who receive sensitive information to lessen the chance that it will be inadvertently disclosed and harm our national security. As such, much of the good news in intelligence is never brought to light.

When the CIA breaks up a terrorist cell in Albania or Egypt it cannot be disclosed. When critical information is discovered by our intelligence community about weapons trafficking on the high seas, the weapons can be confiscated, but the American people are not told.

Unfortunately, only the operations that fail become public. So our CIA Directors are generally not known for their successes, only for their failures.

It is an historical fact that there has been great temptation to use intelligence operations and analysis to achieve political objectives.

As most of my colleagues know, the Senate established the Select Committee on Intelligence in the mid-1970s to review intelligence activities in response to improprieties which occurred in the 1960s and 1970s. During that period, I was fortunate to serve as the first Chairman of the Senate Intelligence Committee.

There have been other unfortunate incidents when individuals in the executive branch have circumvented the law to further their objectives. We all remember the Iran-contra scandal when rogue elements ran an extra legal operation out of the White House.

Some have suggested that intelligence was recently politicized to justify the war on Iraq.

It is my view, and I think history will one day prove that any politization of intelligence that might have occurred on Iraq did not come from George Tenet.

Those who are charged with oversight of intelligence for the Congress have a difficult task. We must review intelligence activities and practices, but the universe is truly enormous. There are not enough hours of the day for us to know all the details of intelligence. We could never amass enough staff to monitor every action of the intelligence community. Therefore, we need to be able to trust our intelligence leaders.

The Senate could trust George Tenet to tell the truth and be forthright with this institution. Perhaps it was because of his background as a Senate staff member, but George was always eager to inform and consult with the Senate to share important information regardless how sensitive it might have been.

My experience with the CIA has been that many past Directors were reluctant to provide detailed information to the Congress. Perhaps it was the ingrained culture that protects secrets, or perhaps it was the lack of trust between the executive and legislative bodies, but for whatever reason, they didn't want to tell the Congress any more than they had to.

With George it was different. He would take time to explain controversial and highly classified issues in detail. At times he would direct his associates in the community to be more forthright in their responses when he felt they might be holding back.

George Tenet trusted the Congress with the Nation's secrets as partners in national security, not adversaries or impediments.

I know the Director has his critics, but they do not come from the Defense Subcommittee. I think I can speak for my chairman when I tell you we both had the utmost confidence in George Tenet. And, no one in the Senate or the House has spent more years overseeing the intelligence community than Ted and I.

George Tenet is depicted today by some as the Director of Intelligence who failed to stop the tragedy of 9/11 and criticized for the description by author Bob Woodward that the case for weapons of mass destruction in Iraq was a ''slam dunk.'' Both of those miss the point.

George Tenet should be remembered as one of the finest Directors in the history of Central Intelligence. He should be remembered as the most honest and forthright of any CIA Director. He should be thought of as the Director who took an agency from the cold war mentality and started to reshape it for the 21st century. I know he will be remembered by the thousands of CIA employees as a great leader who did his very best to support them and the entire intelligence community.

I will remember him as a tremendous public servant who served honorably, effectively and tirelessly.

Mr. President, someday when the records are declassified and the analysis is completed, historians will likely remember George with great regard. It is my view that he should not have to wait. We should all thank him for his dedication to duty and his service to our country.

ELIMINATION OF THE 30-PATIENT LIMIT FOR GROUP PRACTICES

Mr. LEVIN. Mr. President, S. 1887, which the Senate adopted yesterday, ensures that all appropriately trained group practice physicians may prescribe and dispense certain recently approved drugs for the treatment of heroin addiction. It addresses the unintended effect of the Drug Addiction and Treatment Act of 2000, DATA, that hinders access to new treatments for thousands of individuals who seek such help.

When Congress passed DATA as Title XXXV of the Children's Health Act of 2000, Public Law 106–310, it allowed for the dispensing and prescribing of Schedule III drugs, like buprenorphine/naloxone, in an office-based setting, for the treatment of heroin addiction. As a result of DATA, access to drug addiction treatment is significantly expanded; patients no longer are restricted to receiving treatment in a large clinic setting, but now may receive such care from specifically trained physicians in an office-based setting.

DATA limits qualified individual physicians to treating no more than 30 patients at a time. This same 30-patient limit applies to medical groups as to individual physicians. For example, the physician members of the Duke University Medical School faculty practice plan may treat only 30 patients at one time, even though they may have 10 individual physicians trained and willing to treat patients and more than 30 patients would benefit from newly available treatment. The difficulties that have arisen, including the dashed hopes for treatment of many, due to the patient limitation on group practices, are detailed in a May 30 article in the Boston Globe, by Peter DeMarco. I would like to share a few excerpts from that article with my Colleagues, as follows:

When buprenorphine became available as a treatment for OxyContin and heroin addiction 18 months ago, many medical professionals and addicts hailed it as a miracle drug, bringing addicts back from the brink and helping them lead normal lives when all else had failed. But for many addicts, buprenorphine remains one of the hardest drugs to obtain. Approved by the Federal Food and Drug Administration in 2002, buprenorphine is an opiate like heroin or the painkiller OxyContin. Unlike those drugs or methadone, the prescribed drug it's meant to replace, buprenorphine doesn't cloud the minds of patients, allowing them to work or study as if they're not on any drug at all. Nearly all who take buprenorphine, meanwhile, say they lose all physical cravings for street drugs.

But a combination of federal limits on the distribution of buprenorphine, and reluctance on the part of some physicians to offer it to patients has kept thousands of opiate addicts from receiving the drug in Massachusetts and across the country. At the heart of the issue is federal legislation passed in 2000—two years before the drug was approved by the FDA—that restricts individual clinical practices from treating more than 30 patients with buprenorphine at a time.

While many substance-abuse experts say the 30-patient figure is too low for some practices, their main quarrel with the Drug Addiction Treatment Act of 2000 is its failure to differentiate single-physician practices, hospitals, and health care organizations. For example, all the doctors who work for Tufts Health Plan can treat a combined 30 patients—the same total as can be seen by a physician practicing alone.

Boston health officials, along with their counterparts in the State and Federal governments, say the Federal legislation erred on the side of caution, and needs to be changed to allow wider access to buprenorphine.

Boston Medical Center's main practice has 200 or more general internal-medicine doctors, and within that practice, we can only treat 30 people. It's the craziest loophole,'' said Colleen Labelle, nurse-manager of the hospital's Office-Based Opioid Treatment Program. ''We get 20 calls a day from across the state. People are begging, desperate to get treated, who we can't treat.''

The Federal Substance Abuse and Mental Health Services Administration has begun an internal process to increase the 30-patient cap. But because any proposed change would be subject to the public-review process, approval could take as long as two years, said

Nick Reuter, a senior public health analyst with the agency.

It clearly was not the intention of DATA that individuals seeking treatment have less access to new medications simply because they receive care from a physician practicing in a group, or from a group-based or mixed-model health plan. Nevertheless, this is the effect it is having and it is a severe effect. The problem is addressed by removing the 30-patient aggregate limit on medical groups. The patient limitation would remain on individual treating physicians. This is achieved in the bill, S. 1887, which I introduced along with Senators HATCH and BIDEN. It simply removes the statutory limit on the number of patients for whom doctors in medical groups may prescribe certain newly available, FDA-approved medications to treat heroin addiction.

I would like to close with another excerpt from Mr. DeMarco's article regarding the positive impact buprenorphine treatment has had on an individual who sought help with his addiction, and was fortunate enough not to be turned away. It is as follows:

Timothy Tigges says his addiction began after he wrenched his back and bummed a few Percocet pills, a prescription analgesic, from a friend to dull the pain. Before he knew it, he was hooked on opiates, alternating between OxyContin and shooting up heroin as his life went to pieces.

In October, Tigges, a 27-year-old East Boston carpet installer, began taking buprenorphine, placing an orange pill the size of a dime under his tongue until it dissolves, four times daily. He hasn't touched an illegal drug since the day he started the program, has put on 80 pounds from lifting weights at the gym, and has yet to miss a day of work. For the first time in three years, Tigges hopes to see his 5-year-old daughter, whose mother has refused to let him visit.

I've had clean urines, 100 percent, for nine months now. There's nothing I'm prouder of than that,'' he said, choking back emotion. ''What I read on the front page of the paper every day is 18- and 20-year-old kids dying of garbage drugs. There's just no need for it. I would take every ounce of heroin off the street and give them this stuff. You watch the crime rate go down.

Mr. President, I thank my colleagues for their wisdom in adopting this much-needed legislation.

TRIBUTE TO LORRAINE PERONA

Mr. LIEBERMAN. Mr. President, I rise to express my deep gratitude to my long-time office manager, Lorraine Perona, who, after more than 27 years of outstanding and dedicated service to the U.S. Senate, is retiring on June 30, 2004.

When I first took office as a U.S. Senator from the State of Connecticut on January 3, 1989, Lorraine was one of a small group of staff members I had assembled to assist me as I began my service. I was fortunate to have a person of Lorraine's extensive knowledge and years of Senate staff experience to set up my office. She did a wonderful job and has kept my office running for more than 15 years, as office manager and financial director; and she has done so with style and grace. She has been an influential leader in my office, and her contributions have been many. Many staff and interns have passed through the doors of my office over the years. All have benefitted from Lorraine's caring guidance, common sense, and expertise.

Lorraine studied international relations at American University and subsequently worked at Dartmouth College in charge of foreign study programs. Through a contact there, she learned of an opening in the office of Senator John Durkin, Democrat from New Hampshire, and thus began her Senate career in March 1977. Following her work in Senator Durkin's office, Lorraine built her career in the Senate setting up offices for newly elected Members, including Senator CARL LEVIN, Democrat from Michigan, in 1979, Senator FRANK LAUTENBERG, Democrat from New Jersey, in 1982, and, of course, myself in 1989. Lorraine is an expert at creating attractive, functional and comfortable work spaces, not an easy task given our limited space and resources. She is respected and beloved among her office manager colleagues and throughout the Senate community, where she has made many friends.

For the past few years, Lorraine has been faced with many serious health problems. She has faced these personal challenges with great courage. Despite her suffering and hardship, she has continued to do her utmost in service to me and the citizens of Connecticut. Lorraine has been an inspiration to us all.

I know it is difficult for Lorraine to leave my office and her extended Senate family; she often speaks of the Senate as ''home.'' It is difficult for us, as well, for we will miss her kindness, warmth, and wise counsel. But hers is a retirement well earned, and Lorraine can be very proud of her public service and contributions to the work of the Senate. As she completes her Government career, I wish Lorraine good health and every happiness. I know she has a great deal to look forward to with her husband, Bernie Rooney, and lovely daughter, Shannon, and I wish them all the best.

I extend to Lorraine Perona my personal thanks and congratulations for more than 27 years of exemplary service to the U.S. Senate.

ALLIED HEALTH REINVESTMENT ACT

Ms. CANTWELL. Mr. President, last week I introduced S. 2491, the Allied Health Reinvestment Act, with my colleagues, Senators BINGAMAN and LIEBERMAN. As I mentioned at that time, the Allied Health Reinvestment Act will encourage individuals to seek and complete high quality allied health education and training by providing additional funding for their studies. This funding will help provide the U.S. healthcare industry with a supply of allied health professionals support the nation's health care system in this decade and beyond.

The bill has a number of supporters. I would particularly like to express my appreciation to the Association of Schools of Allied Health Professions, ASAHP, for its support of the legislation as well as its ongoing efforts to address the need for allied health professionals and allied health faculty.

ASAHP, founded in 1967, has a membership that includes 105 institutions of higher learning throughout the United States, as well as several hundred individual members. ASAHP publishes a quarterly journal and also conducts an annual survey of member institutions. This annual survey, called the ''Institutional Profile Survey,'' is used for, among other purposes, collecting student application and enrollment data. These data substantiates that there is a pressing need to address existing allied health workforce shortages, which have been further exacerbated by declines in enrollment that have occurred for 4 straight years.

Using data from the Institutional Profile Survey, as well as the General Accounting Office, U.S. Census Bureau, and other sources, ASAHP has compiled what I believe to be a compelling rationale in its support for the Allied Health Reinvestment Act that I introduced. Mr. President, I ask unanimous consent that the text of this Rationale for an Allied Health Reinvestment Act from the Association of Schools of Allied Health Professions be printed in the RECORD.

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

RATIONALE FOR AN ALLIED HEALTH REINVESTMENT ACT

Led by the Association of Schools of Allied Health Professionals, a Washington-DC based organization with 105 colleges and universities as members, a coalition of 30 national organizations supports the enactment of an Allied Health Reinvestment Act. S. 2491 was introduced in the 108th Congress by MARIA CANTWELL (D–WA), JEFF BINGAMAN (D–NM), and JOSEPH LIEBERMAN (D–CT) and H.R. 4016 was introduced in the House by CLIFF STEARNS (R–FL) and TED STRICKLAND (D–OH).

The well-being of the U.S. population depends to a considerable extent on having access to high quality health care, which requires the presence of an adequate supply of competently-prepared allied health professionals. Workforce, demographic, and epidemiologic imperatives are the driving forces behind the need to have such legislation enacted.

THE WORKFORCE IMPERATIVE

Many allied health professionals are characterized by existing workforce shortages, declining enrollments in academic institutions, or a combination of both factors. Hospital officials have reported vacancy rates of 18 percent among radiologic technologists and 10 percent among laboratory technologists, plus they indicated more difficulty in recruiting these same professionals than two years prior.

Fitch, a leading global rating agency that provides the world's credit markets with