these acts are offensive in the eyes of God. This murder had no purpose except to show that these cowards had one purpose, and that is to take an innocent life. They hid behind hoods and executed a citizen of this country who loved the people of Saudi Arabia, who enjoyed working in that country to help the people of Saudi Arabia, who was an innocent, decent, kind husband and father.

This was not an execution but a barbaric and demonic act of torture. If these sadists believe this type of action will unnerve America and weaken our resolve in our war against terror, they are both stupid, as they are wrong.

I take great exception to the speech by the gentleman from Washington moments ago who tries to conclude from the 9/11 report that there is no connection between al Qaeda and Iraq. It all is of the same vein and nature. The death of Paul Johnson, the death of Nicholas Berg, the retaliation against Saudi officials, the attempt to bomb the Jordanian intelligence service, the murder of hundreds of Spanish citizens peacefully on their way in Spain are all interconnected and intertwined.

He says there is no connection. I urge people to read the Wall Street Journal today and its editorial page because there is a lot of spinning going on. Maybe there have not been enough dots to connect yet so the gentleman comes out here and alleges that the President lied, that there is absolutely no connection. If he spoke any longer, I would have assumed he would have called Saddam Hussein just a sad, old, tired man who really should have been left alone to live in peace.

He killed a million of his own citizens. He said there is no link. A citizen of my county died from anthrax. He worked at National Media, the owner of National Enquirer. It is interesting that Mohammed Atta was living in Palm Beach County, a few miles from the facility in which that citizen died in Palm Beach County.

It is interesting, in the 9/11 Report, ''al Qaeda operatives trained in Iran, and al Qaeda helped Iran-backed Hezbollah terrorists obtain explosives.''

''Another revelation concerns al Qaeda and anthrax. The 9/11 panel says al Qaeda had an 'ambitious' biological weapons program and ''was making advances in its ability to produce anthrax prior to September 11.'' '' That is in the report, anthrax, prior to September 11.

It is telling, too, that the henchmen for the Iraqi leader agent al-Ani happened to be in Prague for meetings. Oh, lo and behold, cell phone records indicate that phone calls were placed from Florida to Mohammed Atta's cell phone at the same time he was reportedly in Prague. A coincidence, I guess. A sheer coincidence that Mohammed Atta, the leader of the 9/11 hijacking of planes, who was living in Delray Beach, Florida, close to where a citizen was killed by anthrax, meeting with Iraqi officials in Prague, is all coincidental, all coincidental, all sheer fantasy.

Read this editorial in the Wall Street Journal today.

Paul Johnson died at the hands of terrorists, not because we are in Iraq. They are going to kill Americans and other freedom-loving people because they resent our way of life. They resent who we are. For Members to come to this floor and say there is no link and no connection with the terrorists and Iraqis and anthrax and 9/11 have not read the entire report and are simply spinning a tale that they want America to believe.

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Ohio (Mr. BROWN) is recognized for 5 minutes.

(Mr. BROWN of Ohio addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Oregon (Mr. DEFAZIO) is recognized for 5 minutes.

(Mr. DEFAZIO addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from California (Mr. FILNER) is recognized for 5 minutes.

(Mr. FILNER addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Massachusetts (Mr. MCGOVERN) is recognized for 5 minutes.

(Mr. MCGOVERN addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Ohio (Mr. STRICKLAND) is recognized for 5 minutes.

(Mr. STRICKLAND addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Oregon (Mr. BLUMENAUER) is recognized for 5 minutes.

(Mr. BLUMENAUER addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Washington (Mr. INSLEE) is recognized for 5 minutes.

(Mr. INSLEE addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

AUTISM

The SPEAKER pro tempore. Under the Speaker's announced policy of January 7, 2003, the gentleman from Florida (Mr. WELDON) is recognized for 60 minutes as the designee of the majority leader.

Mr. WELDON of Florida. Mr. Speaker, I rise this afternoon to address the House regarding the very important issue of autism and the epidemic of autism that we are seeing in this country today, but before I begin my prepared remarks on this subject, I want to extend my condolences to the family of Paul Johnson.

His son lives in Merritt Island, an area in my congressional district, and it is indeed a great tragedy for our Nation and very obviously a great tragedy for his family. As I understand it, he was a great person, a great American, a patriotic American, and it goes to show to all of us that the war on terror continues and that there is a great peril to American contractors, probably anywhere in the Middle East, but particularly in Saudi Arabia and, obviously, as we know, in Iraq.

I do want to salute those contractors that do take the risk and go over there. They perform vital functions. In many ways, they are as important as our military people over there and we need to honor them and respect them.

So my condolences go out to the Johnson family, and certainly I hope that they will be comforted by the good Lord in their time of grief.

I would like to take this time to address what I consider to be a very growing problem, the epidemic of autism and neurodevelopmental disorders that are plaguing our Nation.

In January of this year, the Department of Health and Human Services sent out an autism alarm to the Nation's pediatricians. In this alarm, they stated that one in every 167 children is being diagnosed with an autism spectrum disorder. I will repeat that. One in every 167 children being born in the United States today is being diagnosed with an autistic spectrum disorder.

Furthermore, one in seven children is being diagnosed with either a learning disability or a behavioral disability.

Mr. Speaker, something dreadful is happening to our youngest generation, and we must sound the alarm and figure out what is going on with our children.

I had the pleasure of addressing an autism conference in Chicago last month, and I would like to share today some of the thoughts I shared then with about 1,000 researchers, doctors, nurses, educators and, most importantly, parents who were there to seek answers to this growing problem.

I have said repeatedly that the autism community is the 900-pound gorilla that has not had its voice properly heard on Capitol Hill. This is largely due to the endless demands on the time, effort, emotions and financial resources of the parents of these children who are struggling to meet the unique needs of these kids with autism. There is little time, money, energy left to engage in public debates, let alone engage

the Congress when one is trying to raise a child with a disability like autism.

However, I see that changing, and last month's Institute of Medicine report I think has had one positive effect. It has united and reinvigorated parents throughout the country in their efforts to get answers to why children are being diagnosed with autism at such a high rate in the United States.

At the outset of my remarks, I want to make it extremely clear that I support vaccinations. I have a six-year-old son, and he has received all of his vaccinations. Someone in the media recently tried to portray me as a vaccine skeptic. After reviewing my record on this issue and all of my statements in the past, the newspaper printed a retraction. This, however, seems to be part of the pattern, to vilify those who simply ask if our vaccines could be made safer.

I support vaccinations, and indeed, I gave vaccinations to thousands of my patients when I was practicing medicine full-time prior to coming to the U.S. House. However, I believe it is appropriate to acknowledge that like with any other medical intervention, different individuals respond differently. We are all unique. We all have different genetic makeup, and what may cause no harm to the vast majority of people can cause serious side effects in some individuals.

Since we established the National Vaccine Compensation Program in the late 1980s, several thousand individuals have been compensated for vaccine injuries. We know that there are adverse reactions, and I believe it is important that we dedicate resources to better understand why some children have these reactions.

For too long, those who run our national vaccination program have viewed those who have adverse reactions, including those with severe adverse reactions, as the cost of doing business. Furthermore, the vaccine compensation program, which was designed to be a no-fault compensation system, has become so adversarial that only the most obvious cases receive compensation, and too many parents feel that the program is not worth the difficulty of going through it.

The questions I raise are multiple. The number one question has been whether neurologic problems were caused in some children by the high levels of a mercury containing additive that was included in our vaccines in the 1990s. This mercury containing additive is called thimerosol, and in the 1990s, infants and unborn children were exposed to significant amounts of mercury at a most critical point in their development.

Now, this recent Institute of Medicine report, what exactly is wrong with it? What about it has so many people in the autism community upset?

In my 10 years of service in the U.S. Congress, I have never seen a report so badly miss the mark. I have heard some weak arguments here in Washington, D.C., and I can tell my colleagues that the arguments put forward in this IOM report are indeed very weak.

□ 1715

Let us examine this report in some detail. On January 15 of this year, I wrote Dr. Julie Gerberding, the director of CDC, and I asked her to postpone the February 9 Institute of Medicine meeting and this report because of my concern that this was not an exercise in discovering the truth, but was instead a meeting, and I will quote what I said in my letter, ''being driven by a desire to shortcircuit important research and draw premature conclusions.''

I said, ''If the purpose of this meeting is to seriously consider and address these concerns, then this will not be accomplished.''

Quoting further from my letter to Dr. Gerberding, I said, ''It appears to me, not only as a member of Congress but also as a physician, that some officials within the CDC's National Immunization Program, the NIP, may be more interested in a public relations campaign than getting to the truth about Thimerosal.'' I said, ''Pressing forward with this meeting at this time I believe will further undermine the credibility of the Centers for Disease Control on matters of vaccine safety and do damage to the reputation of the Institute of Medicine. I believe the proposed date of this meeting, which you have the ability to change, is in the best interest of no one who is seeking the truth about a possible association between vaccines and neurodevelopmental disorders, including autism.''

Now, I had a follow-up conversation on February 3 of this year with Dr. Gerberding, and she assured me that the Institute of Medicine's February meeting was not an attempt to ''draw conclusions,'' but merely to ''update the science,'' of where we were, basically.

However, it is clear that this report draws conclusions; and what is perhaps the greatest outrage, it goes further to call for the halt of further research.

A public relations campaign, rather than sound science, seems to be the modus operandi of officials at the CDC's National Immunization Program. Why do I say this? Let us look not only at the timing of the IOM meeting in February, the content of the IOM report, but also at studies the IOM used as a basis for their decision.

The Institute of Medicine bases their decision almost entirely on five epidemiologic studies. Epidemiology is essentially the statistical analysis of disease in populations. All of these studies were conducted by researchers with an interest in not finding an association. All of the studies had significant shortcomings, all of which the IOM itself declares would miss the association with autism in a genetically acceptable subset of children.

Not only the timing of the IOM meeting raises suspicions but also the narrowing of the scope of inquiry and the emphasis the IOM placed just on epidemiology.

In 2001 the Institute of Medicine concludes: ''Exposure to Thimerosal-containing vaccines could be associated with neurodevelopmental disorders.'' The IOM also recommended that children not be given mercury-containing vaccines.

What was the response of the CDC? For this most recent report, they narrowed the IOM scope to looking just at autism. Does that sound like an agency interested in understanding whether or not Thimerosal is harmful to some children, or does this response lead one to conclude that they are more interested in designing something to reassure an increasingly skeptical public?

Unlike 2001, this time the IOM was directed by the CDC to only consider the possible relationship between Thimerosal and autism rather than neurodevelopmental disorders as a whole. Anyone familiar with the Verstraeten study, a study published looking at Thimerosal and autism, knows exactly why the IOM scope was narrow, because the 2003 Verstraeten study found associations between Thimerosal and neurodevelopmental disorders in some children with autism may have been misdiagnosed as having speech or language delay. By narrowing the scope, which largely went unnoticed by the media, the CDC has avoided acknowledging that Thimerosal very well may have caused neurodevelopmental disorders in some children.

This latest IOM report is simply part of a PR campaign, in my view. Would we not have had a much more productive report if the CDC had updated the research on possible associations between Thimerosal and neurodevelopmental disorders as a whole? In evaluating Thimerosal's relationship to autism, the IOM relies almost exclusively on these five epidemiologic studies.

The principal authors of all five of these studies have serious conflicts of interest. All five studies were published in 2003, leading up to the IOM's February 2004 meeting. All were conducted while the CDC and the NIH virtually ignored the Institute of Medicine's 2001 biological and clinical research recommendations.

It is critical to note the instructions that the IOM was given, primarily by the CDC, which has been funding the IOM.

Pages 5 and 6 of the IOM report make it clear that epidemiology was to reign supreme. In the absence of epidemiologic evidence to support causality, the IOM was instructed to give biological evidence little consideration and was prohibited from allowing biological evidence to lend evidence towards causality.

Is it any wonder that the CDC has spent the past 2 years dedicating significant funding to epidemiology while

starving funding for clinical and biological research? The IOM notes in their report that the epidemiologic studies they examined were not designed to pick up a genetically susceptible population, and this is the very theory of the link between Thimerosal and autism and autism spectrum disorders. One in 167 become autistic. Why do the other 166 not? It is because they do not have the impaired ability to eliminate mercury from their system. We are looking at a genetically susceptible subpopulation. Yet these studies that they base this report on, they admit, were not capable of picking up these subsets in the populations.

Let us look at these studies. The only study done in the United States, the Verstraeten study, was published in the Journal of Pediatrics in November of last year. Much has been written exposing the study's methodological problems, findings, and conclusions. Most importantly, however, is that this study did not compare children who got Thimerosal to those who did not. Instead, its CDC-employed authors focused primarily on what is called a dose response gradient. Those who got less Thimerosal later in life had less autism is the theory behind the study.

In addition to the study itself, it is important to note the public relations spin surrounding this study. On the day the Verstraeten study was released, a top CDC researcher and coauthor of the study was quick to declare to the news media: ''The final results of the study show no statistical association between Thimerosal vaccines and harmful health outcomes in children, in particular autism and attention deficit disorder.''

Let me repeat that: The final results of the study show no statistical association between Thimerosal vaccines and harmful health outcomes in children, in particular autism and attention deficit disorder. The newspaper headlines of the day read: ''Study Clears Vaccine Containing Mercury,'' the Associated Press and USA Today. ''CDC Says Vaccines Are Safe,'' the Seattle Times. While that was the spin of the day, allow me to quote from the study:

''We found no consistent significant associations between Thimerosal-containing vaccines and neurodevelopmental outcomes. In the first phase of our study, we found an association between exposure to mercury from Thimerosal-containing vaccines and some of the neurodevelopmental outcomes screened. In the second phase, these associations were not replicated for the most common disorders in an independent population. They did find associations, but they changed the study and most of the associations disappeared.

Furthermore, in January 2004, the lead coauthor was forced to admit that many children in the study were too young to have received an autism diagnosis. He went on to admit that the study also likely mislabeled young autistic children as having other disabilities, thus masking the number of children with autism. The message from the CDC to the media was that there is nothing to be concerned about, but the study said something different. The news media to a large degree took the CDC's spin hook, line and sinker. Largely they chose not to read the study itself.

Five months after that study was published in the Journal of Pediatrics and, I might add, after the IOM report was largely written, Dr. Thomas Verstraeten broke his silence in a letter to Pediatrics stating, ''The bottom line is and has always been the same, an association between Thimerosal and neurological outcomes could neither be confirmed nor refuted and therefore more study is required,'' is what Dr. Thomas Verstraeten said. Dr. Verstraeten, the lead author of this study, says that an association between Thimerosal-containing vaccines and neurodevelopmental disorders cannot be refuted based on his study.

Yet the IOM in their assessment of that same study states that it is a basis for concluding, ''There is no association between Thimerosal-containing vaccines and autism.'' The IOM acknowledges that Verstraeten would not have picked up an association in a genetically susceptible population. The IOM also noted that the study was limited in its ability to answer whether Thimerosal in vaccines causes autism because the study tests a dose response gradient, not exposure versus no exposure.

I might also add, Mr. Speaker, that the Verstraeten study cannot be validated. The earlier data sets have been destroyed, and the only data sets the CDC will make available to outside researchers are the ones they have already manipulated. The raw, unaltered data is not available. Additionally, outside researchers are held to a much more restrictive access to information than are the CDC researchers. Only one independent researcher has been granted access to the CDC's VSD database, and the CDC has kicked that researcher out based on ridiculous reasons. They claim their research methods might infringe on privacy, yet they know the database contains no names and it is impossible to locate the patients from this database.

I want to talk briefly about the other four studies that the Institute of Medicine based its conclusions on. The IOM cited the 2003 Hviid study of the Danish population as one of the key studies upon which it based its conclusions. Let us first consider the conflict of interest of the principal author. Dr. Hviid works for the Danish Epidemiology Science Center, which is housed at the Staten Serum Institute, the government-owned Danish vaccine manufacturer. Also, all of his coauthors either work with him at the center or are employed by the SSI.

The SSI, the Staten Serum Institute, makes a considerable profit off the sales of vaccine and vaccine components and the U.S. is a major market for the SSI. SSI has $120 million in annual revenue, and vaccines are the fastest-growing business segment, accounting for 80 percent of its profits. Both the United States and the United Kingdom are important export markets for SSI's vaccines and vaccine components.

Furthermore, if Hviid were to find an association between Thimerosal and autism, SSI, with which he and his center are affiliated, would then face significant lawsuits. These facts are important and are critical when evaluating Dr. Hviid's work. Furthermore, this study looked at autism and not at neurodevelopmental disorders.

The important thing in evaluating this study is that exposure in the Danish population to Thimerosal varied considerably from that in the United States. Danish children received 75 micrograms of mercury in their first 9 weeks of life and then another 50 micrograms at 10 months. By comparison, children in the United States received 187.5 micrograms of mercury by the age of 6 months, nearly 2½ times as much mercury as the Danish population.

Dr. Boyd Haley has said that comparing the exposure of the U.S. children to these children in Denmark is like comparing apples and cows. I think there is a lot of truth to that. Hviid states that the rate of autism went up after they began removing Thimerosal from vaccines in 1992. The numbers in Hviid's study were skewed in that they began to add outpatient autism diagnoses after 1992.

□ 1730

The IOM notes other limitations of the study, including the differences in the dosing schedule and the relative genetic homogeneity of the Danish population; yet even with all these serious limitations, the IOM felt that the study had ''strong internal validity.'' Like the Verstraten study, Hviid would not be able to pick up a group of children who were genetically susceptible to mercury toxicity, principally because they have impaired ability to excrete mercury.

Case in point: Danish autism rates are six in 10,000, where in the United States it is less than one in 200.

I do not believe how they can use a Danish study as a valid conclusion to say that thimerosal did not cause the increase in autism and other autism spectrum disorders and neurodevelopmental disorders in the United States when children in the United States received significantly more mercury exposure.

Another study that the Institute of Medicine relied on was the Madsen study. Madsen et al., once again examined virtually the same population, Danish children, Danish children who received significantly less than they. Let us consider the conflicts of interest in the Madsen study. First of all, two

of Madsen's co-authors are employed by the same Staten Serum Institute. The study, like Hviid, added outpatient cases into the number of cases of autism after 1995, a methodological flaw. The authors acknowledged that this addition might have exaggerated the incidence of autism after the removal of autism. The IOM acknowledged this but yet used the data anyway.

Another study that the IOM relied on, the Stehr-Green study, examined, guess what, the Danish population again, along with the Swedish population. I will not repeat the problems with the Danish data, but with regard to Sweden it is important to note that the children there received even less thimerosal than children in Denmark, receiving only 75 micrograms by 2 years of age versus children in the United States receiving 187.5 micrograms by 6 months of age.

Furthermore, the authors included only inpatient autism diagnoses in the Swedish population. The IOM notes that the ecological nature of this data ''limits the study's contribution to causality,'' but they cite it anyway.

The Miller study also included in the IOM report examines the population of children in the United Kingdom. This study is still unpublished, which limits its ability to be examined critically. It is important to note, however, that Dr. Miller has actively campaigned against those who have raised questions about vaccine safety. We have a person here who is actively campaigning, testifying in lawsuits, against the theory that thimerosal is linked to neurodevelopmental disorders and autism, doing a study supposedly showing there is no link.

So what can we conclude about these five epidemiologic studies? We can see clearly why the IOM is on very shaky ground in drawing the conclusion that it did. They based their decision on these five studies, three of them examining genetically homogenous children in Denmark. At least one employee of the Staten Serum Institute serves as a co-author on three of the studies. Only one study examines the U.S. population, and that study did not compare children who had received mercury with those who had not. Four of them are studies of children receiving less than half the amount of mercury that U.S. children received. None of them with any ascertainment of prenatal or postnatal background mercury exposures, none of them considering prenatal exposure which may have been given to the children, none of them have been able to detect a susceptible subgroup in the population, three of them failing to address how the addition of outpatient cases of autism in Denmark might have previously skewed their results. Four of them examined populations with autism rates considerably less than the United States, and one of these studies has never been published. It is impossible to review the data.

Might I also add they are all statistical studies. There have been numerous biological studies suggesting that thimerosal is linked, mercury is linked to autism, specifically mercury studies that show after chelation therapy, children with autism excrete a tremendous amount of mercury in their urine, whereas normal children do not.

And it is important to note that there was a recent report published by Dr. Emili Garcia-Berthou and Dr. Carlos Alcaraz examining statistical errors in medical publications. They found five volumes of Nature and 11 volumes of the British Medical Journal. They found 11 percent of the computations in Nature and the BMJ were incongruent and at least one statistical error appeared in 38 percent of the papers, despite all the biological evidence suggesting there may be a link with thimerosal and autism here and the obvious knowledge that many of these statistical studies are flawed. The Institute of Medicine concluded, and many people in the press believed it, that there is no link.

Mr. Speaker, something needs to be done. The Institute of Medicine report not only looked at the mercury issue. It as well looked at the issue of the safety of the measles-mumps-rubella vaccine. Many years ago a researcher in England, a Dr. Andrew Wakefield, published a report suggesting that some children with autism have measles virus growing in their intestines causing a condition called inflammatory bowel disease, and, indeed, there have been recent reports in the medical literature that some of these children have measles virus particles in their cerebral spinal fluid and elevations of a protein called myelin basic protein in their cerebral spinal fluid, suggesting they have an active low-grade encephalitis being caused by measles virus.

The IOM was asked to look at this issue. How did they approach this issue? Did they ask for research protocols that attempted to duplicate the Wakefield study? No. What they did was again another epidemiologic study.

I believe that the CDC's conclusion and the Institute of Medicine's conclusion on the MMR is well flawed. I am pleased that finally attempt is underway to duplicate Dr. Wakefield's findings, and hopefully we can get some answers to these questions regarding the safety of the measles-mumps-rubella vaccine.

For the reasons that I have outlined above and other reasons, the Institute of Medicine report I believe is premature, perilously reliant on epidemiology, based on preliminary and incomplete information, and I believe may ultimately be repudiated perhaps in short order. This report will not deter me nor the autism community from our commitment to see that thimerosal and MMR research is properly done. This report will do nothing to put to rest the concerns of parents who believe their children were harmed by mercury-containing vaccines or the MMR vaccine. While this report will lead many clinicians to believe that thimerosal is safe and there are no problems with the MMR, it may contribute further to an erosion of the doctor/patient relationship in the United States.

This report has dragged the Institute of Medicine under a cloud of controversy that has currently engulfed the CDC. Much like the infamous 1989 study by the National Institute of Child and Human Development which missed the link between folic acid deficiencies and neural tube defects like spina bifida, the epidemiologic studies reviewed by the IOM in drawing these findings could easily have missed an association in susceptible populations.

Finally, let us remember that the IOM is not immune to error and has been forced to reverse itself before. Most recently, the IOM reversed a longstanding finding that chronic lymphocytic leukemia was not due to Agent Orange exposure. A similar reversal is very real and possible here.

On April 2 of this year, I introduced, along with the gentlewoman from New York (Mrs. MALONEY), H.R. 4169, the Mercury Free Vaccines Act of 2004. We currently have 22 co-sponsors from across the political spectrum. H.R. 4169 will phase out the use of mercury vaccines over the next 3 years, giving particular attention to completely eliminating mercury from childhood vaccines on an expedited schedule. This bill is a response to the fact that the safety of thimerosal in vaccines is not proven. Mercury is a well established neurotoxin. According to the EPA, one in six newborns is born with a blood mercury level considered unsafe. The FDA and the EPA recently warned pregnant women, nursing mothers, and young children to limit their consumption of certain fish. No one at the NIH or CDC can tell us what happens to mercury once injected into an infant. Where does it go? How much goes to the critical organs, how much to the brain? Can it cause damage to the developing central nervous system? No one has good answers to these questions, and they should have answers to these questions before more infants are exposed to mercury.

The CDC has adopted a policy to reintroduce mercury-containing vaccines to children in the form of the flu vaccine which will be given at 6 months, 7 months, and 23 months of age. Most of the flu vaccine on the market today contains mercury.

I believe we need new legislation. It is critical that we pass the Mercury Free Vaccines Act of 2004. It is also critical, I believe, that we make improvements in how we monitor for and respond to adverse reactions to vaccines. Today there are three government agencies that have responsibilities related to monitoring the safety of vaccines: the FDA, the CDC, and the NIH. The Food and Drug Administration has responsibility primarily to make sure that the vaccines are prepared according to specifications. They

do operate the Vaccine Adverse Events Reporting System.

The NIH does not have a concerted effort to fund vaccine safety research. They provide funding for research in a haphazard manner. If one happens to submit a proposal and it passes peer review, the study may get funded. The NIH has funded only a handful of studies over the past 2 years investigating vaccine safety issues. The CDC has the greatest responsibility in this area. Unfortunately, they have the greatest conflict of interest. The CDC's vaccine safety program amounts to a $30 million, million, a year program, and half of it goes to pay HMOs for access to the Vaccine Safety Database. The biggest conflict within the CDC is that they are also responsible for a $1 billion, $1 billion, vaccine promotion program. The CDC largely measures its success by high vaccination rates, and here lies the conflict. Any study raising concerns that there might be adverse reactions to some vaccines in some children has the ability to lower vaccine rates, and lower vaccination rates are in direct conflict with the CDC's top measurement of success. Clearly due to its overwhelming size and the manner in which the agency measures its success, the vaccine promotion program overshadows and influences the CDC's vaccine safety program. In fact, rightly or wrongly, the Vaccine Safety Office within the CDC is largely viewed by outside observers as nothing more than another arm of the vaccine promotion program, giving support to vaccine promotion policies and doing very little to investigate and better understand acute and chronic adverse reactions.

Further complicating the CDC's role in undermining the research is the fact that the vaccine safety studies produced by the CDC are impossible to reproduce. External researchers are not granted the same level of access to the raw data sets that the CDC's internal researchers are granted. The bottom line is that the CDC studies related to vaccine safety cannot be validated by external researchers, a critical component in demonstrating the validity of scientific findings. The CDC's recently convened Blue Ribbon Panel to examine how the CDC might better review vaccine safety is a step in the right direction. However, I do not hold out much hope because the panel is limited in its scope. Much like the IOM was limited in the outcome they were allowed to draw, this panel is limited to deciding where within CDC vaccine safety monitoring should be housed. The NIH recently recognized the importance of moving patient safety monitoring out of the NIH. I believe the same should be done with vaccine monitoring. It should be completely removed from CDC's jurisdiction. The CDC is too conflicted to oversee this function.

□ 1745

Mr. Speaker, I want to touch on one more additional issue, and that is something called the Brighton Collaboration. I am very concerned about the development of the Brighton Collaboration, which began in the year 2000. This is an international group comprised of public health officials from the CDC, Europe, and world health agencies like WHO and vaccine manufacturers.

The first task of the Brighton Collaboration, created several years ago, was to define what constitutes an adverse reaction to a vaccine. They have established committees to work on various adverse reactions to vaccines. Particularly troubling to me is the fact that serving on these panels defining what constitutes an adverse reaction to a vaccine are the vaccine manufacturers. What is even worse is the fact that some of these committees are chaired by vaccine manufacturers.

It is inappropriate for a manufacturer of vaccines to be put in the position of determining what is and what is not an adverse reaction to its product. Do we allow GM, Ford and Chrysler to define the safety of their automobiles? Do we let airlines set the safety standards for their airlines and determine the cause of an airline accident? Do we allow food processors to determine whether or not their food is contaminated or causing harm? Then, I ask, why are we allowing vaccine manufacturers to define what constitutes an adverse reaction to a vaccine?

This collaboration is fraught with pitfalls, and merges regulators and the regulated into an indistinguishable group. It is critical that the American public look at what is going on here and how this entity may further erode the ability for us to fully understand the true relationship between various vaccines and some adverse reactions in some subsets of our population. I plan to devote additional attention to this effort in the future.

Mr. Speaker, I look forward to working with you and others in this body to address the problem that we face today.

As I stated at the outset of my comments this afternoon, autism was once in America a rare and infrequently seen condition. I went through 4 years of medical school, internship, residency, and years of private practice and practice within the military and had not seen one single case. I have seen case after case in my congressional district over the last 7 years, a disease that I had never seen before.

The disease incidence was previously thought to be one in 10,000. It is now thought to be as high as possibly one in 167, an almost 100-fold increase in the incidence.

We need to get answers to these questions. We need to restore public confidence and safety in our vaccine program. Our vaccine program saves millions of lives, it saves millions of kids from a life of disability, and the best way for us to ensure public confidence and make sure that all the kids get vaccinated properly is to get answers to these questions. The way the CDC and the Institute of Medicine and the industry is going about trying to answer these questions is highly flawed.

Mr. Speaker, I encourage my colleagues to begin to look at this issue. I know that many of them are coming to me saying they have parents coming in their offices now with autistic kids, saying something needs to be done. Something needs to be done.

THE PROBLEM WITH U.S. POLICY IN THE MIDDLE EAST

The SPEAKER pro tempore (Mr. GARRETT of New Jersey). Under the Speaker's announced policy of January 7, 2003, the gentleman from Florida (Mr. MEEK) is recognized for 60 minutes as the designee of the minority leader.

Mr. MEEK of Florida. Mr. Speaker, once again, as I always say, it is a pleasure to address the House of Representatives and the American people. Tonight I will be joined by some of my colleagues who will this evening be talking about the issue that is facing not only our military but our future as we start to deal with this effort against terrorism.

First of all, I would like to give my condolences to the family that lost their loved one that was held hostage. Our thoughts and prayers are with you and your family and your local community. Unfortunately, all too often now, violence has played such a very strong role in the way not only Americans live but also how individuals live abroad.

I just would like to make some opening comments. When we start talking about how we entered Iraq, claiming we were better than the dictator Saddam Hussein, which I do believe very strongly we are still, there are some decisions that are being made that are putting into jeopardy how the world feels about the United States of America and also how the world views our moral high ground, or what is left of it as it relates to abuse.

I think it is important for us to remember that Iraqis at the beginning gave us a great deal of credit. They were believing that we would deliver on our promise of providing security, safety and democracy that they could believe in and live under. Now revelations of prisoner mistreatment have really clouded the minds of many Iraqis that had hoped.

Some Iraqis saw us as being a part of holding out the flag of hypocrisy in the region due to the fact of the Abu Ghraib issue. The scandalous impact of opinions, especially of Iraqis and other members of the world, of photographs that have been made public throughout the Muslim world, is deeply repugnant to most Muslims.

I think it is also, Mr. Speaker, important for us to remember that as we start to look at what is taking place in Iraq, at the top of the week we thought it would be a good week for coalition forces as it pertains to the new Iraqi