

TRIBUTE TO THE 125TH ANNIVERSARY OF THE PHILADELPHIA CHINATOWN

HON. THOMAS M. FOGLIETTA

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 22, 1995

Mr. FOGLIETTA. Mr. Speaker, I rise to commemorate the 125th Anniversary of Philadelphia's magnificent Chinatown.

In 1870, a small laundry was established on Race Street, between 9th and 10th. From that single, small business a bustling community grew. In 1995, the Chinese American community is proudly celebrating the 125th anniversary of Chinatown with events throughout the year. Chinatown has developed into one of the most significant contributors to the Social, economic, and cultural vitality of Philadelphia. Indeed, Chinatown is the city's premier marketplace for Chinese food and oriental products, but it is so much more. It is a meeting place for friends and relatives. It is a home and source of comfort for newly arrived immigrants. Chinatown is where traditional culture is preserved and ethnic identity perpetuated. The central event of Chinatown's 125th Anniversary will be a parade and dedication ceremony at 2:00 p.m. on Sunday, June 25th. The starting and ending point of the parade and the location of the ceremony will be where Chinatown started—Race Street between 9th and 10th. Other celebration events include an art exhibit by Asian American artists; a benefit recital; and an "Honor The Elders Day."

Chinatown's rich, historical roots and ethnic diversity have contributed greatly to the City of Brotherly Love. I am proud of the contributions of the Philadelphia Chinatown and I congratulate Chinatown on its 125th Anniversary.

TENTH ANNUAL FILM FESTIVAL OF PARIS

HON. KEN BENTSEN

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 22, 1995

Mr. BENTSEN. Mr. Speaker, today I rise to bring the attention of the House to an extremely special constituent in my district, Ms. Julie L. Harms. Ms. Harms, a student at Bellaire High School, has recently added another major accomplishment to an already impressive list. Ms. Harms has been selected to represent the United States as a member of the Jury Panel at the Tenth Annual Film Festival of Paris. The selection process, which is coordinated by the U.S. Information Agency, is a nationwide competition that picks only 2 candidates, one male and one female.

Young men and women from 15 countries will be taking part in the festival as jurors and judge various films from all over the world. While in Paris, the film jurors will meet with political and film industry leaders. The Tenth Annual Film Festival will also provide these outstanding men and women the opportunity to view many of the outstanding historical and cultural landmarks in Paris.

Mr. Speaker, I want to recognize this exceptional young woman and her distinguished colleagues for this wonderful accomplishment. Thank you.

WOMEN IN MILITARY SERVICE

HON. BARBARA B. KENNELLY

OF CONNECTICUT

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 22, 1995

Mrs. KENNELLY. Mr. Speaker, today, our country honors U.S. servicewomen at a groundbreaking ceremony for the Women in Military Service for America Memorial at Arlington Cemetery.

When this memorial is completed, it will contain the names of all U.S. servicewomen, past and present, along with a photo and biography. They will be women who served in peacetime and war, women who still serve this country as veterans and those who gave their lives.

The list will include Connecticut women like Wanda Charlinsky who is president of her local WAVES unit; Viola Bernstein, active in the Jewish War Veterans; Linda Schwartz, a member of the National Board of Vietnam Veterans of America, and Cindy Beaudoin who gave her life during the Persian Gulf war.

This memorial will be a reminder to the Nation that our liberty and freedom were secured with the efforts of more than 2 million women who dedicated themselves to our country and our ideals.

It is also a symbol of the respect of a grateful country.

SAFE MEDICATIONS ACT OF 1995

HON. WILLIAM J. COYNE

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 22, 1995

Mr. COYNE. Mr. Speaker, I rise today on behalf of myself and my colleagues Representatives PETE STARK and JOHN LEWIS to reintroduce the Safe Medications Act. This bill improves public health and safety by creating a clear and uniform reporting system for deaths that occur while prescribing, administering, or dispensing drugs. Needless tragedies would be avoided by its enactment.

Billions of prescriptions are written, dispensed, or administered in hospitals, pharmacies, and other health care facilities across the United States every year. Yet, if something goes wrong during drug therapy there is no requirement for facilities to report adverse incidents. As a result, the public could be vulnerable to recurring drug-related mishaps and fatalities that are preventable.

Occasionally, a health care professional misreads a prescription, administers the wrong dosage of a drug, or dispenses medication incorrectly. These errors will sometimes have little or no consequence. Other times, they may produce fatal results. When an individual dies in these cases, there is no place for the practitioner to report the death. Ultimately, the same mistake can be made a number of times. Repeated errors lead to unacceptable risks to patient safety and public health.

Let me sketch how patients and consumers are susceptible to multiple errors. A young boy in New York died when he was administered the wrong dosage of a sedative. A similar incident happened with the same drug to a 4-year-old girl in Texas. In another instance, a community pharmacist confused the names of

morphine and meperidine which resulted in the death of a child. A parallel event proved fatal when a physician confused the names of painkillers. Finally, confusion over like drug names led to a mistaken and ultimately fatal dosage of a medication for a bone-marrow-transplant patient. This drug was involved in a comparable case when, again the name of the drug was confused and the patient was overmedicated. These events show a pattern of drug therapy deaths that could have been avoided and prevented had they been monitored and had medical workers been made more aware of the potential for mistakes.

In October, 1993, the Pittsburgh Post-Gazette published a series of articles that detailed medication errors. Reporter Steve Tweedt's series contained some disturbing statistics in this area. He reported that a Pittsburgh-Post Gazette study of 250 hospital pharmacists across the country estimated that there were 16,000 medication errors in their institutions in 1992; 106 of them caused patient deaths.

Presently, there are a variety of reporting systems. Only two States require reporting; New York has a mandatory program for hospitals and North Carolina has a required reporting system for pharmacies. However, nothing obliges these States to share the information they collect with other States.

Nationally, there are two primary voluntary reporting systems that track errors and deaths that result from drug therapy. The U.S. Pharmacopeia [USP], working with the Institute for Safe Medication Practices, has received over 1,100 reports since it was established in 1991. And, it is estimated that the voluntary system operated by the Food and Drug Administration [FDA], MedWatch, collects information on only 1 percent of the errors that occur. Since these reports are voluntary, however, it is unclear what the actual error and death rate is what their tracking represents.

At the Ways and Means Health Subcommittee hearing on this issue last September, David Work, the executive director of the North Carolina Board of Pharmacy, testified that "about 10,000 deaths occur nationwide from pharmaceuticals each year." Joshua Perper, M.D., chief medical examiner, Browder County, FL, cited in his testimony a study published in the New England Journal of Medicine in 1991 that charted an annual mortality rate of 503 per 100,000 hospital discharges due to drug errors.

These trends can and must be changed. We must have a greater understanding of these incidents and take precautions to see that they are not repeated. The Safe Medications Act of 1995, which I am introducing today, provides a solution to this problem and would significantly improve the public health.

The Safe Medications Act creates a national data bank for information on deaths that result from the prescribing, dispensing, or administering of drugs. This data bank would be maintained by the USP for the Secretary of Health and Human Services.

Within 10 working days after the discovery of a death due to the prescribing, dispensing, and administering of drugs, the health care facility in which the error occurred would be required to report the incident to the U.S. Pharmacopeia.

The Secretary will analyze these reports and work with USP and the appropriate health care provider associations so that they can