skilled workforce to meet Flagship's vacancy demands and keep up with a more diverse economy.

Chuck's dedication to his community is evident through his service on the boards of Community Hospital, Energize East Central Indiana, Extreme Defense Systems, Anderson University Students in Free Enterprise, and Anderson/Madison County Chamber of Commerce. Chuck chaired the Committee for North Anderson Church of God and the Steering Committee of the World Class City Forum. Notably, he served as Chairperson on the Blue Ribbon Committee, responsible for negotiations and an exit strategy with General Motors in Anderson. He also served as President of the Anderson City Planning Commission and the White River Development Commission.

His many awards are a testament to the exceptional work ethic of this incredibly talented individual. In 2006, Chuck received the Community Image Award from the Anderson/Madison County Chamber of Commerce as well as two awards from the Anderson Rotary both for his personal contributions and for his Flagship contributions. In 2003, Governor Mitch Daniels awarded him the Distinguished Hoosier Award for his work in the community. He also received the Chief Anderson Award by the City of Anderson in 2003, the Distinguished Citizen Award from Boy Scouts of America in 2013, and the Sagamore of the Wabash from Governor Mike Pence in 2013.

Chuck has made a remarkable impression on his community through his lifetime commitment to service. He has truly left a legacy of success at the Flagship Enterprise Center that will be built upon for years to come. On behalf of Indiana's Fifth Congressional District, I congratulate my friend Chuck on his extraordinary career and extend my gratitude for the wonderful contributions he made to our Hoosier community. While I know Chuck will be missed at the Flagship Enterprise Center, I wish him a happy retirement, with his wife Lynn, enjoying more time with family and friends.

COMMEMORATING THE PAST EIGHT YEARS OF SERVICE TO THE PEOPLE OF PENNSYLVANIA

HON. LOU BARLETTA

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 12, 2018

Mr. BARLETTA. Mr. Speaker, as the 115th Congress comes to a close, so does my time here in Washington.

First and foremost, I want to thank the people of Pennsylvania's 11th District who sent me here, who trusted me to make Washington work for them. It has been an honor to serve them in the U.S. House of Representatives over the past eight years.

During my time in Congress, I never once forgot that the people of Pennsylvania were the reason why I was here, and I am proud of what I was able to accomplish on their behalf.

From initiating the largest reform to our nation's disaster preparedness system since Hurricane Katrina, to participating in the groundbreaking of the Harrisburg courthouse after years of fighting to make it a reality, to watching my legislation to help newborn babies suffering from opioid withdrawal get signed into law, I am proud of the work I have done to improve not only our district and state, but the nation as a whole.

As a Member of this body I have had the opportunity to help so many of my fellow Americans, and for that I am grateful.

Nothing will ever compare to the day ten-year-old Sarah Murnaghan finally got her life-saving lung transplant, or to when I was able to present our nation's veterans with long overdue medals they so rightfully deserve.

I will never forget the sense of amazement I felt meeting with students from the SHINE afterschool program as they showed me how to program a 3D printer and told me how they planned on running their future businesses, knowing I fought to save the federal funding that makes their program possible.

And those moments were just a few of the highlights.

Over the last eight years, my office has assisted over 14,000 constituents with casework requests, sponsored over 267 ambitious young people dreaming of attending prestigious military service academies, and secured over $9 million for our local first responders through fire grants, as well as $1.2 million for our law enforcement officers.

I have fought to provide small businesses with the tools they need to succeed, eliminated government waste and saved taxpayers $4.4 billion through better management of federal real estate, and worked to make our communities more resilient before disaster strikes through local infrastructure projects, like the Bloomsburg flood wall.

I can confidently say that I leave Washington knowing that the people of Pennsylvania are better off than when I first arrived.

Growing up, I never imagined that I could become the mayor of my hometown, let alone hold a seat in Congress. I could have never made this journey without the support of my family, and in particular my wife, Mary Grace, who has always stood with me from city council to the U.S. House of Representatives.

I also want to thank my staff. Their hard work and dedication to the people of Pennsylvania's 11th District is part of why we were able to accomplish all that we did. It has been a privilege to watch them grow into great professionals, and I have no doubt they will continue to do great things.

As I prepare to leave this position, the last few weeks have given me the opportunity to look back and reflect on all that my staff and I have been able to do, and I couldn't be more proud.

It is my hope that those elected to this office from this point forward will continue to build upon the important work my office has done and always fight to ensure that Washington is working for the people back home.

Mr. Speaker, it has been the greatest honor of my lifetime to represent the people of Pennsylvania's 11th District for four terms in the U.S. House of Representatives, and I thank them for giving me this opportunity.

HONORING HART HASTEN

HON. LUKE MESSER

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 12, 2018

Mr. MESSER. Mr. Speaker, I rise today, on behalf of the entire 6th Congressional District of Indiana, to recognize Hart Hasten for his contribution to our state.

I have had the pleasure of knowing Hart for nearly a decade. He has been a good friend, wise advisor and loyal supporter during my entire tenure in Congress.

Hart is a legend in Indiana politics, both for his business leadership and extraordinary advocacy for Israel. Hart is the founder of Silverock Group, an international real estate developer and the author of the book "I Shall Not Die," which details his experience as a Holocaust survivor. Without a doubt, Hart is one of the most remarkable people I have encountered during my time in Congress. Every day, I strive to be a little more like Hart Hasten.

I want to thank Hart for his friendship and loyalty to me over all these years. I wish him continued success in all that God has planned for his family.

INFORMATION ON THE PATIENT'S BILL OF RIGHTS

HON. RICHARD M. NOLAN

OF MINNESOTA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 12, 2018

Mr. NOLAN. Mr. Speaker, I rise today at the request of Mike Menning who hopes that, by sharing his story, no other family will have to go through what he and his family have.

DROPPED OFF THE OPERATING TABLE

DAWN MENNING WAS DROPPED OFF THE OPERATING TABLE AT INTERMOUNTAIN MEDICAL CENTER HOSPITAL, SALT LAKE CITY, UT ON MARCH 3, 2017

Dawn Menning's Narrative About Injury and Pain

Let me begin by recalling what I can about the abdominal hernia surgery and resulting incident.

At least a year prior to March 2017 I visited Dr. Kelly Nolan about the growth in an abdominal hernia I was observing. She noted that it would be a repair of an earlier surgery in 1996 and would require a more invasive approach.

In early 2017 after visiting my regular health care physician, Dr. Nancy McLaughlin, Madsen Clinic—University of Utah, and recognizing that the hernia had indeed grown I made the decision to go forward with the surgery.

I visited Dr. Nolan at IHC for a pre-op appointment. I spoke to her at length about my concern about the Homozygous Factor V Leiden blood condition that I have—the challenge and potential for blood clotting following surgery. She asked if I could seek advice from my regular doctor or a hematology specialist. Since I had never seen a specialist I contacted Dr. McLaughlin who consulted with Dr. David Kaplan at the University of Utah Clinic. He strongly advised against using regular anticoagulants since the surgery was going to be in the abdomen area and the shots, Lovenox, are administered into the belly area. He suggested the use of a pill instead.

I contacted Dr. Nolan who called me back to say she had not used the pill and advised to use Lovenox as she had prescribed. I purchased the Lovenox 100 mg. on February 28. I began using the shot one time on March 2, the day before scheduled surgery.

I was told to NOT use the Lovenox 100 mg. on March 3, the day of surgery, but resume using it the day after for ten days following

surgery—two shots into the belly area each day.

Now onto the day of surgery as best I can remember. I entered surgery feeling very well and was wondering how I would feel following. I felt I was a pretty strong, healthy 70-year-old woman.

I waited for quite awhile in the hall prior to surgery and noted that the attendant reached for a green flat toboggan like piece of equipment that I assumed was placed under a patient for transport. It had handles on the side as I remember. I even thought, well, I suppose that's how I will be transported from the gurney on which I was lying to the operating table.

The anesthesiologist came into the hall to introduce himself and assured me that they would monitor that I was asleep during the surgery.

Finally I was wheeled in. They asked if I felt comfortable moving myself onto the table and I assured them that I was able. I do not remember what was or if there was anything under my body.

Very soon I was off into another world.

The next thing I knew I was wheeled out of the operating room by a female attendant and greeted by my husband who was very alarmed. His first words were something like—I am so glad you are alive or something close to that. I asked him what in the world he meant. He said, ''Well, did you know that you were dropped to the floor while being moved to the gurney?'' I actually thought he was joking and said the same.

Marion responded with, ''No, I am not joking! They came out and told me that while they were moving you the gurney was not properly locked and you fell to the floor. The anesthesiologist tried to brake the fall by extending his leg and even hyperextended his knee.'' He said Dr. Nolan had come to tell him and said they had examined me and found no evidence of injury but would be sure to examine me further before discharge.

I was wheeled back to the room and did not lose consciousness again. Very soon I was pretty stable and the attendant suggested that I could get dressed and leave as soon as I wished. She recommended that Marion attend me in dressing and take a look if there were any bruises or evidence of injury. There was no one else of hospital personnel who took a look at my backside or the incisions. Dr. Nolan told me at my post-operative exam that she had come to see me but I had already left for home. (It would seem that in the case of the fall she would have been there soon to see how I was doing.)

We arrived at the hospital in the morning and less than five hours I was back home.

I had been prescribed pain medication (Norco 5 mg 1 to 2 tablets every four to six hours as needed) and used it as prescribed.

I resumed the use of the Lovenox 100 mg two times a day for five days. Since I would not have enough 10 more doses on March 8.

The weekend was rough—I experienced much pain and discomfort. I was not able to get up off the couch and was thankful for a bar next to out toilet. Getting into bed required the help of Marion, lifting my legs into bed and even helping me to get up off the bed and turning.

By Monday morning the pain was increasing—rising into my right side rib cage area. By then bruising in the abdominal area had grown far beyond the incision area.

We called Dr. Nolan's office and were invited to come to the office for examination. She checked my incision noting that it was no oozing and agreed to order x-rays. She checked the x-ray and said there was no evidence of cracked ribs and said I should try to cut back on the pain medication as I was able, perhaps using some Ibuprofen in between doses of Norco since it has a high risk of addiction and dependence and a side effect is constipation which is always a challenge for me. Dr. Nolan also explained that she had not seen exactly what had happened since she was doing charting off to the side and didn't see anything until she heard a commotion and saw I was on the floor. She did not offer details of number of people but did retell us that the anesthesiologist had hyperextended his knee.

I resumed my recovery at home. My husband made a visit to the hospital to inquire about the fall. He did not receive too much information but invited the Risk Management Staff to at least offer an apology and visit me at home.

The rest of the week went pretty much the same although in addition to the bruising my abdomen area was swelling and tender. The bruising had spread out, down and up.

On March 8 by recommendation of the Dr. Nolan I purchased a pain medication that would assist the transition from narcotic medications to less strong medications—Triamino 20 mg. I tried using this but was longing for the Norco since the pain was so intense.

During the night on Thursday, March 9 I had so much pain and the pain medication was not helping. We went to the ER at IMC. They noted intense pain, tender to the touch on my abdomen. They started me on an IV for fluids. I begged for a stronger pain medication but did not receive if for several hours.

They did chest x-rays. An ultrasound and I don't remember what else—but the ultrasound clearly showed that I had a large hematoma in the abdomen area! This was obviously the cause of the increased pain—the pressure on the incision and the mesh that was used was causing intense pain.

Twelve hours after arriving I was admitted to a room. They finally started me on an IV pain medication. After just a few hours they said I could be discharged and they would give me a stronger pain medication to take home. I declined insisting that I wanted to be sure I was ahead of the pain before going home. They also discontinued the use of the Lovenox shots. The explanation was that since I had developed a hematoma the blood thinner could interfere with my body's ability to absorb the blood in that area. They explained that since blood in a hematoma is very sticky it wasn't possible to drain the collection but it would be a long process for my body to deal with this. I was told to NOT use Ibuprofen since that is a mild anticoagulant.

I returned home on March 11. I was given Norco 7.5 mg—a stronger dose—one tablet every 4–6 hours. I was eager after four hours!

The next week is kind of a blur—time passed with a perch on the couch, in our bed (continued needing help to lift my legs) and a few visitors.

On Monday, March 13 we had a visit from IHC. They brought a lovely bouquet of flowers and were very sympatric but oh, so careful about what had actually happened. They were evasive about how many people were present.

That week I tried to resume some sort of ''normalcy'' to my life. I went out for short periods of time. I was able to move a little easier and didn't need assistance for getting in and out of bed. However, the pain never left me.

Now onto March 23—I went to visit my primary doctor, Nancy McLaughlin, to report what had happened. She was very alarmed and concerned about the resulting blood problem. I reported a very poor urinary stream and she assured me that this could all be the result of weakened muscle tone and should improve in time.

Time moved on and I even tried unsuccessfully to resume water aerobics that I enjoy. The pain was too much.

On May 3 I visited Dr. McLaughlin again. She noted abdominal pain and pain in my right buttock. She spoke to me again about the H/O hypercoagulable state. She was also pleased that I was scheduled to visit a hematology specialist.

On May 4 I visited Dr. David Kaplin, Hematology. He noted the evidence of a rectus sheath hematoma, sequel and Homozygous Factor V mutation. He was careful how to cast blame but said he certainly would not have recommended the Lovenox shots since they thin the blood and area administered right into the area close to the incisions. He said there are articles speaking of the ill effects of using this anticoagulant for abdominal surgeries. When I asked him—could this have been caused by the fall he answered—caused, yes perhaps but surely exasperated by the presence of blood thinners. He said in a court of law would he be willing to say one or the other was the cause? No, but surely both played a part. I went home with more information than I had come with.

Life went on—the pain was not gone. The swelling had reduced but the muscle tone in my abdomen was very poor. I tried resuming some exercise but experienced pain if I pushed a bit to hard.

The pain in my right buttock improved through recommendations from a physical therapist friend to do a set of exercises in our home.

I can honestly say that I had pain, a kind of pulling muscle pain, well into July 2017. I was cautious with lifting and reaching. Sudden twisting caused a jolt. My stomach area remained sensitive.

Today—I do have occasional pain in my abdomen area but I have no way of determining if that is from the surgery and invasion of four incision point and the one small incision where the mesh was inserted OR the residual effects of the hematoma.

In looking back it appears to me as if there were a succession of errors that caused my pain and suffering.

THE STORY

As told by Mike Menning, Husband/Power of Attorney

On Friday, March 3, 2017 my wife, Dawn Menning, a 70-year-old woman, was dropped from the operating table onto the floor as she was being transferred from the operating table to the gurney at the Intermountain Medical Center. Dawn had what was supposed to be a routine surgical procedure to repair an abdominal hernia. After the procedure Surgeon Dr. Kelly Nolan came to report to me how things went. She explained that the surgery went well, however at the end she said, ''there is one other thing that you should know. Your wife was dropped from the operating table onto the floor.'' Dr. Nolan went on to say that she didn't think Dawn received any major injury. She did add that I should ask the nurse in charge to check Dawn over for any major bruises before she was released from the hospital. Although I asked the nurse in charge to do so, she did not.

A little background—not much consideration was given before surgery in regard to the fact that Dawn has a blood clotting condition, Factor 5 Leiden. Consequently extra precautions needed to be taken to respect the potential of blood clots following surgery. Advice from her primary physician was to use an oral medication to deter clotting. However, the decision from Dr. Nolan was that she would begin shots of Lovenox given into the belly three days prior to surgery and ten days following. This medical condition should have been emphasized to the surgical staff so that precaution and extra concern should have been a high priority during and

following surgery. Extreme caution and tender handling should have been taken in the move to prevent possible bruising or even a hematoma in the area of the surgery—right near the point of entry of the blood thinner.

I stayed in the waiting room bewildered by this news until I received the call from recovery to meet Dawn. It took a very long time before I received the call that she was on her way. I met an attendant coming out of the elevator pushing Dawn on the gurney. I expressed my joy in seeing her and asked her if she knew what had happened. I told her that she had been dropped off the operating table onto the floor. She didn't believe me at first, she thought I was joking. The nurse said, ''Yes, she was dropped, but it was a controlled fall.'' This is the first I heard the words, ''controlled fall.'' I thought, now what does that mean? It was very obvious that the reason it took so long to get her out of recovery may have been because the medical staff had to have time to get their story together and make sure they were all on the same page.

That afternoon, even before Dawn was discharged, I went to see the IMC administrator Joe Mott. He called in Ms. White, Patient Relations. I explained what had happened. Mr. Mott said to me, ''What do you want me to do about it?'' I said your surgical staff violated my wife's unconscious body and personhood. The least you could do is apologize. He said they would stay in touch.

Dawn was discharged and did not see the surgeon again that day. The medical staff completed no further examinations. The nurse suggested that when it was time for my wife to get dressed, I should assist her and I check for any evidence of bruising.

On Monday, March 6 Dawn and I went back to visit with the surgeon, Dr. Kelly Nolan. Dawn was experiencing very sharp pain in her right abdomen and wondered if she could have broken ribs. Dr. Nolan ordered x-rays. She said although she was in the operating room at the time of the fall she did not see what was happened until she saw her patient on the floor. She also explained to us what was meant by the ''controlled fall.'' Apparently the anesthesiologist stuck out his leg under her head and supported her as she fell as best he could. We were not told what appliances or means were being used to transfer. They claim the gurney was not locked and slid away. Who, why and how many were involved—we did not know. The unanswered questions did not help to answer the question, ''why did she have so much pain in a large area of her abdomen?

NOTE: Years ago I served on an volunteer ambulance team in our hometown in Minnesota. I was a trained in Advanced First Aid for ambulance personnel—today's equivalent of an EMT I know from personal experience if the transfer is properly done, it is almost impossible to drop a patient.

Three days later the pain was increasing—not getting better at all. During the night of Thursday, March 9 Dawn was experiencing uncontrollable pain, even using the strongest pain medication she had been prescribed. I took her back to the hospital to the emergency. They kept her there for a LONG time, in fact, twelve hours, attempting to get her pain under control—not successfully. They did recommend the Lovenox be stopped—only after further tests—CAT and ultrasound—which clearly showed a large hematoma. Her abdomen was filled with blood!

Pain continued for months, including a bout with extreme pain far below the site of the incision as well as pain down the right side of her backside and leg.

About ten days after the ''incident'' two people from IMC came to our home, one from the Risk Management Department and one from Patient Relations. They apologized for what happened and gave Dawn a bouquet of flowers. I asked if we could see a copy of the ''incident report.'' We were told that was not possible because under the law it is sealed. Risk management controls IMC's risk WOW—not comforting when my wife continued to experience severe pain. Risk Management repeated the report about ''controlled fall.''

My wife did go to the Department of Records to obtain the medical records from the hospital. They made reference to the fall, but did not explain how it happened or what really happened. IMC did not release the incident report, because under law the incident report is sealed, property of the hospital.

My Response in the Weeks Following the Incident

I consulted attorneys from four well-known law firms. Each one told me that they would NOT take the case because under Utah law it is impossible to win in the courts. They further informed me that under Utah law, when an unconscious person is dropped from the operating table during or after the surgery that the patient and her legal representative are not allowed access to the incident report. Under present Utah law patients taking a case like this to court and winning is out of the question because incident reports are sealed, therefore the medical personnel and the hospital are immune from prosecution. So, the result is; it is impossible to know what has happened or how it happened. Therefore, there is a great need for The National Unconscious Patient's Bill of Rights.

Interesting Thought for Consideration

''Assume that you purchased your first car 50 years ago, a 1947 Cadillac convertible. You took immaculate care of the cherished automobile; own the car today, and then took it in for repairs. Also assume that you entrusted your beloved car to one of the most modem and reputable repair centers in the city, leaving it in the hands of highly qualified, professional mechanics. You were invited to wait in the service garage waiting area because garage and insurance concerns do not permit you to watch the repairs being made. A couple hours later the head mechanic meets you in the waiting area to tell you that your car was dropped off the hoist onto the concrete floor. No more information is given and all you can do is take your broken car home. Later, you go back to the repair center seeking answers and help for your car. You see the repair center's manager and tell him what the car meant to you. His response is, ''Well, what do you want me to do?'' You say, ''Maybe you could start by apologizing.'' About ten days later he and a couple of people from the repair center come to your home to apologize and deliver a bouquet of flowers. He says, ''You will be charged for the original repairs and you need to know that under special legislation for 'repair shop and mechanic protection', you cannot get the report of how it happened or a report of the damage to your car.''

You may say, this is really a terrible comparison, and it is. You see this happened to my wife, Dawn, whom I have loved and cherished for more than 50 years. And now I compare her to an old car—not even close—even an insult, but I think you get the point.

DAWN MENNING SEEKS RESOLUTION BY PROMOTING THE NATIONAL UNCONSCIOUS PATIENT'S BILL OF RIGHTS

I will work to introduce and seek the passage of ''The National Unconscious Person's Bill of Rights.'' This legislation will include language requiring all medical surgical procedures to be recorded by audio and video.

In my search and input from a University of Utah doctor, we can only find four times in recent U.S. medical history that unconscious patients have been dropped off hospital's operating tables.

In the early 90's a lady from Denver area was dropped off the operating table and was paralyzed from the neck down

In the late 90's a 28 year old lady was dropped from the operating table at the Clarion Hospital in Pennsylvania, resulting permanent injuries

In 2012 a 75 year old patient was dropped off the operating table at Duke University Health System Hospital, he died of complications a short time later

In 2010 a patient was dropped off an operating table at St. Joseph Hospital, Minneapolis MN, he died a short time later of complications.

We praise God that Dawn did not die from injury complications or was paralyzed in the process.

Now Intermountain Medical Center is recorded in these statistics.

THE NATIONAL UNCONSCIOUS PATIENT'S BILL OF RIGHTS

The National Unconscious Patient's Bill of Rights shall be placed in Federal Law; such shall include, but not be limited to:

1. All surgical procedures must be recorded by mounted video camera and be kept in the patient's permanent record for a period of two years.

2. In the event of an incident or accident concerning an unconscious patient, the hospital or medical clinic shall maintain the recording as part of the patient's permanent record.

3. The incident reports and video shall be made available to the patient and the patient's legal representative and can be presented as evidence in a court of law.

4. A patient shall have the right to know the names and roles of the members of such person's health care team (taken from the Virginia Commonwealth University Health System).

RECENT HISTORICAL GROUNDS FOR THE NATIONAL UNCONSCIOUS PATIENT'S BILL OF RIGHTS

Legislators and others can lay the foundation for the passage of legislation making video cameras mandatory in medical clinics and hospitals where surgical procedures are performed using the following examples. With today's modern technology video recording of surgical procedures can be provided at minimal cost.

Consider previous precedents—

1. In the State of Utah and other states the Departments of Motor Vehicles mandate that all motor vehicle and emission inspection technicians are videoed by camera as they do the inspections. Any MV (motor vehicle) inspection facilities shutting off the state-mandated video camera shall be fined and/or have their license revoked. Surely if the State of Utah requires the Motor Vehicle inspection to be videoed doing their work, the legislature can pass legislation requiring hospital to video patients under anesthesia the same privilege.

2. In the case of Andrea Constand vs. William Cosby Jr, one of the issues was that Ms. Constand was abused while she was in an unconscious state. Similarly, should a Utah law remain on the books giving medical professionals and the Intermountain Medical Center immunity from the law when a 70-year-old woman, my wife, was clearly abused while in an unconscious state? The question is—was it an accident? Or was it an incident? Whatever happened, we will not know because there is no video and there are no means to obtain the information legally. This is the heart of the matter.

3. Most state and local officials, as well as the public, encourage and support body and car cams for law enforcement. These video cameras have been proven to be very helpful for protection of policeman and the public.

4. Consider the most recent case of Nurse Alexandra Wubbels barring police from drawing blood from an unconscious patient. Her position was that the unconscious patient has a right to know what is happening to their body. She stood her ground. The police thought they had a right under the law, it didn't play well in the media. The end result, Salt Lake City and the University Hospital settled for $500,000 payment to Ms. Wubbels.

Today's society will not longer accept gross mistreatment of unconscious patients presently shrouded in secrecy. The National Unconscious Patient's Bill of Rights will promote the use of modem technology, cameras mounted and in use during surgical procedures. Upon request from the patient such recordings must be available to patient or assigned legal representative. Doctors and medical staff will be held responsible for their actions.

SENATE COMMITTEE MEETINGS

Title IV of Senate Resolution 4, agreed to by the Senate of February 4, 1977, calls for establishment of a system for a computerized schedule of all meetings and hearings of Senate committees, subcommittees, joint committees, and committees of conference. This title requires all such committees to notify the Office of the Senate Daily Digest—designated by the Rules Committee—of the time, place and purpose of the meetings, when scheduled and any cancellations or changes in the meetings as they occur.

As an additional procedure along with the computerization of this information, the Office of the Senate Daily Digest will prepare this information for printing in the Extensions of Remarks section of the CONGRESSIONAL RECORD on Monday and Wednesday of each week.

Meetings scheduled for Thursday, December 13, 2018 may be found in the Daily Digest of today's RECORD.

MEETINGS SCHEDULED

DECEMBER 14

10:30 a.m.
Commission on Security and Cooperation in Europe
To receive a briefing on best practices for keeping families safely together.
SD–G11

DECEMBER 19

2:30 p.m.
Committee on the Judiciary
Subcommittee on Antitrust, Competition Policy and Consumer Rights
To hold hearings to examine a comparative look at competition law approaches to monopoly and abuse of dominance in the United States and European Union.
SD–226