

Barr	Hansen	Paul
Barrett (WI)	Hastings (FL)	Pease
Bartlett	Hastings (WA)	Peterson (MN)
Barton	Hayes	Petri
Bass	Hayworth	Pickering
Bateman	Hefley	Pickett
Bentsen	Herger	Pitts
Berkley	Hill (IN)	Pombo
Berry	Hill (MT)	Portman
Bilbray	Hilleary	Pryce (OH)
Bilirakis	Hilliard	Radanovich
Bishop	Hinojosa	Ramstad
Bliley	Hobson	Regula
Blunt	Hoekstra	Reyes
Boehmer	Holt	Reynolds
Bonilla	Hooley	Riley
Bono	Horn	Rivers
Boswell	Hostettler	Rodriguez
Boucher	Houghton	Roemer
Boyd	Hulshof	Rogan
Brady (TX)	Hunter	Rogers
Brown (FL)	Hutchinson	Rohrabacher
Bryant	Hyde	Ros-Lehtinen
Burr	Isakson	Rothman
Burton	Istook	Roukema
Buyer	Jackson-Lee	Royce
Callahan	(TX)	Ryan (WI)
Calvert	Jefferson	Ryun (KS)
Camp	Jenkins	Salmon
Canady	John	Sandlin
Cannon	Johnson, Sam	Sanford
Chabot	Jones (NC)	Saxton
Chambliss	Kaptur	Scarborough
Chenoweth-Hage	Kasich	Schaffer
Clement	Kelly	Scott
Clyburn	Kilpatrick	Sensenbrenner
Coble	Kind (WI)	Shadegg
Coburn	King (NY)	Shaw
Collins	Kingston	Shimkus
Combust	Klecza	Shows
Condit	Knollenberg	Simpson
Conyers	Kolbe	Sisisky
Cooksey	Kucinich	Skeen
Cox	Kuykendall	Skelton
Cramer	LaFalce	Smith (MI)
Cubin	Lampson	Smith (NJ)
Cunningham	Largent	Smith (TX)
Danner	Latham	Smith (WA)
Davis (FL)	LaTourrette	Souder
Davis (VA)	Lazio	Spence
Deal	Leach	Spratt
DeFazio	Lewis (CA)	Stearns
DeLay	Lewis (GA)	Stenholm
DeMint	Lewis (KY)	Stump
Deutsch	Linder	Sununu
Dickey	LoBiondo	Sweeney
Doggett	Lucas (KY)	Talent
Doolittle	Lucas (OK)	Tancredo
Duncan	Maloney (NY)	Tanner
Dunn	Manzullo	Tauscher
Edwards	McCarthy (NY)	Tauzin
Ehlers	McCollum	Taylor (MS)
Ehrlich	McCrery	Taylor (NC)
Emerson	McDermott	Thomas
Everett	McGovern	Thompson (MS)
Ewing	McHugh	Thornberry
Fletcher	McInnis	Thune
Foley	McIntosh	Thurman
Ford	McKeon	Tiahrt
Fossella	McKinney	Trafficant
Fowler	Meek (FL)	Turner
Franks (NJ)	Menendez	Udall (NM)
Frelinghuysen	Metcalf	Upton
Frost	Mica	Velazquez
Galleghy	Miller (FL)	Vitter
Ganske	Miller, Gary	Walsh
Gibbons	Mink	Wamp
Gillmor	Moore	Watkins
Gilman	Moran (KS)	Watt (NC)
Gonzalez	Moran (VA)	Watts (OK)
Goode	Nethercutt	Weldon (FL)
Goodlatte	Ney	Weldon (PA)
Gordon	Norwood	Weller
Goss	Obey	Wexler
Graham	Ortiz	Whitfield
Granger	Ose	Wicker
Green (TX)	Oxley	Wilson
Green (WI)	Packard	Wolf
Gutknecht	Pallone	Wu
Hall (OH)	Pascrell	Young (AK)
Hall (TX)	Pastor	Young (FL)

□ 1450

So the amendment was rejected.
The result of the vote was announced
as above recorded.

PERSONAL EXPLANATION

Mrs. NORTHROP. Mr. Chairman, I was unavoidably detained and unable to record a vote by electronic device on the LaHood amendment to H.R. 2418. However, had I been present, I would have voted "no."

I was unable to cast a vote on the DeGette amendment to H.R. 2418. Had I been present, I would have voted "aye."

I was unable to cause a vote on the Luther amendment to H.R. 2418. Had I been present, I would have voted "no."

The CHAIRMAN pro tempore (Mr. EWING). It is now in order to consider Amendment No. 4 printed in House report 106-557.

AMENDMENT NO. 4 OFFERED BY MR. BARRETT OF WISCONSIN

Mr. BARRETT of Wisconsin. Mr. Chairman, I offer an amendment.

The CHAIRMAN pro tempore. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 4 offered by Mr. BARRETT of Wisconsin:

Page 28, after line 3, insert the following subsection (and redesignate subsequent subsections accordingly):

"(c) GRANTS TO STATES.—The Secretary may make grants to States for the purpose of assisting States in carrying out organ donor awareness, public education and outreach activities and programs designed to increase the number of organ donors within the State, including living donors. To be eligible, each State shall—

"(1) submit an application to the Department in the form prescribed;

"(2) establish yearly benchmarks for improvement in organ donation rates in the State;

"(3) develop, enhance or expand a State donor registry, which shall be available to hospitals, organ procurement organizations, and other States upon a search requests; and

"(4) report to the Secretary on an annual basis a description and assessment of the State's use of these grant funds, accompanied by an assessment of initiatives for potential replication in other States.

Funds may be used by the State or in partnership with other public agencies or private sector institutions for education and awareness efforts, information dissemination, activities pertaining to the State organ donor registry, and other innovative donation specific initiatives, including living donation.

Page 28, line 12, strike "\$10,000,000" and insert "\$15,000,000".

The CHAIRMAN pro tempore. Pursuant to House Resolution 454, the gentleman from Wisconsin (Mr. BARRETT) and a Member opposed each will control 10 minutes.

Mr. BLILEY. Mr. Chairman, I rise to claim the time in opposition, although I am not in opposition.

The CHAIRMAN pro tempore. Without objection, the gentleman from Virginia (Mr. BLILEY) will control the time in opposition.

There was no objection.

The CHAIRMAN pro tempore. The Chair recognizes the gentleman from Wisconsin (Mr. BARRETT).

Mr. BARRETT of Wisconsin. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, this amendment provides a direct mechanism to foster State organ donor awareness, public education and outreach activities and programs designed to increase the number of organ donors within the State, including living donors. Stated simply, the amendment provides a financial incentive for States to tackle creatively the challenges inherent in organ donation awareness and education.

States can play a pivotal role in organ donation success, despite the huge geographic variations and differences across State lines. This amendment authorizes direct grants to States and allows partnerships with other public agencies or private sector institutions within States to mutually undertake organ donation activity.

Under this amendment, States must submit applications in the form prescribed by the Secretary of Health and Human Services and shall establish yearly benchmarks for improvements in organ donation rates in the States. States would be required annually to provide a report to the Secretary, including a description and assessment of the State's use of grant funds and identification of initiatives for potential replication in other States.

Mr. Chairman, this amendment correctly recognizes that States need flexibility designed to address their own organ donation priority areas of concern, yet provides the necessary challenge and financial incentives to address the underlying reason for the organ allocation program in America today, namely, the scarcity of donated organs.

Mr. Chairman, I reserve the balance of my time.

Mr. BLILEY. Mr. Chairman, I yield myself such time as I may consume.

I rise in support of the amendment offered by the gentleman from Wisconsin (Mr. BARRETT) and the gentleman from Wisconsin (Mr. KLECZKA).

This amendment would provide financial incentives for States to creatively tackle the challenges inherent in organ donation awareness and education. It would also authorize direct grants to States to allow partnerships with other public agencies or private sector institutions within States to mutually undertake organ donation activities.

As I have said many times before, Americans who donate their organs, tissue, bone marrow or blood to save another's life are heroes. But, despite the generosity of the American people and improvements in medical treatments for transplant patients, the supply of organs continues to be tragically short of the need for transplantation among patients with in-stage organ disease and organ failure.

Every year, the number of patients who die while waiting for a transplant increases, as does the national waiting

NOT VOTING—13

Brady (PA)	Fattah	Nussle
Campbell	Greenwood	Shuster
Cook	Martinez	Vento
Crane	Myrick	
Diaz-Balart	Northup	

list, which now exceeds 65,000 patients waiting for various organ transplants. We must do more.

As many know, the Committee on Commerce has spent a great deal of time and effort in the last year working to develop good solutions to the difficult problem of increasing the supply of donated organs while safeguarding the system from unintended bureaucratic interference that would dramatically harm efforts to increase donations. Many of these ideas are embodied in H.R. 2418. I believe this amendment will strengthen our public education campaign with respect to organ donation and ultimately increase the amount of organs, tissue, bone marrow, or blood in our transplant centers. Organ donation and awareness is half the battle, and I applaud the gentleman from Wisconsin for tackling the inherent challenges in organ donation activities.

Mr. Chairman, I urge my colleagues to support this amendment.

Mr. Chairman, I reserve the balance of my time.

Mr. BARRETT of Wisconsin. Mr. Chairman, I yield 1½ minutes to the gentleman from Indiana (Mr. ROEMER). (Mr. ROEMER asked and was given permission to revise and extend his remarks.)

Mr. ROEMER. Mr. Chairman, I rise in strong support of this amendment on education, information, and inspiration.

There is a true story about a family, Reg and Maggie Green, who took their young sons to Italy on vacation, and one of them, Nicholas, was tragically killed in a shooting on the highway, on the super highway. This couple, instead of sprinting, leaving out of Italy, decided to donate seven of Nicholas' organs to citizens of Italy. In the first few days after Nicholas' death, the number of people signing organ donor cards in Italy quadrupled, quadrupled; and donations there last year were more than double the rate that they were in the year before he died.

Mr. Chairman, this is an inspirational story about Nicholas Green, his family, and now the "Nicholas Effect." When we can get these kinds of stories shared, a foundation started, the Nicholas Green Foundation, more people aware of the importance of organs and organ donation programs, sharing of inspiration, sharing of these true stories, we will help address this program and this problem.

So no matter where one is on the question of medical necessity versus location or geography, support this good amendment and support efforts to get information, education, and inspirational stories out there.

Mr. Chairman, I include the following for the RECORD:

Warm, moving, and uplifting . . . a father's story of how a boy's life helped save thousands.

Reg Green knows sorrow. He also knows, first-hand, of people around the world who have risen to the challenge of tragedy with acts of compassion and greatness. Here is the

intimate story (behind the headlines and talk shows) of the Greens' fateful trip to Italy: how a botched robbery changed their lives and how Reg and Maggie's private decision to donate their son's organs thrust them into the world spotlight.

The world's response to the Greens' personal tragedy is called the Nicholas effect. No matter their nationality or calling, people respond from the heart—presidents, movie stars, schoolchildren, grandmothers, Boy scouts, soccer players, surgeons, and organ recipients. Organ donor cards are signed. Poems are written, pictures painted, parks dedicated, scholarships established, medals given, children hugged.

The effect continues today, stronger than anyone could have predicted. More than a tale of loss, this is a testament to the power of healing and love.

AN INTERVIEW WITH REG GREEN

(By Doug Hill)

Reg Green is a British-born financial writer who lives in Bodega Bay, California. On the night of September 29, 1994, he was on vacation in southern Italy with his wife and two children when highway robbers shot out the windows of their rented car. Nicholas Green, age 7, asleep in the back set, was hit in the head. Two days later, he was declared brain dead, and the parents agreed to donate his organs for transplant. Nicholas' heart, kidneys, corneas, liver and pancreas cells transformed the lives of seven Italians while the Greens' generosity and spirit inspired the world.

Since then, Reg Green, 70, and Maggie Green, 37, have become international leaders in the movement to promote organ donations, while the power of what is called "the Nicholas effect" continues to move anyone who hears their story. They live with their daughter Eleanor, 9, and twins, Martin and Laura who will be 3 in May.

Reg Green has just completed a book which describes the Greens' incredible journey in exquisite and often painful detail. "The Nicholas Effect" is to be published by O'Reilly & Associates in April. Recently, Green took time out to discuss "The Nicholas Effect" with interviewer Doug Hill.

Hill: What is the Nicholas Effect?

Green: The Nicholas Effect started out by being a very big increase in people in Italy signing their donor cards. Within a few days of Nicholas' death, those signings quadrupled. That was the initial response, and that took our breath away at the time, but I was determined, as Maggie was, that this shouldn't be just a transient thing. We both had this feeling that this could turn out to be one of those things that people would look back on sadly when they remembered it, but would have no real effect on their actions. Some other tragedy would come along that would supersede this one. So we wanted to try to make sure that whatever effect there was would be more lasting. Therefore, we did everything we could to etch it into people's minds. We contacted the media and we gave all the interviews that anybody asked for—we've hardly ever turned down a request for an interview. We made two videos, we've written articles, we dressed up as Santa Claus for an Italian magazine. The main thrust of all this was to remind people of the terrible loss of life around the world because of the low rate of organ donation. There were subsidiary things, however, which we began to see as we got into it. People were being brought closer together by this story. I imagined parents all over the world giving their children an extra hug before they went off to school in the morning or reading an extra page to them at bedtime. So we wanted that to continue as well.

Hill: You've said that the Nicholas Effect is about "life coming bravely out of death." Is that the idea?

Green: Yes. Absolutely.

Hill: That message runs counter to a lot of the cynicism we encounter today, doesn't it?

Green: Yes. I think one of the wonderful things about the Nicholas Effect is that it has uncovered this sense of togetherness—what the Italians call "solidarity"—that exists between people, people who are often complete strangers. Obviously that's true with organ donation, where you've no idea where the organs are going. White men are walking around with black women's hearts, Anglos are breathing with Mexican lungs, and American children are alive because of donations made by foreign parents—and vice-versa. Human parts are interchangeable. I think that's a wonderful lesson. The differences between us are trifling compared to what we have in common.

Hill: I was struck when reading the book how many times you met someone and then found out quite a bit later that they had experienced some sort of tragedy in their own lives.

Green: Yes, that struck me too, very forcibly. Both in the case of strangers or people I've known for a long time about whom I never suspected anything of that sort. But somehow the barriers come down and they tell us these stories. Just the other day I went into the grocery store and went to the butcher counter. The lady who served me said, "By the way, you're the father, aren't you?" I said yes, and she said, "We had a similar incident," and she proceeded to tell me about a personal tragedy. I've seen that woman a lot of times and that never emerged. She was just the woman who was serving the sausage. Now behind that is the real person.

Hill: How much of the Nicholas Effect has to do with the special qualities of Nicholas himself?

Green: I've often asked myself that. I think quite a lot. I know, of course, that it was our decision to donate the organs, that he wasn't old enough to know what that meant, but somehow with Nicholas you wanted to be your very best. He was a very good little boy and he made you want to live up to his expectations. He stamped his personality on this story. Time and again when reporters would come here, somehow they've been captured by his personality. So the effect was shared according to his own character.

Hill: I must say that as a father I sometimes felt jealous of the bond that you seemed to have with him.

Green: Well, we were very close. I'm quite old, you know, to be the father of a young child. That may have something to do with it. It may be when you're a younger father you've got your own career to worry about, you're very busy, you haven't settled down yet. I work from home, so that helped, also. But, yes, we were very close.

Hill: You describe yourself as an agnostic. Still, do you see a spiritual quality to the Nicholas Effect of any sort?

Green: No, I don't, really, not in any conventional sense. I still don't believe in an afterlife, for example. I've never been tempted to believe in it. It would be nice in a way to think that was true now, but I've never been comfortable with the idea and I've never dabbled at it since Nicholas died. I've always taken hope from the idea that there's a lot you can do here in the world, and that what you do here can be about love rather than hate—kindness rather than cruelty. So my solace comes from what can happen on earth, and I see so much good coming out of all this. Nicholas' example has helped save literally thousands of lives in Italy alone, because the organ donation rates have more than doubled. So that's part of it. The other part of it is that other thing we've been talking about, the sense of people feeling closer together than they did before.

Hill: Was the book difficult for you to write?

Green: I had tears in my eyes many times while I was writing it and some of it was wrenching, going back over Nicholas' death, for example, having to recreate that. But, for the most part, the loss of Nicholas has been so great that talking about it really doesn't make it worse. It was also nice to be able to put down on paper the happier times I remember too.

Hill: What do you hope to accomplish with the book?

Green: Again, there's the two levels of things. On the practical level, I'm hoping it will be another of the building blocks by which organ donation becomes not unusual or horrifying, but the natural thing to do, as natural as putting on a seat belt. And I think it can become as natural as that. There's no organized opposition to organ donation. Whenever they take a poll, eighty percent or more of the people in this country say they are in favor of it and would do it. They don't do it, but not because there's a principled objection to it, but because of circumstances. I think people can be overwhelmed when there is a sudden death. So what I'm hoping to do on that front is make them aware of the importance of it—of the consequences of a refusal. When people are asked to do it, they tend to think of that child or husband of theirs and the organs being taken away from them, and they're frightened or worried by it. I want them to see the other side. If you don't do it, this is what somebody else has to suffer. Somebody else has to go through what you're going through if you don't make that decision. On the organ donation level, that's it. I also wanted to show the sense of solidarity between quite different kinds of people that this incident has produced.

Hill: What specific steps should people take to make sure that their organs will be available for transplant?

Green: The most important is to discuss it with your family so that if there is a brain death in the family, their minds are already attuned to this and it doesn't take them by surprise. There's a new initiative started by the American Society of Transplant Surgeons, and what they ask you to do, instead of signing the donor card, is to just sit down with the family and say, "Look, if anything were to happen, I'd want you to give my organs and tissues." The others in the family who agreed would sign a document, the Family Pledge, and then they'd probably put it away and forget where it was and that would be the end of it. It would have no legal standing, but it would mean that when death did occur, perhaps sooner than anyone expected, that conversation, that joint decision, would come to mind. It wouldn't work every time, but we think in many cases it would have the right effect—people would say, "Yes, that's just what he wanted."

Hill: I was struck by your comment in the book that transplantation means we're "no longer at the mercy of arbitrariness. We have a say in the outcome." Could you elaborate on that?

Green: I connect it with the idea that death has a purpose. Death is not simply some terrible thing that happens. None of us is going to like it, but it's there for a reason: the old and the feeble have to be replaced by younger and stronger ones. But people die every day because of the failure of one organ. Many of them are young, some only babies. People with whole lives in front of them are suddenly dead. Transplantation means that we can step in and save such people.

Hill: Did you have any thoughts about donation before your experience with Nicholas?

Green: Not really. I had been very impressed by Christiaan Barnard's early experiments with heart transplants, which seemed

like going to the moon. But apart from that, no. I can't recall any conversation that Maggie and I had beforehand. She, it runs out, had signed a donor card and I hadn't.

Hill: So you were pretty much like most of us.

Green: Yes, that's right. It was a revelation to me how much could be achieved. I think in our cases, either one of us would have done it for the other, because it would have been so obvious to us, just as it was in Nicholas' case. And I think many families are like that—they know each other well and would know enough to go ahead and do it, without prior agreement. But still, it's very valuable to have had a discussion, particularly for bigger families, where one person objecting can stop the whole process. This thing has to be done quite promptly—you've only got a short time to make the decision. You may be able to get in touch with your husband, for instance, but suppose you can't get hold of your mother, or his mother? That's what often happens. People take the safe course because it's too difficult to contact everybody, and they're afraid that somebody might object.

Hill: You often describe the decision to donate Nicholas' organs as "obvious" or "easy." I think many readers may find that hard to understand—I know I did. Why would it have been that obvious?

Green: It was obvious simply because Nicholas was dead. There was no question in our minds that he wasn't in a coma, for example. Those organs were of no use to him anymore. Not only did Nicholas not need those organs anymore, but the essential Nicholas was clearly not in that body. Whether it was a soul or our memories of him, or the legacy he left behind—that was where Nicholas was. In no way conceivable to us could we be hurting him by using his body, and yet we could be using it to help other people. On top of that, we know that it was a decision he would have approved of. We never discussed it with him, obviously, but if he'd understood the situation, there would have been absolutely no question in Nicholas' mind that that's what he would have wanted us to do.

Hill: The letters chapter in the book is amazing. I was struck by your comment that it isn't possible to read those letters without the sense of a "momentous event" having taken place. I assume that's another example of the Nicholas Effect at work?

Green: Yes, on the face of it, it's just one tragedy among many. In terms of numbers, of course, Nicholas' death was a very small tragedy, and yet it had these amazing consequences. The letters we received weren't written the way condolences from strangers often are. They didn't write "We're sorry your little boy has died . . . He will be in our thoughts and you too . . . Goodbye." Instead, their letters talked about big things having happened in their lives because of this event. Some people felt their whole view had shifted, or that they'd taken some quite big action that they hadn't done before. They clearly felt that something had happened of importance that they should pay attention to.

Hill: Why? Why did this one death have that effect?

Green: Well, there must be a lot of elements to that. I think the slaughter of an innocent was part of it—the sheer wantonness of it all. And I think it probably had something to do with the fact that Maggie and I were willing to talk about it to the press right from the beginning, so that Nicholas' personality appeared in the very first stories that were written. He wasn't just figure with a name who was killed; he had a rounded personality. And because there were pictures, there was also a face to go with the story. I

think also that having been a journalist, I knew that when you tell a story, you can't wait for two or three days to figure out what you feel about it, or to get it correct to the third place of decimals. You've got to talk right away. Another part of it was the reaction of Italy to it. It took the whole country by storm, and I think that regardless of what we did or didn't do, there would have been that explosion of sympathy. They were horrified that a child had been hurt, many were ashamed. The President and the Prime Minister made it into a national event. All those things together made it an event of importance. When we came back on one of the Italian President's planes, the press was waiting, and the momentum that Italy had given the story continued here, to a higher level still.

Hill: The force of that must have been astonishing to you.

Green: Yes, it was. By now we've grown used to people being moved by this story, but at the beginning we had no idea there'd be this reaction. I remember when we made the decision to donate the organs, we stayed to sign some forms, and then left the hospital. By the time we got back to the hotel, the press already knew. Until then we had thought we were making a purely private decision. Then by the next day there was a sheaf of telegrams from some of the leading figures in Italy.

Hill: As someone who has been a journalist, how well or how poorly did your colleagues in the media handle the story? They come off fairly well in the book, and I wondered if you were bending over backwards to be diplomatic.

Green: No. There were a lot of detailed mistakes, people getting our ages wrong and that sort of thing. A couple of magazines quoted us as saying that "Nicholas lives"—meaning he lives on through the organ recipients—and we never said that. But, as a whole, people treated the story seriously and they treated organ donation in a very mature and positive way. So we have nothing to complain about. In fact, I'm grateful to the press, because without the mass media this would have been a small story instead of a worldwide story.

Hill: It's unusual for anyone who's been the focus of media attention these days to come out of the experience with much positive to say.

Green: I think they all felt very sorry for us. They didn't want to hurt us anymore.

Hill: How are the recipients doing?

Green: They're all back in the mainstream. There are seven of them and most are in very good shape. Let me think. The two who received corneas, yes, no problems there. Two kidneys, yes, Liver, fine, she just had a baby. So those five definitely. Now what have I missed? The boy with the heart, who had had six previous operations, he worried people for a time. He was in the hospital a lot longer than the others and there were side effects, and I remember hearing there were some concerns about rejection. However, a year or so ago I was on a TV program with his mother, and she said he's fine now. The seventh is Silvia, a long time diabetic, a brutal disease. She had been in a series of comas before her transplant and still has serious complications from that time. However, she has recovered enough that when I saw her last she was able to live in an apartment on her own.

Hill: How are Eleanor and the twins doing?

Green: Fine. Eleanor still says from time to time things like, "Wouldn't Nicholas have enjoyed this?" or, "Do you remember when Nicholas did that?" But the twins have changed her life beyond recognition. She had become an only child and we began to worry that she would turn inward. But the twins have brought out all her maternal instincts

and she looks after them in a very mature way. They dote on her and love it when she comes home from school.

Hill: And Maggie is well?

Green: Yes, she's fine. Maggie's very strong. If you ever met Maggie, you'd see the gentleness in her, but it's the combination of that and the strength behind it all that's made all the difference.

Hill: What about you, Reg? I have read that you now consider increasing awareness of the need for organ donations as your life's work. Is that accurate?

Green: Yes, that's true. What this has given us is a genuine cause that has got two things going for it. One is, we know it does good. We can feel it in the air when we go places—the things people say to us, the statistics in Italy, the letters we get—we just know that it's having the kind of results we want it to have. Secondly, even though we're amateurs in the world of organ donation, and tens of thousands of other people working on this problem know infinitely more about it than we do, I do feel we have a special message.

Hill: My last question is really about the impact of the Nicholas Effect on you. You said at one time that "while we lost everything, we did get something back." What was it you got back?

Green: I suppose the nub of it is knowing so much good came out of what could easily have been just a sordid tragedy. I often think people don't realize, as we didn't, what a mighty gift they have in their hand when they are faced with a decision about making a donation.

Mr. BLILEY. Mr. Chairman, I yield 2 minutes to the gentleman from Wisconsin (Mr. GREEN).

Mr. GREEN of Wisconsin. Mr. Chairman, I thank the gentleman for yielding me this time.

I would like to begin by associating myself with the remarks of my friend and colleague from Milwaukee and congratulate both he and my other colleague from Milwaukee (Mr. KLECZKA) for bringing this amendment forward.

This is the "good news amendment" of this process. Up to now, our debate, our battle has been over how to arrange the chairs around the table. This amendment is the first amendment that takes square-on the important challenge of how we make the table bigger, of how we make sure that we have more organs in the donor system.

□ 1500

As we have heard several times today, there is a sad shortage, and the shortage is a matter of life and death. But the good news is that in some parts of the country, like my home State and the gentleman's home State of Wisconsin, we have shown that public education and outreach efforts can work. We can increase the percentage of those who donate their organs. We can raise public awareness.

This amendment is so important because it turns to the States and it challenges the States, and works with and reaches out to the States to do what States like Wisconsin have done so we are not bickering over who sends what where, who will make these decisions, whether or not we are going to bring politics into this, turn this over to bureaucrats.

Instead, we can increase the number of organs donated, number of organs in the system, and that is really what this should be about today. That is the most important thing.

Again, I congratulate my colleague for bringing this amendment forward.

Mr. BARRETT of Wisconsin. Mr. Chairman, I yield 3 minutes to my colleague, the gentleman from Wisconsin (Mr. KLECZKA), a coauthor of this amendment.

Mr. KLECZKA. Mr. Chairman, let me thank my colleague, the gentleman from Wisconsin (Mr. BARRETT) for yielding time to me.

Mr. Chairman, I rise not only to support the amendment, but also to support the underlying bill. The entire issue of organ donation is very near and dear to our family, for it was about 6 years ago that my brother received the gift of life. He received a new lung at a local hospital in my district. Without that, my brother would not be with us any longer, or his four children, or his wife.

When we start talking about the allocation of organs and changing the system, I take a very strong interest in that. It seems that, after listening to the debate from those who oppose the bill, it is more of a question of where the organs are harvested, where they are available, and the fact that they are not necessarily sent to areas of the country where they do not do a very good job of procuring organs.

I am saying the answer to that dilemma, to the most serious problem, is not to throw out the current system that works, but let us adopt the Barrett amendment, which provides more Federal resources to educate and to try to provide more donations from individuals in our country.

It is a very simple step, Mr. Chairman. I wonder how many Members of Congress have affixed to their driver's license the organ donation sticker, or have signed on the back of the driver's license the fact that should something happen to us, our organs should be preserved and not let gone to waste?

The question here is, let us provide the same type of education and programming at States other than those who do a good job, like Wisconsin and Florida and Kentucky, to the other States like Pennsylvania and some others of Members who spoke on the floor today.

One of the Members previously in the debate indicated that there are organs available, so someone calls the local golf course. I thought that was a rather crass statement. No one is going to have an organ transplanted into the body because it is newer than what they got. It is not done like a set of tires on your car which would provide for more mileage for getting around. It is a lifesaving thing.

We are told of the sad statistics where 4,000 people a year die because there are no organs available. The waiting lists are in excess of 65,000 around the country. But Mr. Chairman,

even in areas where the organs are available, those waiting lists are there, also. They are doled out on medical need. My brother would probably not have received the lung he needed to live if the decision was made in Washington, because what physician, what bureaucrat, is going to know his condition versus the doctors who have attended him for years and years while he waited?

So those 4,000 who passed away because of unavailability of an organ also come from States where the organs are available because they are not plentiful enough. Adopt the Barrett amendment, provide some needed dollars, so we all can enjoy the gift of life that some States might have a couple more than others.

Mr. BLILEY. Mr. Chairman, I yield 2 minutes to the gentleman from Wisconsin (Mr. RYAN)

Mr. RYAN of Wisconsin. Mr. Chairman, I rise as a cosponsor of the Barrett amendment. I would also like to thank the gentlemen from Wisconsin, Mr. KLECZKA and Mr. BARRETT, the cosponsors, the authors of the amendment, for this excellent amendment. I believe this amendment can do a great deal to improve our Nation's current organ donation system.

We have witnessed in several States innovative programs to encourage increased organ donations that have produced dramatic results. In my home State of Wisconsin, we have developed a highly successful organ donation system that has served as a model throughout the country. I believe that Wisconsin has offered much to those States that currently lack high donation rates.

The Wisconsin State legislature just recently passed a bill requiring teenagers to take 30 minutes of instruction on organ and tissue donation as part of their drivers education program. It is innovative programs like these that keep our rates high.

In addition to this program, Wisconsin has also introduced legislation for a donor registry, and currently utilizes driver's license checkout programs, donor cards, and power of attorney for health care forms to encourage organ donation.

This amendment would provide a cooperative environment that shares successes and helps to diminish failures. We should seek to eliminate our national organ shortage by improving the donation rates in all States, not by penalizing States with more effective programs.

I, too, am an organ donor. On the back of my Wisconsin driver's license, I have this great little sticker. We are doing well in Wisconsin. We have a program we are proud of. This amendment does a lot to improve the base text of a good bill to make sure that the States that are doing well continue to do well, and encourages those States that have room for improvement to improve themselves.

Mr. Chairman, I encourage all Members to vote in favor of the Barrett amendment.

Mr. BARRETT of Wisconsin. Mr. Chairman, I yield 2 minutes to the gentleman from Wisconsin (Ms. BALDWIN).

Ms. BALDWIN. Mr. Chairman, I thank the gentleman for yielding time to me.

Mr. Chairman, in my home State, as Members have heard, we are blessed with one of the Nation's most successful organ transplant and procurement programs. People in Wisconsin care about helping their neighbors and loved ones, and we benefit from a very successful education and outreach program.

Everyone is involved in this effort, from families to physicians, small clinics and larger transplant hospitals. Additionally, the local media takes the time to emphasize and praise the actions of organ donors.

For instance, just this past weekend, one of my hometown newspapers featured a front page story on the recent tragic death of a 15-year-old boy in my district from a severe asthma attack. But even in the face of this awful tragedy, the family and the journalist made a point of noting the boy's commitment to organ donation.

Jason Frederick had talked about donating his organs. It was something he felt very strongly about. He wanted to be an organ donor, but he did not yet have his driver's license. His family made sure that his wishes were carried out.

Rules and regulations at the Federal level addressing organ allocation will not address the critical issue of organ shortage. That is why this bill and the Barrett-Klecza amendment are necessary. I am a cosponsor of this amendment because I want all States across the country to share Wisconsin's success in organ procurement and transplants.

I urge my colleagues to support this amendment and to provide States with the resources to address the underlying reason for the organ allocation problem in America today, the scarcity of donated organs.

Mr. BLILEY. Mr. Chairman, may I ask, do I have the right to close?

The CHAIRMAN pro tempore (Mr. EWING). Under the circumstances, the gentleman from Wisconsin (Mr. BARRETT) has the right to close, since the gentleman from Virginia (Mr. BLILEY) is not opposed to the amendment.

Mr. BLILEY. Mr. Chairman, I yield the balance of my time to the gentleman from Florida (Mr. BILIRAKIS).

Mr. BILIRAKIS. Mr. Chairman, I want to just take a few seconds, really, to commend the gentleman from Wisconsin (Mr. BARRETT). He is on the committee, he is on the subcommittee, and he has heard all of the arguments and debate in the hearings.

In the process, unfortunately, of taking something which should have been worked out by the parties, and this is

something we all were strongly hoping for and unfortunately it did not work out, because, as somebody said earlier today, we should not even really have to be doing something like this on the floor. The truth is that we should not have to, but we were forced to.

In the process of all that, however, many people said that what we really have to concentrate on is how to improve the harvesting of organs to get additional donations of organs and whatnot.

I think that the gentleman from Wisconsin (Mr. BARRETT) by his amendment is basically the only one who has addressed that at this point in time. We are hopeful we can work together to improve what he has come up with once this is behind us.

We want to commend him. I support his amendment and I want to publicly say so, particularly to commend him for coming up with these very innovative ideas. They do not go as far as we all would like them to go, but it certainly goes in the right direction. I want the gentleman to know that I appreciate it very much. I do commend the gentleman.

Mr. BARRETT of Wisconsin. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I want to thank the gentleman from Florida. I wish he had more time, because he is so nice to me.

Mr. Chairman, I yield 2 minutes to the gentleman from Wisconsin (Mr. KIND).

(Mr. KIND asked and was given permission to revise and extend his remarks.)

Mr. KIND. Mr. Chairman, I thank my friend for yielding me this time.

For someone just tuning in, Mr. Chairman, they are probably a little surprised to see that we are not actually debating dairy policy right now. Instead, we are talking about the organ donation system in the country. That is because it is very important for the people in Wisconsin, but it is actually as important for people across the country.

I know most of the Members here today are approaching this based on the very local and parochial viewpoint on the issue, but hopefully all of us can see the need and agree to support this very important amendment. I commend my friends, the gentlemen from Wisconsin, Mr. BARRETT and Mr. KLECZKA, for offering this.

This amendment is very simple. It establishes grants to States to foster public awareness, education, and outreach activities designed to increase the number of organ donors within the State. There is a shortage of organ donors across the States. I am very proud that my own State of Wisconsin has an excellent record of organ procurement. In 1999, the University of Wisconsin was one of the top organizations in organ procurement.

In fact, many States across the country including Alabama, California, Hawaii, Indiana, Missouri, Montana, and

Texas, just to name a few, have implemented innovative programs to increase organ donation. In fact, Wisconsin has a model intensive education program that works closely with schools, community groups, church groups, and the hospitals to allay individuals' questions and concerns relating to organ donation.

This amendment recognizes the critical role that States can play and are playing in improving organ donation. I would urge my colleagues to support it.

Mr. BARRETT of Wisconsin. Mr. Chairman, I yield back the balance of my time.

The CHAIRMAN pro tempore. The question is on the amendment offered by the gentleman from Wisconsin (Mr. BARRETT).

The amendment was agreed to.

The CHAIRMAN pro tempore. It is now in order to consider amendment No. 5 printed in House Report 106-557.

AMENDMENT NO. 5 OFFERED BY MR. SCARBOROUGH

Mr. SCARBOROUGH. Mr. Chairman, I offer an amendment.

The CHAIRMAN pro tempore. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 5 offered by Mr. SCARBOROUGH:

Page 29, after line 17, insert the following:
SEC. 8. NULLIFICATION OF FINAL RULE RELATING TO ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK.

Notwithstanding any other provision of law, the final rule relating to the Organ Procurement and Transportation Network, promulgated by the Secretary of Health and Human Services and published in the Federal Register on April 2, 1998 (63 Fed. Reg. 16296 et seq. adding part 121 to title 42, Code of Federal Regulations) and amended on October 20, 1999 (64 Fed. Reg. 56649 et seq.), shall have no force or legal effect.

Page 29, line 18, redesignate section 8 as section 9.

The CHAIRMAN pro tempore. Pursuant to House Resolution 454, the gentleman from Florida (Mr. SCARBOROUGH) and a Member opposed each will control 15 minutes.

Is there a Member opposed to the amendment?

Mr. BROWN of Ohio. Mr. Chairman, I rise in opposition to the amendment.

The CHAIRMAN pro tempore. The gentleman from Ohio (Mr. BROWN) will be recognized for 15 minutes.

The Chair recognizes the gentleman from Florida (Mr. SCARBOROUGH).

Mr. SCARBOROUGH. Mr. Chairman, I yield myself 5 minutes.

Mr. Chairman, first of all, I rise in strong support of this bipartisan legislation, which obviously is going to reorganize the National Organ Transplant Act of 1984. It is a critical piece of legislation that will obviously save lives, and I want to say right now that I certainly heartily support the bill. I want to thank the gentleman from Virginia (Mr. BLILEY) and the gentleman from Florida (Mr. BILIRAKIS) for their hard work on the bill.

The Scarborough-Thurman amendment is actually a friendly amendment

that preserves the use of real science and medicine in allocating organs. It keeps organ allocation out of the hands of Federal bureaucrats and keeps it with local doctors and also with local communities.

Unfortunately, in 1998, a bureaucratic rule was passed that tried to centralize all the power in the Department of HHS, and also centralize all of the decision-making authority with Donna Shalala and her bureaucracy. It was nothing less than a hijacking of the process, and today, as we talk about passing this important, critical bipartisan legislation, it is important to remember that this centralizing rule that allows bureaucracies to make decisions and not local doctors and local hospitals, local medical providers, and local communities, is still in effect.

□ 1515

The recent Institute of Medicine study concluded that the current organ transplant system is fair and does a very good job of acquiring and allocating organs for transplantation. However, like any system there is room for improvement but those decisions for improvement should be made by the people who are best equipped to make the decisions, the transplant community rather than the HHS bureaucracy.

My amendment clarifies that the authority to set transplant policy rests with the transplant community and results from bottom up consensus driven processes, not by a regulatory fiat.

The Institute of Medicine also contradicted the underlying rationale for the controversial rule on organ allocation proposed by the Department of HHS. In an analysis of 68,000 liver patient records, the IOM panel said, quote, the overall median waiting time that patients wait for organs, the issue that seems to have brought the committee to the table in the first place, is not a useful statistic for comparing access to or equity of the current system of liver transplantation, especially when aggregated across all categories of liver transplant patients.

HHS has vigorously maintained that reducing regional differences in waiting time was the primary goal of the rule on organ allocation, but the practical effect of the rule would be to shift organs that are currently used for transplants in many local or regional transplant centers across the country to just a few very large national centers. This centralization of the process in Washington, D.C. could mean that patients waiting for a transplant at a local center are going to have to wait much longer or actually have to relocate closer to a national center if they hope to get the transplants that they so desperately need.

Now, for many patients, particularly poor, lower income patients, this could present a formidable economic obstacle for them and their families. To make matters worse, States where these national centers are located may not ac-

cept Medicaid from the patient's home State. Again, who is penalized? It is the low-income patient. The policy mandated by HHS will impair access to transplantation services for these low-income patients and lack of access to organs may drive some regional transplant centers completely out of business, inflicting a fundamental blow to patient access and, most importantly, to patient choice.

Congress must step in and act to assure that allocation policies that have been developed will not harm patient access to local transplantation services. The amendment that the gentlewoman from Florida (Mrs. THURMAN) and I would offer simply nullifies the final rule issued by HHS Secretary Donna Shalala that gives HHS the sole, centralized bureaucratic authority to approve or disapprove organ allocation policies that are currently established by the private sector transplant community.

It just makes absolutely no sense to centralize this process in one Washington bureaucracy and basically dictate what transplant centers across this Nation will do.

The Shalala rule is a bad rule. It makes no sense. It hurts those that are the lowest income transplant patients and, most importantly, it hurts choice.

Mr. Chairman, I reserve the balance of my time.

Mr. BROWN of Ohio. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I rise in strong opposition to the Scarborough amendment. The Department of Health and Human Services has worked with the transplant community and with UNOS to develop a final rule that reflects the Institute of Medicine recommendations, that reflects common sense.

On what basis should this body nullify those months of work, those hours and hours of time put in by HHS and outside experts?

Let me quote William Payne, MD, the President of UNOS. Dr. Payne, from listening to the debate today, must be quite a special man. After all, proponents of H.R. 2418 are comfortable bestowing upon him authority over matters critical to the public interest and to public health and to ensure that his decision-making is unencumbered by accountability to the public.

Let me quote Dr. Payne. In a letter he wrote a couple of weeks ago to my friend, the gentleman from Michigan (Mr. DINGELL) Dr. Payne said, quote, UNOS and HHS are working closely together to ensure an effective and efficient implementation of the Department's final rule, including the organ allocation provisions.

Let me read that again. UNOS and HHS are working closely together to ensure an effective and efficient implementation of the Department's final rule, including the organ allocation provisions, unquote.

So, even the President of UNOS seems supportive of HHS rule. So why should we overturn those rules?

Mr. Chairman, HHS has worked hard to ensure the final rule reflects Institute of Medicine recommendations. HHS has worked hard to ensure that the final rule reflects the views of patients, of donors, of the medical community, and the current contractor handling organ allocation.

The only reason, the only reason to nullify the HHS rule, is to perpetuate inequities in the system that we have heard so much about today and the lax oversight that has allowed these inequities to become entrenched in our organ allocation system.

Proponents of H.R. 2418 claim that HHS is engaging in a power grab. I maintain HHS is claiming, on behalf of the public, on behalf of taxpayers whom it represents, authority that does not belong to a private contractor.

Again, the right way to serve the public interest is not to protect a private government contractor from public input. It is to ensure that private and public interests work together to build the best, most equitable system possible. That is the fundamental principle articulated in the Institute of Medicine report, and it is a defining principle underlying the HHS final rule.

I urge my colleagues to oppose the Scarborough amendment, which undercuts both IOM, Institute of Medicine findings, and a final rule that is thorough and is fair.

Mr. Chairman, I reserve the balance of my time.

Mr. SCARBOROUGH. Mr. Chairman, I yield 1 minute to the gentleman from Virginia (Mr. BLILEY), the chairman of the committee.

Mr. BLILEY. Mr. Chairman, I thank the gentleman from Florida (Mr. SCARBOROUGH) for yielding me this time.

Mr. Chairman, I rise in support of this very straightforward Scarborough-Thurman amendment which nullifies the administration's organ regulation. This amendment clarifies for HHS that once H.R. 2418 becomes law, the Department must issue a new regulation to comport with the new authorization and to include lessons learned from 2 years of fighting with Congress.

I encourage my colleagues to join me in voting yes on the Scarborough-Thurman amendment.

Mr. BROWN of Ohio. Mr. Chairman, I yield 5 minutes to the gentleman from Pennsylvania (Mr. KLINK).

Mr. KLINK. Mr. Chairman, I thank the gentleman from Ohio (Mr. BROWN) for yielding me this time.

Mr. Chairman, this is a difficult issue because we have good friends who we respect on both sides of this amendment, on both sides of this bill. We come to our decisions with very deep and heartfelt life experiences that we have seen. This, I think, unlike most other pieces of legislation that we should argue and debate about, many of us have had firsthand experience.

I kind of grew up professionally, before I was a Member of Congress, I was

in the news media in Pittsburgh and knew and still know Dr. Thomas Starzel, who is the father of much of the transplant technology that we have not only across this Nation but around this world.

The University of Pittsburgh, where Dr. Starzel and many of the other doctors who he trained and they trained other doctors, really went from an infancy of transplanting where there was seldom people that really survived for very long to the point where it is almost as commonplace as changing a carburetor in an automobile or an engine in a truck or a car to change major body parts and have people survive.

What a miraculous and historic time we live in.

The question here is, who plays God? Let us not make any questions or any qualms about this. It is, where is the authority? The question is, do we take a private contractor, UNOS, and allow them to be the sole decision maker here? Or is there some government oversight?

I have heard much of the rhetoric today that we do not want some centralized, bureaucratic decision-making process based here in Washington, D.C. Well, that is what we typically call folderol in western Pennsylvania, because there is certainly not any monopoly on bad decision-making process in government.

I have been the ranking Democrat on the Subcommittee on Oversight and Investigations that has jurisdiction over, among other agencies, the Health Care Finance Administration. As we looked at the fiscal intermediaries, those insurance companies that we put in place to handle Medicare payments to hospitals, we found vast numbers of them that have ripped off the system for tens of millions of dollars. They have paid criminal and civil penalties for doing it. They have admitted their guilt.

We must have some government oversight. As I said earlier when we were debating the LaHood amendment, we depend on the Secretary and the agency to help us determine what medicines and what medical devices are safe and to tell us what the NIH criteria should be for research, what Medicare should cover. Now all of a sudden we want the government out and we want a private contractor making all of these decisions.

One cannot talk very badly, when they talk about the transplants, about the so-called national centers, whether it is at Pittsburgh, Stanford University, Cedar Sinai because these centers, and I have seen it firsthand, accept the sickest patients, patients quite often that would not be accepted for transplant in some of the smaller institutions around the country.

They accept people not just from their State, not just from their geographic location but from everywhere. We have seen circumstances where patients would come to the University of Pittsburgh, for example, and would not

be able to get an organ from their home State because that State wanted to keep those organs in that State. We are simply talking about Health and Human Services, the Federal Government, working with UNOS, working with the transplant community, to set up a better, more definitive decision-making process. It does not have to be all one way or all the other way.

We cannot put private contracting agencies, with no recourse, with no checks and balances, in the position of playing God. That is what this amendment would do.

I must rise in strong, strong objection to this amendment, and I hope that there are Members who are not here that are watching on their TVs in their offices and that they will come here and vote against this amendment. It is not because I have an objection to the authors. I think that they have offered this with the best of aforethought, but on this, Mr. Chairman, we have a very deep-seated disagreement, and this amendment should be voted down.

Mr. SCARBOROUGH. Mr. Chairman, I yield myself 30 seconds.

Mr. Chairman, I would say, first of all, it sounded to me like we were really having to choose between two false choices there because right now the Federal Government does have oversight. HHS does have oversight. It had oversight when this bill was passed into law in 1984.

HHS has oversight, but what has happened now is oversight is not enough. They want to completely hijack the process. They want to be able to dictate whether somebody that dies in the Congressman's district near Pittsburgh can get an organ transplant in Pittsburgh or whether they decide they are going to have to go to Stanford University in California. It is unfair to the poorest people and it is wrong. Donna Shalala does not have a right to hijack the process.

Mr. Chairman, I yield 5½ minutes to the gentlewoman from Florida (Mrs. THURMAN).

Mrs. THURMAN. Mr. Chairman, I thank the gentleman from Florida (Mr. SCARBOROUGH) for yielding and I want to say that he has done a lot of hard work on this and I am proud to be standing here as a cosponsor with him on this floor today.

Mr. Chairman, I am rising in strong support of the underlying bill, H.R. 2418, but as well to this amendment. Some people might say well, why do we have to have this amendment when the bill reauthorizes the pre-HHS rule organ policies? Well, the truth is that this bill will reauthorize and strengthen the organ policies of our country. However, the HHS rule will still be in place and we would need to nullify that rule in order to turn these decisions back over to medical doctors.

So if one is for this underlying bill, they need to be for this amendment.

We have talked about that there are more than 63,000 Americans who are

awaiting an organ transplant and each year about 4,000 Americans die because there are not enough donated livers, kidneys, and other organs to go around.

□ 1530

I just might insert here that, under the Health Resources and Services Administration, while they go through talking about reasons that we should improve the Nation's organ transplant, this is a part of HHS, the very last statement that they make is: the primary problem remains the shortage of organs available for transplantation. Absolutely the bottom line of all of this. So we all agree that we must increase the number of organ donations in our country. However, not all of us agree on how to do this.

The Department of Health and Human Services believes the way to solve the problem is to move the organs from one part of the country to another. Although many people think this may help the organ shortage problem, do my colleagues know what I think? I believe this will only change the demographics of where people will die.

As long as there is an unequal number of patients needing transplants compared to organs available, people are going to die.

I do not disagree with Secretary Shalala's assertion that people in different areas of the country are waiting for different lengths of time. However, I have to insert here that it is important to remember that the very sickest patients, those who are in intensive care units, the current waiting period among all transplant centers is very short, less than 6 days in all regions of the country, in all regions of the country. This was publicly acknowledged by HHS officials at the same time that they issued the regulations.

However, we also do not believe, or that it is clearly an oversimplification to think that reallocating the available organs will have a positive impact on the outcome. UNOS says history shows that organ donation is a local phenomena. Organ donations rise in communities that have transplant centers and fall when centers close.

I have also heard several Members rise and talk about how lower-income individuals are not receiving organs in a timely manner. First, my colleagues should know that income is not taken into consideration when a patient is put on a transplant list.

Also, my colleagues should know that HHS regulations could have a negative impact on individuals who will have to travel great distances and be separated from their loved ones at a time when they are needed most.

Under the HHS rule, the additional travel cost could make it impossible for the 20 percent of transplant patients who are on Medicaid actually who would receive a transplant. Now, how would this happen? Because we think, if this rule stays in place, that

in fact there would be centers in their communities that actually would close.

I also have to tell my colleagues, with the rule, there is a further problem generated by these regulations, one that was never taken into account; and that is the patients will have to become extremely ill before they receive a transplant. However, under the current rules and the UNOS policy, an individual's likelihood for a successful transplant is taken into consideration.

Why should the Secretary have the power to determine who gets an organ? UNOS, along with the medical community, needs to determine who needs the organs the most and who will most likely be a successful transplant recipient.

My State of Florida has done an incredible job of increasing the number of individuals who agree to be an organ donor. Why should my State and my local transplant centers be punished for doing a good job? Why should the Federal Government dictate that someone who is a status 2 patient in another State should get an organ before a status 2 patient in Florida?

Allocation policies must be based on sound medical decisions, decisions made by the board of UNOS, not decisions handed down by the Federal Government.

My colleagues might also be interested to learn that kidneys must be compatible, and I do have personal experience on this. With regard to the liver, UNOS has recently taken steps to approve a new liver allocation plan which calls for developing new, more objective criteria for listing patients in the progressive illness categories.

The bottom line is we need to pass this amendment. If my colleagues agree with the underlying bill, then this amendment is what is needed so that we can make sure of what the gentleman from Ohio (Mr. BROWN) said, that UNOS and the Department can sit down and come up with one that is more aggressive for everybody.

Mr. BROWN of Ohio. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I want to recap sort of where we have been with this controversy in the last couple of years. Two years ago, almost exactly to this day, in early April of 1998, HHS promulgated what was called the final rule at that point on this. Soon after, our colleague who has since left, Mr. Livingston, inserted or added in the appropriations process a rider calling for an Institute of Medicine study and saying that he was particularly unhappy, as many Members of Congress were, in some cases legitimately, with what had transpired and with the HHS rule.

The Institute of Medicine study came up with several interesting things. This is the study I hold here. It is 200 pages. It is clearly well thought through and well considered and well constructed with good recommendations. This Institute of Medicine study was factored into revised rules by HHS. The pro-

posed finalized, revised version, which was issued October 20, 1999, included IOM rules. It included some of the considerations and ideas from the public. It included input from UNOS.

That is why, in the end, that Dr. Payne, and I said this earlier, why Dr. Payne, the President of UNOS, has written that UNOS and HHS are working closely together to ensure an effective and efficient implementation of the Department's final rule set for March 16, including its organ allocation provisions.

That is exactly the point. HHS issued a rule. Congress stepped in, said we need this IOM study. We got this IOM study. The study from the Institute of Medicine was incorporated in the new HHS rule. In this proposed finalized, revised version issued October 20, other changes recommended by UNOS, recommended by the public were incorporated.

That is why the very respected Dr. Payne, who is head of UNOS, said that UNOS and HHS is working together. That is why we should oppose this amendment. That is why we should oppose this bill if the amendment is incorporated.

Mr. Chairman, I reserve the balance of my time.

Mr. SCARBOROUGH. Mr. Chairman, can I inquire how much time each side has remaining.

The CHAIRMAN pro tempore (Mr. HOBSON). The gentleman from Florida (Mr. SCARBOROUGH) has 3½ minutes remaining. The gentleman from Ohio (Mr. BROWN) has 5½ minutes remaining.

Mr. SCARBOROUGH. Mr. Chairman, I yield 1 minute to the gentleman from Alabama (Mr. BACHUS).

Mr. BACHUS. Mr. Chairman, March 16, 2000, that was last month. It was a Thursday. HHS and Donna Shalala decided that they knew better than doctors, they knew better than hospitals, they knew better than the entire transplant community. They substituted their opinion for that of patient, for doctor, family, and decided that they would make the call that their opinion was what counted when it came to transplants. It was a day on which they issued a rule that threatens the health of tens of thousands of Americans.

This amendment is necessary because we need to send a strong signal, this body, that medical decisions are not made by Federal bureaucrats that do not have a medical degree. They are made by the medical community. They are made by the hospital. They are made by the patients.

This amendment is a good amendment. On three occasions, the Congress has voted to stop that rule. It is time to put a stake through the heart of that ill-conceived rule.

Mr. SCARBOROUGH. Mr. Chairman, do I have the right to close?

The CHAIRMAN pro tempore. The gentleman from Ohio (Mr. BROWN) has the right to close.

Mr. SCARBOROUGH. Mr. Chairman, I yield the remaining time to the gentleman from Florida (Mr. BILIRAKIS).

Mr. BILIRAKIS. Mr. Chairman, I support the amendment, and I am in support of the final passage of the basic bill.

Really, the transplant community has put it a lot better than any of us could. I would like to just share with my colleagues some excerpts from some of their comments. "A 'sickest first' policy would increase the number of retransplants as more patients experience graft rejection, and thus reduce the number of organs available for transplantation overall. Patients would have to become 'sicker' in order to receive a transplant, thus reducing their chance for survival. This would be completely counterproductive and result in increased cost with reduced success." I quote Dr. R. Robert Higgins, Director of Thoracic Organ Transplantation, Henry Ford Hospital in Michigan.

He went on to say, "A national list coupled with a sickest-first policy would make it all but impossible for my patients and in particular patients everywhere that are poor or minority patients, to receive a transplant. From a physician's point of view, without available organs, there is nothing I can do to help my patients over the longer term. If the rule were in effect today, the Federal Government would essentially be denying the benefits of organ transplantation to a broader number of patients." Dr. Higgins of Henry Ford Hospital made those comments.

Joseph Brand, chairman of the National Kidney Foundation: "We believe that less patients would receive liver transplants if the OPTN were required to develop policies where organs are allocated to the sickest candidates first. Such candidates are likely to have poor outcomes and require repeat transplants, thus reducing the number of organs available for other candidates. Furthermore, NKF has maintained that a 'sickest first' policy should not be applied to renal transplantation because of the availability of dialysis as an alternative therapy."

Mr. John R. Campbell, senior vice president and general counsel of LifeLink says, in talking about the great instances of the donations: "First, costs will dramatically increase, because of the required private jet transportation of hearts and livers. Second, 'warm' time," W-A-R-M time, "or the time from organ procurement to implantation, will increase, and thereby decrease the function of the organs. This will also increase costs. The patients at the 'top' of the transplant list are very sick, and do not do as well with their transplants as other patients. Therefore, retransplants will increase because very sick patients are more likely to experience rejection of the organ, and transplant hospital stays will increase."

Mr. Chairman, I include all of these comments for the RECORD as follows:

ADMINISTRATION REGULATION WOULD HURT
ORGAN SUPPLIES

QUESTION POSED FOR APRIL 15, 1999 HEARING ON:
PUTTING PATIENTS FIRST: INCREASING ORGAN
SUPPLY FOR TRANSPLANTATION

The proposed HHS regulations to reallocate organs state that "the OPTN is required to develop equitable allocation policies that provide organs to those with the greatest medical urgency, in accordance with sound medical judgment." When President Clinton signed H.R. 3579, the Supplemental Appropriations and Rescissions Act, on May 1, 1998, which extended the public comment period and implementation deadline for the HHS OPTN regulations, he issued a written statement in opposition to extending the comment period on the rule. In stating his reasons for opposing the extension, President Clinton stated that "The final rule would ensure that organs are allocated to the sickest candidates first." What would be the supply-side effects of a policy where organs were to be allocated to "the sickest candidates first"?

RESPONSES

"A 'sickest first' policy would increase the number of re-transplants as more patients experience graft rejection, and thus reduce the number of organs available for transplantation overall. Patients would have to become 'sicker' in order to receive a transplant, thus reducing their chance for survival. This would be completely counterproductive and result in increased cost with reduced success."—Dr. R. Robert Higgins, Director of Thoracic Organ Transplantation, Henry Ford Hospital.

"The supply-side effects would result from the increased transplant of sicker patients, at great distance from the location of the donation. First, costs will dramatically increase, because of the required private jet transportation of hearts and livers. Second, 'warm' time, or the time from organ procurement to implantation, will increase, and thereby decrease the function of the organs. This will also increase costs. The patients at the 'top' of the transplant list are very sick, and do not do as well with their transplants as other patients. Therefore, retransplants will increase because very sick patients are more likely to experience rejection of the organ, and transplant hospital stays will increase. Data indicates that a new allocation scheme would substantially increase organ wastage. Also, in States like Florida, the hard work and dramatic success of our local and state organ donation partnership will be diluted by siphoning organs to out-of-state transplant centers. We believe donor families are more likely to donate knowing that the organs will benefit their local community. But we also believe that the staff responsible for acquiring consent and arranging the logistics of organ donation are also motivated by the knowledge that patients in their community are being helped by their hard work. The immediate results are apparent to everyone involved, and give them the greatest incentive to work at their maximum efficiency."—John R. Campbell, P.A., J.D., Senior Vice President and General Counsel, LifeLink.

"We believe that less patients would receive liver transplants if the OPTN were required to develop policies where organs are allocated to the sickest candidates first. Such candidates are likely to have poor outcomes and require repeat transplants, thus reducing the number of organs available for other candidates. Furthermore, NKF has maintained that a 'sickest first' policy should not be applied to renal transplantation because of the availability of dialysis as an alternative therapy."—Joseph L. Brand, Chairman, National Kidney Foundation, Office of Scientific and Public Policy.

"UNOS modeling of a 'sicker patient first' policy indicates that more organs would be wasted and fewer patients transplanted with poorer overall results. Unfortunately, sicker patients are more likely to die or lose their transplants to post operative complications. My experience in the private practice of medicine for over 25 years, taught me early on that I couldn't 'cure' everyone; that, unfortunately, not everyone would ever have equal access to medical care, and one had to learn to deal with 'the hand you were dealt.' It is, and always will be, an imperfect world."—Robert A. Metzger, M.D., Medical Director, Translife.

"The ASTS has made it clear that we believe the impact of such a 'sickest first' policy would be contrary to our goal of insuring that the precious organs presently available provide the maximum benefit to the maximum number of Americans in an equitable fashion. This point was made in testimony presented at two previous Congressional hearings by Dr. Ronald W. Busuttil, President-elect of the Society and director of the world's most active liver transplant center in UCLA, and I am submitting copies of his testimony with this response. I also include a copy of our written testimony to the Institute of Medicine, presented by Dr. Busuttil on April 16th, which expands on these points. Unfortunately, critical care medicine and vital organ transplantation is not an exact science. That is why a significant number of Status 3 liver patients, those thought to be the least sick, die while in that status. We urge the Congress to leave decisions of this kind in the hands of the medical professionals—who battle these life-and-death issues with their patients every day—and not permit them to be imposed by governmental authority far from the trenches where life and death is played out. The simple answer is that there are some changes that must evolve in the distribution of life-saving organs for transplantation, as they have evolved in the past. This can be accomplished with the help of the federal government, but not with the implementation of a radically new OPTN rule which with its current inferences, language, and preamble has resulted in soundbites such as 'sickest patients first.'"—Joshua Miller, M.D., President, American Society of Transplant Surgeons.

"This has been discussed in detail by PAT Coalition. Allocation to the 'sickest first' on a national level will increase wait list mortalities, waste organs, increase retransplantation rates, disadvantage medically and economically disenfranchised segments of the population by limiting access to transplantation for indigent patients as smaller centers are forced to close their doors. The organs would be diverted to the most critically ill patients first, regardless of their location. While this may sound like a fair and reasonable way to allocate organs, a policy such as this may actually result in lost lives. The immediate and long term survival of liver transplant recipients is directly dependent on their preoperative condition, with significant decompensation adversely affecting survival. Blindly applied legislation may mean that a significant number of organs are given to people with little chance of survival. Organs may not become available for others until they too are critically ill with little chance of survival."—Amadeo Marcos, Assistant Professor of Surgery, Director of the Living Donor Liver Program, Division of Transplantation, Medical College of Virginia.

"We believe that the current system of policy development is sound. It is based on consensus building and medical judgement. Major changes to the liver and heart allocation policies have been instituted during the

past two years by the Organ Procurement and Transplantation Network ('OPTN') contractor, the United Network for Organ Sharing ('UNOS'). This includes standardized listing criteria for patients and changes to the status designations for liver and heart patients. We believe that the current system, while not perfect, is designed to ensure that the sickest patient is offered the organ first. We know in our region that the vast majority of patients receiving heart and liver transplants are transplanted at the highest level of acuity and are the sickest patients in our region. We believe that further changes to mandate a single national list for allocation, may lead to organs being wasted and potential donors lost given the attendant medical and social issues."—Howard M. Nathan, President and Chief Executive Officer, Coalition on Donation.

ADMINISTRATION REGULATION WOULD HARM
LOCAL ACCESS TO TRANSPLANT SERVICES

QUESTION POSED FOR APRIL 15, 1999 HEARING ON:
PUTTING PATIENTS FIRST: INCREASING ORGAN
SUPPLY FOR TRANSPLANTATION

In your estimation, how would the Department of Health and Human Services regulations published April 2, 1998, affect your patients and your ability to provide the highest quality of medical care for them? What impact will this rule have on local access to transplant services nationwide?

"A national list coupled with a sickest first policy would make it all but impossible for my patients and in particular patients everywhere that are poor or minority patients, to receive a transplant. From a physician's point of view, without available organs, there is nothing I can do to help my patients over the longer term. If the rule were in effect today, the federal government would essentially be denying the benefits to organ transplantation to a broader number of patients."—Dr. R. Robert Higgins, Director of Thoracic Organ Transplantation, Henry Ford Hospital.

"We believe that our local transplant center patients will be significantly and negatively impacted, as will the vast majority of the country's 120 liver transplant centers. Donated livers will be sent from Florida to a half dozen urban regional transplant centers—none of which are in the southeast. Our community will be deprived of this life-saving resource, a resource which our local citizens and the community have developed together. Highly skilled doctors and nurses will no longer perform the same number of transplants. Local centers may be forced to close their doors. In addition, access for low-income patients may be decreased. Medicaid patients may be unable to obtain transplants outside their home state, and other patient families may not be able to accompany their loved one to support them at a faraway transplant center. Also, organ donation will be affected. Many donor families have stated that a key factor in their decision to donate was the knowledge that they would be helping someone within their community. Eliminating this motivation may substantially reduce voluntary organ donation nationwide."—John R. Campbell, P.A., J.D., Senior Vice President and General Counsel, LifeLink.

"We are concerned that the April 2, 1998 regulations have politicized the organ donation/organ allocation process since they give the DHHS Secretary veto power over OPTN Policy. Transplantation should be based upon medical science, not politics. We are concerned that the rule may cause some local transplant centers to close and that would make it difficult for low income transplant candidates to receive a transplant. Such candidates may not be able to afford to

travel to distant transplant centers for evaluation, the transplant itself and post-operative care and testing.”—Joseph L. Brand, Chairman, National Kidney Foundation, Office of Scientific and Public Policy.

“The Health and Human Services rule that would mandate ‘broader’ sharing would result in increased waiting times for Florida recipients as our patients currently have shorter waiting times when compared to the national averages. This could potentially lead to further deterioration in their health prior to transplantation. Local access to local organs, the optimal transplant situation, would occur less frequently.”—Robert A. Metzger, M.D., Medical Director, Translife.

“In general the rule as currently written will impact negatively upon patients nationwide. I personally work in a large transplant center, one of the five largest in the world, and am proud of our record over the years. I also have been proud of our organ procurement agency, the University of Miami OPO. This has repeatedly over the years had one of the most enviable records nation- and worldwide in organ retrieval for life-saving transplantation. This is due to our local OPO Director, Les Olson, with whom I have had the privilege of working for 30 years, first in Minnesota, and then for over 20 years in South Florida. Please make no mistake. Organ donation is a local phenomenon dependent on the expertise of professional personnel. That also accounts for the great records in organ retrieval of Lifelink in West Florida, for Translife in Central Florida, and for the University of Florida OPOs. How could those who drafted the OPTN rule not acknowledge this? Some of the language in the OPTN rule also will have a negative impact on local access to service. I can expand on this, but I refer you to comments already made by our ASTS (enclosed). It is also worth noting that the vast majority of the written comments on the rule, collected by DHHS and not yet described by the Department, are understood to have been negative.”—Joshua Miller, M.D., President, American Society of Transplant Surgeons, University of Miami School of Medicine.

“The portion of the April HHS rule which would create a national wait list will severely limit access to transplantation for the indigent population by forcing small and moderately sized centers to close their doors. This concept is designed to support only a select few very large transplant centers, which would regionalize access to transplantation to only a few places in the entire country. It is obvious that moderately sized centers, such as our own, not only can provide high quality transplant patient services, but also provide the innovative driving force required to develop something like a ‘living donor adult-to-adult right lobe’ liver transplant program, etc.”—Amadeo Marcos, Assistant Professor of Surgery, Director of the Living Donor Liver Program, Division of Transplantation, Medical College of Virginia.

“Mandating a national allocation system for all organs is likely to spur growth at a few large centers in the country but may impact the viability of smaller programs. This may have the effect of reducing or inhibiting access to services by those recipients and their families who are not able to travel to large centers due to economic and other barriers. Additionally, mandating a national allocation system of organs will eliminate the concept of local neighbor helping neighbor. Complete elimination of the concept of neighbor helping neighbor may adversely impact donation. Finally, a national allocation system disregards differences in medical judgment and opinion. It also disregards the practices of transplant surgeon who perform

the organ recovery and view the organ in the donor patient and evaluate biopsy results (for livers) in order to evaluate suitability for transplant generally, as well as suitability for a specific recipient.”—Howard M. Nathan, President and Chief Executive Officer, Coalition on Donation.

Mr. BROWN of Ohio. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, people have sort of heard these debates and arguments on this over and over. I would just like to recap, not just on the Scarborough amendment, but sort of this whole debate, and ask my colleagues to vote “no” on Scarborough and “no” on final passage.

We have heard Dr. Payne’s comments, the president and head of UNOS, and his comments about the importance of these pending negotiations. If my colleagues read what his comments said in his letter to the gentleman from Michigan (Mr. DINGELL) and his other comments, they can clearly see that he wants this process to go on, these negotiations to go on, and not particularly welcoming of congressional interference.

I would also add that we have inserted in the RECORD a statement from the President’s advisors that they will recommend a veto on this legislation if, in fact, anything close to its present form reaches the President’s desk.

We have also received a letter from the Justice Department reiterating that they strongly believe that this is unconstitutional; and if for some reason, which they do not think would happen, it is not declared unconstitutional, their belief is it shifts power in some sort of the wrong way from the Government to a private sector, private interest group that does not really have any public accountability.

Equally as important, Mr. Chairman, the main argument that the proponents of this bill have made, the proponents of the Scarborough amendment, is that this process, by turning over authority to UNOS, that this process will actually increase the number of donations, organ donations, which is the goal we all aim for.

I would cite from the Institute of Medicine on page 10: “The committee believes strongly that the effectiveness and productivity of organ procurement is highly dependent on good working relationships at the local level.” That is clearly what we need to do. But they go on in spite of what we have heard from the other side to say: “However, our committee finds no evidence that broader organ-sharing arrangements will lead to reduced rates of donation.” That if organs go farther across the country, it simply does not affect people’s proclivity to donate organs. What makes people want to donate organs is that they believe it will save lives.

The Institute of Medicine supports the role of HHS. The Institute of Medicine study here is included in the HHS rules. Shifting power from representatives of the people, from elected and appointed government officials to a

private bureaucratic organization is the wrong way to go. The HHS rules will save lives.

We should vote “no” on Scarborough. We should vote “no” on final passage.

Mr. BILIRAKIS. Mr. Chairman, will the gentleman yield?

Mr. BROWN of Ohio. I yield to the gentleman from Florida.

Mr. BILIRAKIS. Mr. Chairman, I really appreciate the gentleman yielding, because he knows I am going to rebuff some of what he has said.

Basically it is not a shifting of power. For 16 years, it has been UNOS, which is contracted, set up by HHS quite some time ago with the rights to terminate those contracts and that sort of thing.

□ 1545

So it is not a shift of power. In fact, the effort is being made to shift the power from this private agency contractor, from UNOS, back to the Federal Government. That is the shift.

The gentleman from Pennsylvania (Mr. KLINK) talked earlier about all of a sudden. Well, all of a sudden is really what has taken place here. Because for 16 years it was being done a certain way and, all of a sudden, HHS has decided to grab the power.

I appreciate the gentleman yielding.

Mr. BROWN of Ohio. Mr. Chairman, reclaiming my time and in closing, I would reiterate that there is no place in our entire government where the government has abdicated its responsibility and given this kind of authority, this kind of power, with so little government oversight to a bureaucratic organization that is not really accountable to the public.

That is why most of us on this side of the aisle ask for a “no” vote on the Scarborough amendment and a “no” vote on final passage.

The CHAIRMAN pro tempore (Mr. HOBSON). All time has expired.

The question is on the amendment offered by the gentleman from Florida (Mr. SCARBOROUGH).

The amendment was agreed to.

The CHAIRMAN pro tempore. The question is on the committee amendment in the nature of a substitute, as amended.

The committee amendment in the nature of a substitute, as amended, was agreed to.

The CHAIRMAN pro tempore. Under the rule, the Committee rises.

Accordingly, the Committee rose; and the Speaker pro tempore (Mr. CHABOT) having assumed the chair, Mr. HOBSON, Chairman pro tempore of the Committee of the Whole House on the State of the Union, reported that that Committee, having had under consideration the bill (H.R. 2418) to amend the Public Health Service Act to revise and extend programs relating to organ procurement and transplantation, pursuant to House Resolution 454, he reported the bill back to the House with an amendment adopted by the Committee of the Whole.

The SPEAKER pro tempore. Under the rule, the previous question is ordered.

Is a separate vote demanded on any amendment to the committee amendment in the nature of a substitute adopted by the Committee of the Whole? If not, the question is on the amendment.

The amendment was agreed to.

The SPEAKER pro tempore. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

The SPEAKER pro tempore. The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. BROWN of Ohio. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

The vote was taken by electronic device, and there were—yeas 275, nays 147, not voting 12, as follows:

[Roll No. 101]

YEAS—275

Abercrombie	Cubin	Hilleary
Aderholt	Cunningham	Hilliard
Allen	Danner	Hinojosa
Andrews	Davis (FL)	Hobson
Archer	Davis (VA)	Hoekstra
Armey	Deal	Holt
Bachus	DeFazio	Hooley
Baird	DeGette	Horn
Baker	DeLay	Hostettler
Baldacci	DeMint	Houghton
Baldwin	Deutsch	Hulshof
Ballenger	Dickey	Hunter
Barcia	Dicks	Hutchinson
Barr	Doolittle	Insee
Barrett (WI)	Dreier	Isakson
Barton	Duncan	Istook
Bass	Dunn	Jackson-Lee
Bateman	Edwards	(TX)
Bentsen	Ehlers	Jefferson
Berkley	Emerson	Jenkins
Berry	Everett	John
Bilbray	Ewing	Johnson (CT)
Bilirakis	Fletcher	Johnson, E.B.
Bishop	Foley	Johnson, Sam
Bliley	Ford	Jones (NC)
Blumenauer	Fossella	Kaptur
Blunt	Fowler	Kasich
Boehner	Franks (NJ)	Kelly
Bonilla	Frelinghuysen	Kilpatrick
Bono	Frost	Kind (WI)
Boswell	Gallegly	Kingston
Boyd	Ganske	Klecicka
Brady (TX)	Gephardt	Knollenberg
Bryant	Gibbons	Kolbe
Burr	Gillmor	Kuykendall
Burton	Gilman	LaFalce
Buyer	Gonzalez	Lampson
Callahan	Goode	Largent
Calvert	Goodlatte	Latham
Camp	Gordon	LaTourette
Canady	Goss	Lazio
Cannon	Graham	Leach
Chabot	Granger	Lewis (CA)
Chambliss	Green (TX)	Lewis (GA)
Chenoweth-Hage	Green (WI)	Lewis (KY)
Clement	Gutknecht	Linder
Clyburn	Hall (TX)	LoBiondo
Coble	Hastings (WA)	Lucas (KY)
Coburn	Hayes	Lucas (OK)
Collins	Hayworth	Manzullo
Combest	Hefley	Matsui
Cooksey	Hergert	McCollum
Cox	Hill (IN)	McCreery
Cramer	Hill (MT)	McDermott

McGovern
McHugh
McInnis
McIntosh
McKeon
McKinney
McNulty
Meek (FL)
Menendez
Metcalfe
Mica
Miller (FL)
Miller, Gary
Mink
Moore
Moran (KS)
Moran (VA)
Nethercutt
Ney
Northup
Norwood
Nussle
Obey
Ortiz
Ose
Oxley
Packard
Pallone
Pascrell
Pastor
Pease
Petri
Pickering
Pickett
Pitts
Pombo
Portman
Pryce (OH)

Radanovich
Ramstad
Regula
Reyes
Reynolds
Riley
Rivers
Rodriguez
Rogan
Rogers
Rohrabacher
Ros-Lehtinen
Rothman
Roukema
Royce
Ryan (WI)
Ryun (KS)
Salmon
Sandlin
Sanford
Saxton
Scarborough
Schaffer
Scott
Sensenbrenner
Shadegg
Shaw
Shays
Shows
Simpson
Sisisky
Skeen
Skelton
Smith (MI)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder

Souder
Spence
Spratt
Stearns
Stump
Sununu
Sweeney
Talent
Tancredo
Tanner
Tauzin
Taylor (MS)
Taylor (NC)
Thomas
Thompson (MS)
Thornberry
Thune
Thurman
Tiahrt
Traficant
Turner
Udall (NM)
Upton
Vitter
Walden
Walsh
Wamp
Watkins
Watts (OK)
Weldon (FL)
Wexler
Whitfield
Wicker
Wilson
Wolf
Wu
Young (AK)
Young (FL)

□ 1614

Messrs. OWENS, DOOLEY of California, PORTER, HINCHEY, and Mr. DELAHUNT changed their vote from "yea" to "nay."

Messrs. SHAYS, GILMAN, Mrs. MEEK of Florida, Ms. KILPATRICK, Mr. INSLEE, and Mr. MATSUI changed their vote from "nay" to "yea."

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

□ 1615

AUTHORIZING THE CLERK TO MAKE CORRECTIONS IN THE EN-GROSSMENT OF H.R. 2418, ORGAN PROCUREMENT AND TRANS-PLANTATION NETWORK AMEND-MENTS OF 1999

Mr. BLILEY. Mr. Speaker, I ask unanimous consent that in the engrossment of the bill, H.R. 2418, the Clerk be authorized to correct section numbers, punctuation, and cross references and to make such other technical and conforming changes as may be necessary to reflect the actions of the House.

The SPEAKER pro tempore (Mr. HOBSON). Is there objection to the request of the gentleman from Virginia?

There was no objection.

GENERAL LEAVE

Mr. BLILEY. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and to insert extraneous material on the bill, H.R. 2418.

The CHAIRMAN pro tempore. Is there objection to the request of the gentleman from Virginia?

There was no objection.

REPORT ON RESOLUTION PRO-VIDING FOR CONSIDERATION OF H.R. 3660, PARTIAL-BIRTH ABOR-TION BAN ACT OF 2000

Mr. LINDER, from the Committee on Rules, submitted a privileged report (Rept. No. 106-559) on the resolution (H. Res. 457) providing for consideration of the bill (H.R. 3660) to amend title 18, United States Code, to ban partial-birth abortions, which was referred to the House Calendar and ordered to be printed.

REMOVAL OF NAME OF MEMBER AS COSPONSOR OF H.R. 1824

Mr. MASCARA. Mr. Speaker, I ask unanimous consent to have my name removed as a cosponsor on H.R. 1824.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Pennsylvania?

There was no objection.

NAYS—147

Ackerman
Baca
Barrett (NE)
Bartlett
Becerra
Bereuter
Berman
Biggett
Blagojevich
Boehlert
Bonior
Borski
Boucher
Brown (FL)
Brown (OH)
Capps
Capuano
Cardin
Carson
Castle
Clay
Clayton
Condit
Conyers
Costello
Coynne
Crowley
Cummings
Davis (IL)
Delahunt
DeLauro
Dingell
Dixon
Doggett
Dooley
Doyle
Ehrlich
Engel
English
Eshoo
Etheridge
Evans
Farr
Filner
Forbes
Frank (MA)
Gedjenson
Gekas
Gilchrist
Goodling

NOT VOTING—12

Brady (PA)
Campbell
Cook
Crane

Gutierrez
Hall (OH)
Hansen
Hastings (FL)
Hinchey
Hoeffel
Holden
Hoyer
Hyde
Jackson (IL)
Jones (OH)
Kanjorski
Kennedy
Kildee
King (NY)
Klink
Kucinich
LaHood
Lantos
Larson
Lee
Levin
Lipinski
Lofgren
Lowey
Luther
Maloney (CT)
Maloney (NY)
Markey
Mascara
McCarthy (MO)
McCarthy (NY)
McIntyre
Meehan
Meeke (NY)
Millender-
McDonald
Miller, George
Minge
Moakley
Mollohan
Morella
Murtha
Nadler
Napolitano
Neal
Oberstar
Olver
Owens
Paul

Payne
Pelosi
Peterson (MN)
Peterson (PA)
Phelps
Pomeroy
Porter
Price (NC)
Rahall
Rangel
Roemer
Roybal-Allard
Rush
Sabo
Sanchez
Sanders
Sawyer
Schakowsky
Serrano
Sessions
Sherman
Sherwood
Shimkus
Slaughter
Stabenow
Stark
Stenholm
Strickland
Stupak
Tauscher
Terry
Thompson (CA)
Tierney
Toomey
Townes
Udall (CO)
Velazquez
Viscosky
Waters
Watt (NC)
Waxman
Weiner
Weldon (PA)
Weller
Weygand
Wise
Woolsey
Wynn