inevitable, so the sensitivity with which policies and laws are drafted is absolutely critical for the future health of the nation.

The foregoing are dramatic changes in long-accepted traditions. Privacy of the health care record, legally regulated, is the visible ''new kid on the block.'' Unlike professional confidentiality, it has little ''wisdom of history'' behind it. Not surprisingly, there is a tendency to address privacy by tactics that might work for confidentiality but do not work for privacy, by placing heavy penalties on professional breaches. This is ineffective when little attention is given to the leaky-sieve aspects of the health care record system itself. In fact, it can be severely counter-productive if it poisons the traditional trusting relationship between patient and professional. The urgent need is for highly sensitive and highly enlightened health care policy that preserves the wisdom of the past.

Tentative Answers to Complex Questions: Five questions arise in the context of the new privacy era in health care.

1. How extensive should the health care record be? The health care record will, and should, become increasingly complex and extensive. Information technology allows the retention and utilization of vast quantities of information. The future health care record will almost certainly be in electronic form. With electronic data manipulation techniques, even an extensive record can be efficiently sorted to allow quick decisions about immunizations, allergies, past responses to specific treatment approaches, drug interaction risks, excessive or inappropriate drug use, and similar questions of care. Aggregated data across a given problem or disease spectrum could identify both promising and ineffective treatment approaches. The potential gain from having such records is impressive indeed, and the technology for collecting, preserving, and utilizing them is already largely in place.

2. Who should have access to what information? Portions of the health care record should be accessible by every health care practitioner with whom each client will potentially interact. Other portions should be accessible by insurers, managed care officials, and similar non-health-care personnel who have a direct and necessary ''need to know.'' Portions should be available for malpractice monitoring and similar purposes. Portions should be available to research programs, perhaps stripped of data identifying the individual source. The number of people who should have legitimate access, in the interest of improving the health of both our individual citizens and the nation itself, will inevitably grow.

3. How can access be made easy on a ''need to know'' basis? In this electronic age, partitioning the record for limited access is technologically easy. For example, a school nurse needing to certify an immunization record neither needs nor wants to sort through the entire record. An electronic summary of immunizations can be programmed into the record and be made immediately available to a coded request by a ''school health worker.'' Similarly, current health status and current proposed or completed treatments can be electronically isolated for benefit of reimbursement or managed care assessments without exposure of the entire chart. The mental health record can be sequestered, with access limited to those with legitimate interest in that area. In general easy electronic access to appropriate data can be designed into the system, provided inappropriate policies do not frustrate legitimate access in the name of security.

4. How can inappropriate access be prevented? Any effective solution requires that the electronic record itself be designed from the beginning to incorporate essentially failproof security features. In the past, ''loose lips'' were the primary problem, people with legitimate information intentionally or unintentionally leaking that information. Control of people was the primary solution. Within the health care professions, lapse of confidentiality has long been addressed by guild ethics and by licensing laws that regulate the actions of the professionals. Outside of the health care professions, especially in the economic sector, abuse of confidentiality still needs to be addressed more effectively.

Although important, loose lips are not the primary problem. They usually endanger only one person at a time, rather than thousands whose data may be accessible in the electronic record. Limiting access to the electronic record to those with a legitimate need to know is the most significant key to guaranteeing privacy. Electronic data can be hacked, copied, transported, collected, sold, and otherwise manipulated in ways that are difficult to detect by people who are hard to identify. Passwords and other access codes, encryption, and the like may be essential, but they are not enough. The Internet, the primary platform for current electronic data portability, has not yet achieved the levels of security that are necessary.

A workable system might involve a completely separate health information network operating out of a centralized data bank and accessible only through authorized terminals. Security might involve requiring bioelectronic screening for palm prints, iris patterns, voice prints, or the like prior to system access. Electronic ''footprints,'' or audit trails, could preserve a record of all data accessed and for what purposes. An alarm system could alert a central information-monitoring group when an unauthorized access was attempted or when an unusual pattern of access was detected. Such steps would make unwarranted penetration of the system rare, access to the system by authorized persons easy, and apprehension of violators probable.

5. Who should control the privacy information? Privacy rights should guarantee that health care information is held confidential within the health care system, except as the patient explicitly opts out of the privacy agreement. It is the patient's knowledge that his or her own sensitive information will be used only for health care purposes that assures the trust necessary for effective cooperation. Circulation of the information within the legitimate health care system is necessary and functional, but circulation outside of that system, without explicit and uncoerced patient consent, should be taboo. Public knowledge of personal health problems can be severely damaging. One only has to recall Eagleton's vice-presidential nomination.

A few legally mandated requirements, such as the duty to protect or the duty to alert authorities of abuse of helpless patients, currently require exceptions to confidentiality. Perhaps other exceptions are warranted, but professional experience suggests that they should be rare and very carefully crafted. We suggest that they should be limited to those circumstances that pose an explicit future threat to others or an abuse against which a patient is not capable of protecting himself/herself.

While a patient may voluntarily choose to waive some privacy rights, perhaps in exchange for convenience or other benefits, waivers that are determined by law as part of health care policy, as in certain sections of HIPAA, are often more disclosure notices than they are matters of voluntary consent. Without true voluntary consent, there is no choice and no trust. These complexities reflect the early growing pains of privacy law and can have serious unintended consequences.

It is in these areas of developing health care policy and related privacy law that health care practitioners can make some of their most important policy contributions. The danger is that others who determine such policies may either fail to understand or simply disregard the practitioner perspective, at great harm to the nation's health.

Conclusions: Practitioner work is anchored on two premises that have stood the test of time: patient trust, which is necessary for essential communication, and the guarantee of confidentiality of information, which requires that the health care record be used exclusively for health care purposes. The National Academies of Practice recommends that information in the health care record should be exclusively available for health care purposes and that the record should be protected from access for any other use.

Maintaining privacy with an ever expanding and easily accessible electronic health care record, in an ever more complex health care delivery system, requires new approaches. These approaches must be integrated into the record keeping and service delivery systems themselves, through technological safeguards. Health care practitioners cannot control the privacy of the health record and do not control privacy policy, but our long experience with confidentiality issues and our pragmatic wisdom concerning the treatment process offer understanding that should be an essential part of policy development.

Some present trends in national privacy policy are threatening the integrity of the practitioner/patient relationship. A sensitive and sophisticated privacy policy for health care records that does not jeopardize the necessary trust of the patient is critical to assure the effectiveness of health service delivery. Health care professionals that represent the wisdom of the multidisciplinary practitioner community are an indispensable resource for such policy development. Failure to incorporate them, visibly and functionally, into the policy making process risks jeopardizing the millennia-long practitioner tradition of establishing consumer trust on which the effectiveness of health care depends.

THE POLICE UNITY TOUR

HON. RODNEY P. FRELINGHUYSEN

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Wednesday, May 3, 2006

Mr. FRELINGHUYSEN. Mr. Speaker, I rise today to honor the Police Unity Tour. On May 9th, the Police Unity Tour will kick-off their 10th anniversary bicycle tour to our Nation's capitol.

For the past nine years, police officers have mounted their bicycles and cycled from New Jersey to Washington, DC, in memory of the men and women of the police force, who have sacrificed their lives while protecting our communities from harm. This year, the ride will begin on May 9 and end on May 13. The officers will depart from the Florham Park Police Headquarters, in Florham Park, NJ and will arrive at the National Law Enforcement Officer's Memorial in Washington, DC, culminating their journey with a candlelight vigil.

Established 10 years ago by Patrick P. Montuore of the Florham Park, NJ, Police Department, the Police Unity Tour started with 18 riders and has grown into a Nationwide project with participants and supporters from all over the country. The mission of the tour is to bring awareness to the lives of police officers who have died in the line of duty. The number of participants continues to grow with over 700 police officers participating last year.

In route to Washington, the tour will stop at Ground Zero, a place that will forever remind us of American heroes. The Police Unity Tour honors the heroes who lost their lives that day and reminds us that everyday our police officers, firefighters, and emergency service personnel devote their lives to protecting and serving our communities. Too many of these officers make the ultimate sacrifice and to them we are eternally grateful. We must never take their actions for granted and always remember the families and friends they leave behind.

Mr. Speaker, I urge you and my colleagues to join me in congratulating the participants of the Police Unity Tour on their 10th anniversary and for the work they do honoring those police officers who have died in the line of duty.

CELEBRATING THE 60TH ANNIVERSARY OF LA PERLA CAFÉ IN PHOENIX, AZ

HON. ED PASTOR

OF ARIZONA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, May 3, 2006

Mr. PASTOR. Mr. Speaker, I rise before you today to pay tribute to La Perla Cafe, a Mexican food restaurant in Glendale, Arizona, and its owners, the late Joseph Peralta Pompa, his wife Eva Macias Pompa, and their family, on the occasion of the 60th Anniversary of their restaurant.

La Perla has been a popular family-operated restaurant in the west Valley since 1946. In an industry where small business owners sometimes struggle to survive, the Pompas have thrived by following one simple rule: Serving food as good as what you make at home.

The Pompa family history in Arizona dates back to the early 1900s. Joseph Pompa was born in Pierce, Arizona, the son of the Pompas from Sonora, Mexico. When he was one year old, his father abandoned the family, which included his mother and seven sisters. The family moved to Jerome, Arizona, and Joseph, or Joe, began working as a copper miner at the age of 14.

Eva Macias Pompa was born in Camargo, Chihuahua, Mexico, and immigrated to the United States at the age of 1, along with her widowed mother. They arrived in Clarkdale, Arizona, where Eva's mother made a living by cleaning houses. She eventually remarried and had five more children. Eva's stepfather later became very ill so Eva had to quit high school in order to work to support her family. She cleaned houses to help make ends meet.

Joseph and Eva Pompa met and married in 1935. When Joe married Eva, he was the Welterweight Champion for Arizona. Eva couldn't bear the violence of boxing, and Joe retired from the sport. He took correspondence courses on electronics when he had free time, and received his degree. He was then hired as an electronic engineer at Goodyear Air Research.

The couple opened La Perla in 1946, determined to make their restaurant a success. Eva learned her cooking skills from her mother and had a passion for not only cooking Mexican food, but all ethnic foods. The Pompas were very kind, hard working people who wanted their children to have all the educational opportunities available, and to pursue a life defined by faith in God, pride in one's work, and happiness. As the restaurant took off, Joe and Eva had four children: Sylvia, Gloria, Joanne and Joseph. In 1961, Joseph senior passed away. Despite his sadness, the younger Joseph, also known as Butch, started working in the restaurant at the age of 13 to take his father's place. Butch grew up, married and had four sons and a daughter. Butch's son Gabe, a graduate of the San Francisco Culinary Art School, now is head of catering for La Perla and oversees cooking assistants.

La Perla has at one time or another employed aunts, uncles, cousins, and multiple generations of Pompa family members. The four generations of Pompas number into the hundreds and are part of the great American success stories woven into our U.S. history. Working as cooks, chefs, lawyers, teachers, salespeople, or real estate agents, all the Pompas have contributed to this country in their pursuit of the American Dream.

For this reason, I wish to honor The Pompas and I ask my colleagues to join me in congratulating the family on the occasion of La Perla Cafe's 60th Anniversary, and wishing them many more years of success.

COVER THE UNINSURED WEEK

HON. DENNIS J. KUCINICH

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 4, 2006

Mr. KUCINICH. Mr. Speaker, this is Cover the Uninsured Week. As we take this occasion to reflect on the ways in which we can cover the uninsured, I encourage my colleagues to address the issue head-on. We need a solution that will not only address the uninsured problem, but will also address the rising cost and inequities.

Consider that we pay almost twice as much for health per person than the average of other industrialized countries. Yet the World Health Organization ranks our health care system 37th in the world. The situation is worsening as costs continue to increase, employers continue to scale back coverage and the number of uninsured, now 46 million, continues to rise. Four out of five (82%) of the uninsured are in working families. 46% of all bankruptcies were either fully or partly caused by illness or medical bills according to a Harvard study. Three-quarters of those bankrupted by illness were insured when they first got sick. Our health care system based on private health plans gives us low quality, inefficiency, inaccessibility and is ultimately unsustainable.

The inefficiency of privately administered health care is especially stark. Between 1970 and 1998, total healthcare employment in the US grew 149 percent while the number of managers in health care grew 2348 percent. Our businesses bear the burden of that inefficiency because they provide health care to most Americans lucky enough to have it. All other industrialized countries have universal health care that costs less. The result is that our businesses are losing competitive advantage. Ontario now makes more cars than Detroit. Canadian GM, Ford, and Daimler Chrysler signed a letter in support of their single payer heath care system because of the advantage it gives them.

Managed care has failed. Employer based insurance is failing and dragging down American businesses. Consumer driven health care being trumpeted by right wing ideologues tries to control costs by providing less care, not more. Instead, we need to control costs by addressing the real inefficiencies, not by growing the uninsured and underinsured. We know exactly how to do it.

Traditional Medicare enjoys consistently higher satisfaction ratings than private insurance. Its overhead costs are about 3 percent compared to overhead costs of private health plans which average about 31 percent. Medicare's rates of cost increase have been significantly lower than in private health plans. We need such a time tested, rock solid model like Medicare to address our health care crisis. In fact, by addressing the inefficiencies, we could bring everyone in the U.S. under Medicare and they would pay no premium, no deductible, and no copayments.

Polls consistently find that Americans favor expanding government guaranteed health insurance like Medicare to all Americans. The Deans of medical schools including Harvard and Stanford, 14,000 doctors, including the former editor of the New England Journal of Medicine, and two former Surgeons General now support national health insurance like HR 676. Newspapers around the country are making the case for Medicare for All, including two recent editorials in the New York Times and the Wall Street Journal. Over 100 unions have officially endorsed it. HR 676 boasts the support of 69 members of Congress, including 9 ranking members of full committees and 28 ranking members of subcommittees.

Access the high quality health care is a right. I encourage my colleagues to support real health care reform that covers all of the uninsured and contains costs. Please support HR 676, the Expanded and Improved Medicare for All Act.

IMMIGRANTS ANSWER CALL TO SERVICE, CALL TO NEW LIFE

HON. DAVID G. REICHERT

OF WASHINGTON

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 4, 2006

Mr. REICHERT. Mr. Speaker, I rise today to call attention to a problem we're seeing the effects of all over the country, immigration.

As a former cop, I respect and appreciate those who've dedicated their lives to serving others as well as those who appreciate the rule of law and honor it. In my time in Congress, I've seen these two values come together in an interesting way as my office has assisted in immigration casework.

Abdullah Yousify contacted my office because he needed citizenship to continue his work in Iraq with Northwest Medical Teams.