

global economy requires global, multinational negotiations. However, the continued divisions between Northern and Southern hemispheres will make them excruciatingly difficult.

I was struck, at both Kyoto and Seattle, by the ferocity of distrust notwithstanding the fact that developing countries are almost universally desirous of foreign investment, and by the extent to which many of them are still deeply suspicious of developed countries and see their interests fundamentally different from ours, despite the degree to which we bore the global economy on our shoulders during the recent financial crises.

Under such circumstances, talks are often unable to construct agreements that rise above the lowest common denominator. I have also learned some hard lessons from the sanctions negotiations in which I have been so deeply engaged.

Unilateral sanctions rarely work, although they must be resorted to at times to defend U.S. values. Multilateral sanctions, while far harder to fashion, are the only ones likely to achieve the desired results in terms of changing target country behavior.

Sanctions should be targeted to the state or entity whose behavior we are trying to change rather than to companies from third countries who are investing or trading there, as much as we might oppose their involvement. Third countries see such sanctions as extraterritorial. It is also critically important that sanctions legislation contain a provision for Presidential waiver authority, to protect the national interest and provide negotiating leverage.

Let me finally say a few personal words, as a non-career politically appointed diplomat to a roomful of men and women who have devoted their lives to the art of diplomacy. I have learned during the Clinton Administration, even more than as President Carter's chief domestic advisor, what a privilege it is to represent the United States both as an Ambassador and in international negotiations around the world.

The power, the majesty, the moral values, and the influence of our nation gives anyone negotiating for the United States a greater ability to accomplish his or her goals than would be possible representing any other country. These are precious resources, which we must husband, nurture and deploy in ways that do not dissipate our innate advantage.

I hope in the next century, the United States will, through the art of diplomacy, use its enormous capacity to do good to make this a better world.

I am especially honored by this award, not because I am receiving it myself, but because it recognizes the work of the economic officers, both in the State Department in Washington and in our embassies abroad. It is a signal of the increasing importance of economics as a diplomatic tool of American foreign policy.

Thank you for your award, and continue in your important work.

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THE HEALTH CARE FAIRNESS ACT  
OF 1999

**HON. ROBERT A. UNDERWOOD**

OF GUAM

IN THE HOUSE OF REPRESENTATIVES

*Monday, February 7, 2000*

Mr. UNDERWOOD. Mr. Speaker, in February 1999, the Institute of Medicine issued a report concluding that federal efforts to research cancer in minority communities are insufficient. The report concluded that more re-

sources are needed in this area and that a strategic plan is needed to coordinate this research.

In June of 1999, the Commonwealth Fund reported that minority Americans lag behind on nearly every health indicator, including health care coverage, access to care, life expectancy and disease rates. Just in terms of health care access, 45 percent of Hispanic adults, 41 percent of Asian American adults, and 35 percent of African American adults reported difficulty in accessing health care. The report also cited the statistics nearly half of Hispanic adults, more than one third of African American adults and more than 40 percent of Asian American adults report difficulty paying for medical care.

Last October, the Kaiser Family Foundation released a national survey showing that minority groups have concerns about the quality of health care they are receiving.

The common line of these reports is that there is a disparity that exists when it comes to health care for minorities.

Although we have made great advances in science and medicine, not all American citizens have shared in the benefits of these advances. Furthermore, despite the knowledge of these alarming statistics, we have not made the commitment that is necessary to understanding how barriers to health care or genetic and behavioral differences affect the outcomes of our community.

This new legislation (the Health Care Fairness Act of 1999) lays out a plan to reduce racial and ethnic disparities in health care and health outcomes. By elevating the Office of Research on Minority Health to create a center for health Disparities Research at the national Institutes of Health, we will significantly increase the support for research on health disparities, including data collection relating to race and ethnicity and funding major increases in minority medical training and curriculum development.

We need to make a serious effort to eliminate racial and ethnic disparities in this country. As the Chairman of the Congressional Asian Pacific Caucus, I am extremely pleased to join with Senator EDWARD KENNEDY, Congressman JOHN LEWIS the leaders of the Hispanic and Black Caucuses in support of the passage of "Fair Care".

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CONGRATULATING THE KAREN  
ANN QUINLAN HOSPICE ON ITS  
20TH ANNIVERSARY

**HON. MARGE ROUKEMA**

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

*Monday, February 7, 2000*

Mrs. ROUKEMA. Mr. Speaker, I rise to commend the Karen Ann Quinlan Hospice on its 20th year of operation. The Quinlan family has turned the desperate personal tragedy they shared with the world into a caring, compassionate program to help others faced with the impending loss of a loved one. The courage and faith they have shown is extraordinary.

As a girl, Karen Ann Quinlan was a vibrant athlete who taught her younger brother to wrestle. As a young woman, she had a beautiful voice and dreamed of becoming a singer.

In 1975, however, Karen Ann Quinlan's name quickly became a by-word for the legal

and ethical dilemmas surrounding the treatment of terminally ill patients. On April 15 of that year, 21-year-old Karen Ann suffered cardiac arrest. Doctors saved her life but she suffered brain damage and lapsed into a "chronic persistent vegetative state." Accepting doctors' judgment that there was no hope of recovering, but frustrated by their refusal to remove Karen Ann from her respirator because signs of brain activity continued, her parents sought court permission to disconnect the respirator.

In 1976, the New Jersey Supreme Court handed down a landmark decision giving Joe and Julia Quinlan the right to remove their daughter from the respirator that assisted her breathing. The respirator was removed and Karen Ann remained alive but comatose another nine years at a Morris County nursing home before her death June 11, 1985.

As a result of their personal tragedy, the Quinlans established the Karen Ann Quinlan Memorial Foundation in order to offer a community program to help families in similar challenges. The result was the Karen Ann Quinlan Hospice, which opened in Newton on April 15, 1980, the fifth anniversary of Karen's accident. The mission of the hospice is to afford all terminally ill individuals the opportunity to die in dignity and comfort in a home setting surrounded by the people they love. Services are offered without regard to ability to pay and include bereavement support for family and friends after a patient's death, and community education about terminal illness.

The non-profit Hospice is accredited by the Community Health Accreditation Program and has received national commendations on its quality of care. More than 300 patients and family utilized the Hospice last year, bringing the total to more than 3,500 since it opened. Some 76 percent of the patients served have suffered from cancer, but others have suffered cardiac, renal, respiratory, and kidney complications, as well as Alzheimer's.

Mr. Speaker, Karen Ann Quinlan was the first modern icon of the right-to-die debate. The widespread news coverage, two books, and a movie helped spread the word internationally of the challenges facing a family when a loved one is stricken by a terminal illness. Her precedent-setting legal case paved the way for the living will, advance directives, and hospital ethics committees of today. Thousands of other terminally ill patients and their families have been able to die with dignity thanks to the battle waged by the Quinlan family.

The Quinlans' sad loss has made it possible, with their loving support services, for others to bear their own losses. God bless the Quinlans for the courage to allow something good to come from such a tragedy and to bring comfort to the suffering.

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DIVERSITY OF AMERICAN SOCIETY

**HON. JOHN CONYERS, JR.**

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

*Monday, February 7, 2000*

Mr. CONYERS. Mr. Speaker, today I, Representative HASTINGS and Representative WEXLER are introducing a resolution condemning the conduct of U.S. District Judge Alan McDonald for bringing the appearance of improper racial, ethnic and religious bias upon