural family planning, it's at most rare.

This has also been applied to the problem of teen pregnancy. And I would like to call everyone's attention to Sister Dr. Hannah Clause, maybe the only Catholic nun who's an OB/Gyn. Right here in Washington, D.C. at a junior high school, she had a junior high school; on the left under the before column, a junior high school grades seven to nine with pregnancy rates of 95%. That's pretty high. But her intervention was to teach these natural family planning and responsible sexual behavior for which I could substitute chastity. And after that, she found the pregnancy rate of 5% and a virginity rate of 50%. Now, finding a virginity rate of 50%, that could be impressive. And certainly it would be impressive in that junior high school.

So in conclusion, chastity, true love and deeply held beliefs can be and must be integrated into our modern

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gynecology and other professional disciplines. Inner-disciplinary dialogue should not ignore the disciplines of the foundations of wisdom in our society, i.e., deeply held beliefs. Inner-disciplinary dialogue has great potential of solving pressing problems today because others may have the solution that we need. Thank you.

MR. WILLIAMS: Look. I'm really feeling at home now. You can interpret that any way you'd like by the way. Yes, sir. I'm feeling it now. I'm about to take my shoes off. I'm going to tell you doctor, you keep surprising me. Last but not least, because I know you guys have so many questions that you'd like to ask, and no statements to make. The [inaudible] J.E. McJunkin, is a graduate of [inaudible] College, Ashland Theological Seminary and New York Theological Seminary. He has served the last two years as the Executive Minister of the Philadelphia Baptist Association, which is comprised of 120 [inaudible] in metropolitan Philadelphia. I'll tell you. This guy has probably one of the most diverse congregations in the country in terms of people who attend his church.

So it'll be very interesting to hear a [inaudible] perspective on this issue. [Inaudible].

DR. JAMES E. McJUNKIN: Good afternoon everybody.

MR. WILLIAMS: And good afternoon to you.

DR. JAMES E. McJUNKIN: Dr. Satcher and persons who

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have organized this day, I really appreciate the invitation to be here and I'm going to try to move quickly through the presentation that I have for you. I am Executive Minister of the Philadelphia Baptist Association. It's one of 36 American Baptist regions in the United States, and the oldest Baptist body in the United States. We'll be celebrating our 300th anniversary in 2007. And we're comprised of 128 autonomous congregations in urban and suburban settings. We have great diversity. We're across a five county area. Our theological sweep is spread, it's probably from conservative to liberal, depending on how you define it. Varied racial/ethnic constituency. Varied social/economic background.

So one of the things that I discovered very early after taking the job was it really didn't matter what I thought about anything, there was always somebody on the other side. And you know, the question becomes how seriously you want to take it. No matter what statement I make or what opinion I share, it doesn't with someone's perspective that's a significant part in the meaningful part of our association. So I don't have the opportunity to gloss over anyone, but I have the challenge of trying to figure out how to help people belong to an organization in which they have to live with diversity for which sometimes makes them feel uncomfortable. And we do that by fostering Baptist quality and affirming and tending to this

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[inaudible] through regular review and interpretation.

In short, we have to encourage people not to engage in polarity thinking, thinking that it's this side versus this side. And help people to come to a benevolent understanding truth, maybe somewhere in the middle. It's very rarely all this or all that. And so I enjoy that experience.

When it comes to dealing with sexual health issues, the strategy that I put in place was to recruit professionals, people of faith from our congregations, who could help us interpret the issue to our diverse constituency. So therefore, Dr. Stayton and others are among those who we turn to and say look, we're trained as theologians. I'm a theologian. I'm a preacher. I'm a church administration. And I'm a [inaudible] to understand why the church does what it does based on the theology. But I am not an expert in teaching people about sexual health. And I don't try to pretend to be one. So what I need to do is to have people that I can trust, believers like myself, or persons of good conscious, who want to come, sit down, help us to unpack the issues and learn how to be in dialogue.

So we recruit to our various committees, the kinds of skills that we need to work with people. Pastoral counselors, educators, social workers, physicians, nurses, and clergy. And I want to go back to that clergy one, one last time and hit it.

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We make an assumption whenever we deal with clergy that we're supposed to be able to understand everything and everybody. Once after getting after seminary, I designed all kinds of programs for community based ministry. And I had to work very hard to understand the language of social work community, psychologists and others. But the ability for those disciplines to reach back and talk to me, understanding how faith develops, doesn't often seem to be equal.

So if we want to talk about common ground and moving head, I think we need to learn how to talk across disciplines and learn how to trust each other a little bit more.

I'd better get to this one. One of the things that we've done is a model with our association, is to have regional dialogue sessions on sexual health issues. We've completed the first one, gay and lesbian sexuality. Now, remember I told you we're Baptist. And we had a successful day. Well attended. I even saw persons with tears in their eyes because the first time they came together across the isle and nobody shouted at them, insulted them, but they really worked to listen and to hear the differences of perspectives.

One of the things that was important for us; well, I'll get to that later. We're going to go to single persons and the ministry in the church. And actually we got a lot of conversations about folks that are married. Well, we've got a

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lot of folks who are single and don't intend to be otherwise. Impact of popular media on the understanding of sexuality and sexual behavior among teens and young adults in our congregation was another discussion that we had to have. All of these can be emotionally charged issues. Women in the expression of their gifts. And then I like this one, the socialization of boys and men with regard to self perception. Being men of faith, self care and nurturing families. This has to get back to the disparity in healthcare. Also one of the things that I had to say very early on was that we couldn't get men to take care of their health. And how do we get them to talk about that and what is it; how is it that we are socializing, that we can't get the men in our church to go to the doctor and take care of themselves, or take care of their families.

Key components. We often training through to clergy to facilitate dialogue in emotionally charged topics. One of the ways that I disagree with many of you all is that I don't see these issues as deeply held. I see them as emotionally charged. They're passively held. They're not understood, but they're deeply, emotionally charged. And so you have to find a way to do that.

And we [inaudible] to discuss controversial issues without making official statements. We don't want to get into

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the battle. Well, what do Baptists believe? Well, we believe a whole lot of things and here's some of them.

And [inaudible] theological reflection on the tradition and practices of the creation in church. Highlight opportunities for persons of faith to understand the perspective of the believer. This is important. Some people don't get to hear other folks. We tend to group in pockets of sameness. Social economically, wherever else. And they don't get a chance to talk across the isle and hear somebody else that shares the same kind of faith as they do, and understand that there is a difference in perspective and that we all have Christianity or our faith in common.

This is the Commission that Dr. Stayton was telling you about on which he helps us to look at standards with regard to ordination and the ethics of clergy. And we are working diligently to review now our policies. And we want to try to look at the issues that the church itself is facing, i.e., sex abuse and you know, occurrence of sex abuse in the congregation because of staff people, that kind of thing, as well as issues that pastors have to deal with when they relate or counsel their constituents.

The last slide for me I think, closely anyway. These are issues that our church is working on. This is not qualitative, it's quantitative. We need more help from good

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people like you to get these conversations more substantive. For me that's the common ground. I can't teach this. I need help from people who are sensitive to the folks I'm charged to work with, to come in and help them understand these issues and have a discussion about it and make a responsible decision. Strengthening families. That's something our church is definitely concerned about. Access to healthcare services. Domestic violence. Elimination of the racial and ethnic disparities in health. Targeting resources [inaudible] is a big one. We have people who [inaudible] like that, but; and want to come into our churches to talk a bit about it because they want to sell some kind of medical product or insurance. [Inaudible] funding to really go in and help people do education around health issues and disparities, is short in supply. And if we can find a few R.N.s or doctors or whatever in our churches, we can get people to talk to folks about that kind of issue. Unintended pregnancy. Prevention of sexual abuse and coercion. Addition and recovery programs. We don't have as many of those being developed as we need to have in our community. And with that I'm going to end my comments and say thanks for your attention.

MR. WILLIAMS: Okay. This is the fun part. Where's the mic? Did they go for a mic? Is there a mic? Here's how we're going to do it. We're going to go in the order from left

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to right. You ask a question. No person will be asked the same question --

[TAPE CUTS OUT]

MALE SPEAKER: -- overall and published rates of fertility awareness are far different from yours than in Princeton and Georgetown. Where are your data coming from?

DR. PADDY JIM BAGGOT: Thank you. Okay. Thank you for the question. There's quite a lot of confusion around the issue of what is the effectiveness of natural family planning. One still today, in modern America, sees statistics in major textbooks saying that it's basically worthless. There's a article in the British Negetal [ph?] journal by Rider, 1994, reviewing approximately 30 solid studies on the effectiveness of the ovulation method of natural family planning. There are studies with as many as 20,000 poor, illiterate women in; one study has 20,000 poor illiterate women in northern Indian, one-third Muslims, one-third Hindus, one-third Christians, 99.8% effective. So it's unclear why the false notion that it's not effective persists and despite; you know, if we've got 30 solid studies, how many more studies would it take for people to get the point? There is a recent study, or a review of five more studies by Hilgers [ph?] in the *Journal of Reproductive Medicine*, 1998, reviewing 1,800 couples, 17,000 a couple of months, effectiveness 99.5%. How much more data does it take?

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MR. WILLIAMS: Thank you. I want to make sure we go to both sides here. Please. I'm not just going to stay on this side. We're going to both sides. Yes?

MS. SONYA CANDICE: Hi. My name is Sonya Candice.

MR. WILLIAMS: Who are you directing your question to, ma'am?

MS. SONYA CANDICE: Oh, it's to Dr. Baggot. I'm sorry. I think you're getting a lot of them.

MR. WILLIAMS: Oh, no, no, no. Not Dr. Baggot. This is directed to someone else. Who has a question for someone else? He just answered; we want to mix it up.

MS. SONYA CANDICE: It's a data driven question. It is a data driven question.

MR. WILLIAMS: You know what? The majority rules. Okay? I don't want you mad at me. Ask the question.

MS. SONYA CANDICE: Thank you. I appreciate that.

MR. WILLIAMS: Okay. No problem. All right.

MS. SONYA CANDICE: Dr. Baggot, you had spoken about the difference in abortion rates between contraceptive users and natural family planning users. And I wanted to ask if the difference in the lower number of abortions in the natural family planning users might be a reflection of the construct of the perception of belief about abortion in that population, rather than simply the notion that natural family planning

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actually causes or you know, less abortion. So I just am curious about the [inaudible].

MR. WILLIAMS: Thank you.

DR. PADDY JIM BAGGOT: Well, you know, it's hard to get objective data on motivation. That's possibly one very good reason. Another very good reason is that when you're doing natural family planning, you're making the decision whether to conceive or not before you actually get pregnant. So maybe you've made the decision that you're either willing or not willing to accept a child at this time before you wind up pregnant. So that could also be a reason.

MR. WILLIAMS: Thank you, Dr. Baggot. The lady in red. Could you stand? And always state your name and where you're from please.

FEMALE SPEAKER: [Inaudible].

MR. WILLIAMS: Could you bring a mic that works?
[Inaudible]. Okay. Go ahead.

FEMALE SPEAKER: [Inaudible]. You spoke to the unintended pregnancy in the United States on married couples, not in teenagers, mostly married couples. And since in the United States we cannot talk about prevention of sexually transmitted infections or methods of birth control, what do you see as the answer?

MR. WILLIAMS: Dr. Baggot again, I see.

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FEMALE SPEAKER: Dr. Baggot. Yes, sir.

MR. WILLIAMS: Okay. Dr. Baggot?

DR. PADDY JIM BAGGOT: For clarification, could you restate the question?

FEMALE VOICE: I want to know what you see as the answer since most of the intended pregnancies in the United States are in married couples. And since we cannot talk about prevention of sexually transmitted infections or methods of birth control in schools in the United States, what do you see as the answer so we don't have all of these unintended pregnancies occurring in years down the way?

DR. PADDY JIM BAGGOT: Well, I would say that the data of Dr. Hilgers would clearly show, if you want to prevent unintended pregnancies and especially you know, how many people would actually intend an abortion, the data of his would suggest if you really want to prevent unintended abortions, you should use natural family planning.

If we want to address the question to the premarital or the teenage situation, then I would certainly agree with you that sex is not just limited to teenagers, and nor are the problems thereof. But if you would ask the same question about the teenagers, the data of Sister Dr. Hannah Clause is very interesting. And you know what's kind of interesting about hers is she's given her courses in many areas around the world,

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but most of her courses are outside of the United States. I think we need more of those courses in this country.

MR. WILLIAMS: Thank you. No follow up. This side. [Inaudible]. No. It doesn't matter. We go [inaudible] that side. We're going right through here. Go ahead, sir.

MR. DON DICE: My name is Don Dice [ph?] and I teach at the Widner University program in human sexuality and I work for the New Jersey Department of Health and Senior Services in the STD program. My question is for the whole panel, but Dr. Satcher, because you're making me pick someone -

MR. WILLIAMS: No, no, no. [Inaudible] the panel; the three people [inaudible].

MR. DON DICE: But everyone except for Dr. Baggot can answer; no, I'm just kidding.

MR. WILLIAMS: Okay.

MR. DON DICE: My question is this. Since this is supposed to be a panel and a discussion on finding common ground, and this is specifically on training healthcare professionals, my question is what skills are all of you teaching professionals, whether they be doctors or clergy or educators, for working intentionally with people's strongly held beliefs, rather than running from them, which I see so often, into either objective science or into dogma?

MR. WILLIAMS: Dr. McJunkin? Please. Thank you for

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your question.

DR. JAMES E. McJUNKIN: Thank you. One of the things I've been working with my staff on for the next couple of weeks is to look again at the work of Fallers and stages of faith, so that we can understand how it is that people come to faith and how they derive meaning. And the purpose of that is to teach our staff to be able to work within a diverse constituency, respecting each group for the way that they organize their thoughts, where they are in the journey, where they are in whatever stage that they're in, and how to have authentic relationship with them that is respectful and to shape messages in a way that they'll hear it. So whether I want to talk; if I want to talk about something about sexual health, I'm not going to go to a liberal congregation with the same kind of information that I would take to a conservative one. I want to have an authentic relationship, not to be double-minded or doublespeak, but to know who it is I'm talking to and what they respond to, what they care about.

MR. WILLIAMS: Dr. Baggot, you wanted to respond also? Did you?

DR. WILLIAM STAYTON: What I would like to respond -

MR. WILLIAMS: You did. Okay. Okay.

DR. WILLIAM STAYTON: - if I can get a microphone -

MR. WILLIAMS: Sure.

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DR. WILLIAM STAYTON: - that works.

MR. WILLIAMS: Sure.

DR. WILLIAM STAYTON: Is that working?

MR. WILLIAMS: [Inaudible]. Yes, please.

DR. WILLIAM STAYTON: Okay. One of the things I found in working over the years with the deeply held systems or however you; I like the way you said it; is that you have to find out if the person or; help them to understand where they're coming from. Are they coming from looking at sexual behaviors as being moral or immoral or are they looking at relationships and the motives and consequences of behaviors that are moral or immoral? There are very, very different moral value systems. And what's important to me in working with people is that they both understand where they're coming from and that they understand where another person, who is also a person of faith, is coming from. And that somehow they have to find middle ground, but knowing where they're coming from and where the others are coming from.

The difficult person is the person who is in the middle and trying to pick A here and B here from this column. And it just doesn't work because they can't figure out where they're really coming from.

MR. WILLIAMS: Thank you, Dr. Stayton. Right here. State your name and where you're from please.

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MR. DREW MADISON: I'm Drew Madison. I'm President of the Society for [inaudible] Human; Scientific Study of Human Sexuality. And –

MR. WILLIAMS: Who are you directing your question to?

MR. DREW MADISON: To Dr. Stayton.

MR. WILLIAMS: Okay. Dr. Stayton.

MR. DREW MADISON: Reverend, McJunkin, you talked about your wonderful openness about wanting to get practical, good information on human sexuality. Dr. Stayton, what are some more practical things that you do to keep this process going, to keep the counsel moving forward on implementing the call to action?

DR. WILLIAM STAYTON: Well, one of the things is looking at the various issues that the faith communities are facing. Gay and lesbian issues is a big one. Bisexual transgender issues are a big one. And one of the things we do is have what I like to call exposure events. That is that one of the best ways in working with people is helping them to meet people with a face and with a voice and with a name. And to be able to converse with them and see that they are also people with deeply held feelings and beliefs. And that that is one of the greatest breakthroughs I think in working in this field.

MR. WILLIAMS: You know, it's so good that I'm the moderator today and I'm not giving my opinion. I'm really

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happy. Yes? Please. And I'm going to stick to that. I'm going to only moderate and let the panel speak. Please.

MR. WAYNE POLOWSKI: Wayne Polowski [ph?], sexuality educator and clinical social worker. And this is directed towards Bill Stayton. I'm increasingly concerned with the growing phenomenon of allowing trained licensed professionals to let their personal attitudes and values take precedence over their professional responsibility. For example, licensed pharmacists who can opt out of filing prescriptions for pills or emergency contraception for single women. First of all, do you agree that this is a problem and secondly, if it is, what should we be doing about this in professional education?

MR. WILLIAMS: Thank you.

MALE SPEAKER: Who was it directed to?

MR. WILLIAMS: Dr. Stayton.

DR. WILLIAM STAYTON: Yes. I absolutely think this is wrong. And I think that one of the things that we need to do is to begin to educate in the area of pharmacists so that they also begin to develop a comfort level and understanding and education and skills on how to deal with these issues.

MR. WILLIAMS: [Inaudible].

DR. JAMES E. McJUNKIN: I want to get in on that one because this goes to again; an issue that troubles me is that people who don't bother to examine the theological assumptions,

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or understand their own beliefs, often get in the public arena and make statements that sound spiritual-like and they say it's because I'm a believer that I do this. And they kind of give a black eye to the rest of us who are trying to work a little bit more deeply in understanding why we do what we do and how we relate to people.

So it just gets to be an issue for me that we can be so simplistic. You all talk about studies and the best information and the best data and the best research, but we don't spend any money understanding how it is that someone's belief helps them to become motivated for effective change in their life. This is a significant issue for me because I often hear professionals who are very well trained, sound like Sunday School 101 when it comes to discussion of their beliefs and their religion.

MR. WILLIAMS: Quickly, Mr. Baggot.

DR. PADDY JIM BAGGOT: A flipside of what the gentleman described, he's talking about people refusing based on their conscious, to do things which they think are wrong. It could be that maybe that's what we ought to be encouraging. It could be that; many people think that we've a general decline in societal morality going across all of our professions, and if we could find somebody who would stand up for what's right at whatever personal sacrifice, I'm sure those pharmacists might

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have lost their jobs or something like that; we ought to applaud them rather than trying to coerce them into doing what we think they should do.

MR. WILLIAMS: Thank you. And to go in the back and then move towards the front again because we've sort of been just focusing on the front. Ma'am, state your name please.

MS. KATHLEEN SULLIVAN: Kathleen Sullivan from Project Reality based in Chicago. A national abstinence organization. I was wondering just exactly who the funders are for your work, Dr. Satcher, ongoing work right now, and do you intend to apply for federal money, tax money, to implement or carry on whatever comes out of this meeting today?

MR. WILLIAMS: Well, you know what? Ma'am, the questions are for the panelists. No disrespect to you. We want to stick with the subject ma'am. If you want to deal with that, after this panel goes, that's fine. Ma'am, do you have a question for anyone on the panel? Thank you. Sorry about that, Dr. Satcher, but we're going to stick with the program here today.

MS. TRACY POSTSLICKER: My name is Tracy Postlicker [ph?]. I'm with the Robertwood Johnson Human Sexuality Program, UMBNJ. I used to work at Planned Parenthood and use natural family planning to plan pregnancies. One oops. And my question is for; well, [inaudible] who I ask, for Dr. Stayton

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who I've worked with. How do we move past; I mean this is phenomenal day, Dr. Satcher, I appreciate it, to have all these people from so many different walks of life, people I would never have sat across the table and eaten lunch with and discussed these issues, abstinence only programs, Planned Parenthood all together, how do we move now from lunch to creating a space where we cannot only talk and just say here's my rhetorical position, here's mine but really working together, because as we've heard throughout the day, people are dying, children are dying. Where do we go now? What's our next step? Instead of just walking out of the ballroom feeling frustrated or angry, where do we go?

MR. WILLIAMS: Thank you.

DR. WILLIAM STAYTON: That's a great question because that's what this is all about. What we're trying to do is to get this dialogue going, that's going to move from talking to action. And we're going to have to work together as a community. And that what we want to do is to get people talking about these issues in a comfortable way where emotions don't take over. But understanding, based upon best science does.

MR. WILLIAMS: Thank you. I'm going to still; I'm going to get to you, ma'am. Don't you worry. Over here. I want to keep it fair. It's important. Sir, where are you

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from?

MR. EARL FOX: Earl Fox. I'm an Episcopal priest from Alexandria Virginia.

MR. WILLIAMS: Yes?

MR. EARL FOX: For Dr. Stayton. You've talked; well, we've all talked about deeply held beliefs and the dialogue going on between us and so forth. Attila the Hun had, I'm sure, I've never met the man, but I'm sure he had deeply held beliefs. Hitler had deeply held beliefs. How do we decide which people, whose deeply held beliefs we do not accept in the dialogue, if any, and do not; we have to have some concept of objective truth in order to do that.

MR. WILLIAMS: [Inaudible] right after that. That's a reasonable question.

DR. WILLIAM STAYTON: It is a good question. I think that there are some universal, moral principles that we find every good faith community throughout the world would hold to. Love, respect, understanding, education. I think that there are some moral principles of not hurting another person or abusing or violence that's unnecessary or done. I think that that's what we need to appeal to because if we take all the difference systems around, we're going to keep the confusion going. But there are, I'm sure, if we go to our universal systems, we're going to find universal morals. I was really

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impressed with Dr. Mohammed yesterday, talking to us about Islam. And so many of us say oh yes, you know, that's true. And we began to have some common ground even though on some of the others we didn't agree.

MR. WILLIAMS: Please.

DR. JAMES E. McJUNKIN: I'm concerned about deeply held beliefs to the degree that they help persons to live a healthy lifestyle, healthy lives. I want to know how people come to the decisions. I want to know how faith in a religious system interacts, and they come to conclusions about the way that they should live and the way that they should act. So that's when I hear the word deeply held beliefs, that's where I clue in. That's why I said in my presentation that most people's faith is very tacitly held because they don't know why they come to conclusions that they do. They don't spend time in introspection or in [inaudible]. They tend to believe whatever the group that they identify with is. Whether it be a political etiology or theological perspective, it's largely unexamined. And that is a part of the discussions that we need to have.

MR. WILLIAMS: In the back. Thank you.

MS. LESLIE WATSON: Thank you. My name is Leslie Watson and I'm the Director of the Black Church Initiative for the Religious Coalition for Reproductive Choice. And my

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question is directed toward Reverend McJunkin. And I'm wondering, Reverend, if we in training persons within your congregation or within your denomination in the region, to do this kind of work and recognizing the importance of this kind of work, what kind of suggestions or thoughts would you give to persons such as myself, who do training for members of a congregation who are not, as had been noted, not all of them have degrees in sexuality education, not all of them have expertise in sexology, but just everyday folks who are working with, who are trusted by members of their congregation, especially when you recognize that whether it's a teen or an adult, that a member of your congregation can come to you and say pastor, teacher, minister, leader, teach me, tell me what; excuse me; if you want to say my soul, teach me the words, but if you want to save my life, teach me how to use a condom.

DR. JAMES E. McJUNKIN: I think I caught the intent. I think it has a lot to do with relationships. For persons who do the kind of work that you do, getting to know leaders of congregations, spending the time, investing the time to get to know them, to build trust, to open up dialogue, will get you access to people. And you can come alongside members of the congregation as an education within the congregation and provide additional information and resources. But we tend not to invest in building relationships and getting to know people.

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MR. WILLIAMS: One last -

DR. JAMES E. McJUNKIN: Trust gets you -

MR. WILLIAMS: I'm sorry.

DR. JAMES E. McJUNKIN: - access to folks.

MR. WILLIAMS: One last question. Yes, ma'am?

MS. IRELAND MILLER: [Inaudible] answer my question.

I'm Ireland Miller, a psychologist. I don't know about statistics. I don't know too much about pastoral things, but I do know the influence on everybody of the media, of the internet, of the porno films. I don't know how anybody on any of the panels really feels that they have the power, stronger than the media and the influence of the media. And I think that's what is missing in terms of our addressing this. Cyber sex, sexual addictions. These are the things that are really big right now. What are we going to do about it?

DR. WILLIAM STAYTON: Can I answer it?

MR. WILLIAMS: Yes, please.

DR. WILLIAM STAYTON: You know, maybe some of what's intended as sex education might be perceived as sex promotion. And maybe in our society we have a widespread problem of sex addiction. We could say that we had a President with sex addiction. We have a lot of people who have sex problems.

MR. WILLIAMS: Please. Respect please. It's just his opinion. Go ahead.

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DR. WILLIAM STAYTON: And so maybe we should, you know, as ourselves if this is also a problem and maybe we should address it in the way that we address the other addictions.

MR. WILLIAMS: Well, I want to in close, I want to really give our panel a round of applause. You know, this has been a very interesting experience for me. You know, I come from the old school. Call me crazy, I'm just old fashioned. I believe in moral absolutes. I believe there's a right, there's a wrong. You can make people feel good, you can make them happy, but in the end there's accountability and responsibility for your actions. And let me tell you, [inaudible] from the beginning of time that remains true to today. And let me; [inaudible]. Thank you very much. I can have that. Thank you. I don't know about you, but the Ten Commandments still live with me. You all have a good day. Yes, it does.

DR. DAVID SATCHER: Could I have the mic on five please? Is it on? Thank you, Mr. Williams.

MR. WILLIAMS: You're quite welcome.

DR. DAVID SATCHER: Thank you. All right. And thank all of the panelists. What we are really hoping, although you've had a long day, that you will now participate in our breakout groups. It gives you an additional opportunity to have input, it gives us an opportunity to get your input. So please; quiet back there if you would. Folks. Please. We

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have to give just quick instructions about what's going to happen next. For the facilitators, let me point out that all of the folks who are facilitating in these breakout rooms, are volunteers. They stuck around, came early for extra training, not in facilitation, but so that all of you would have the same kind of experience in your breakout sessions. So be good to them, okay? That's number one.

Number two, they're going to have about the same ground rules we've had for the day. And they've been asked to take you to a certain exercise with certain questions so that we can get a consistent kind of response.

A couple of messages to the facilitators themselves. Two new things. One is that there is sign-up sheet. We ask you to send that around to everyone in the breakout room. And two, your summary sheets will not be on the large flipcharts. They will just be on ordinary white paper, and then we're going to project them from the back.

[END RECORDING]