national anthem. I thought of another night sky some 150 years ago by the light of rockets of a different sort when Francis Scott Key penned those magnificent lines about the United States of America.

The rocket cleared the tower. Moments after, a burst of light appeared before the gantry way. The moment the main orbiter engines reached the top of the tower, Mr. Speaker, the humid Florida night sky turned as bright as day. The same instant, the sound with all its earthshaking force struck our location like a hurricane. The Earth shook and an explosion of hot air rushed past. I felt as if the wind had been knocked out of me, the sound only becoming louder as the rocket climbed in the early morning sky.

Mr. Speaker, it was as though the Earth gave birth to a piece of sun and was sending it home. *Atlantis* seemed almost lazy in its rate of ascent. As the ship climbed, the light from the rocket which had, at first, shone dimly like the dawn, turned to midday brightness, revealing a blue sky and leaving shadows on the landscape.

I turned to look at my wife. Karen stood with wet eyes in that other worldly brilliance. I was nearly overcome with emotion. But there was still serious work to be done.

The shuttle climbed, leaving in its wake a sycamore-like column of smoke that seemed a pillar holding heaven itself. When the vehicle jettisoned its temporary booster rockets the crowd broke out into applause, but NASA Administrator Daniel Goldin would have none of it. His demeanor remained silent and stern. He explained that he did not celebrate launches until 8 minutes and 30 seconds into the launch. At that time the main engine cutoff occurred and the astronauts safely reached orbit.

As the light faded and the sky returned to the darkness of night, *Atlantis* appeared as a red dot disappearing into the Northeast sky. Still visible 160 miles away, we heard the words ''main engine cutoff'' on the public address system. The entire crowd broke into applause, relief and tears.

Later that morning I had the honor of speaking to over 100 mission specialists in the Firing Room. I would have called it mission control, but I learned that title belongs in Houston.

I made a few comments to those Purdue graduates on hand and then told all the heroes wearing headsets how the words of the national anthem that morning had struck me. I thanked them for their professionalism, for another safe launch, and for the inspiration which their teamwork and their spirit of exploration continues to provide to all Americans.

After sharing a meal of beans and cornbread with the crew, which is a traditional post-launch fare at NASA, we boarded a plane to Washington. As I drifted off to sleep, Mr. Speaker, the words of our national anthem rang in my ears, and I became more convinced than ever that the rockets' red glare still gives proof in the air that this is the land of the free and the home of the brave.

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The SPEAKER pro tempore (Mr. FLAKE). Under a previous order of the House, the gentleman from Ohio (Mr. BROWN) is recognized for 5 minutes.

(Mr. BROWN of Ohio addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

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## DIVERSE COMMUNITY GROUPS OPPOSE H.R. 7, COMMUNITY SOLUTIONS ACT OF 2001

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Texas (Mr. EDWARDS) is recognized for 5 minutes.

Mr. EDWARDS. Mr. Speaker, today the House was scheduled to vote on H.R. 7, the so-called Charitable Choice Act. However, the House Republican leadership had to delay the vote because of objections from both Republicans and Democrats alike that this bill would allow discrimination in job hiring based on a person's religious faith when using Federal funds.

Mr. Speaker, the truth is that we all support the good work of thousands of faith-based charities across this country. But the truth is also that, as more Members of Congress and more American citizens learn about what is actually in H.R. 7, the support for this bill is faltering badly.

Over 1,000 religious leaders, pastors, priests and rabbis have signed a petition urging this Congress tomorrow to oppose the President's faith-based charity bill.

Why? Because it would harm religion, not help religion.

Why? Because it would not only allow discrimination in job hiring using Federal dollars, it would actually subsidize such discrimination.

Mr. Speaker, let me mention some of the diverse religious and education and civic groups and civil rights groups that stand firmly opposed to the passage of H.R. 7: The American Association of School Administrators; the American Association of University Women; the American Federation of State, County, and Municipal Employees; the American Federation of Teachers; the American Jewish Committee. The Anti-Defamation League opposes this bill, along with the Baptist Joint Committee on Public Affairs, the Leadership Conference on Civil Rights, the National Education Association, and the National PTA.

Mr. Speaker, the Presbyterian Church U.S.A. opposes this bill, along with the Episcopal Church U.S.A., the Interfaith Alliance and the United Methodist Church, General Board of Church and Society, along with many other religious and civic groups strongly oppose the passage of this bill on the floor of the House tomorrow.

Mr. Speaker, let me talk about what is wrong with this bill. Let me emphasize three points: First, the bill is unnecessary. It is unnecessary. Under long-standing law in this country, the Federal Government has been able to support faith-based groups under several conditions and several proper conditions. First, that they not be directly churches or houses of worship. That if churches want to do faith-based work with Federal dollars, they should set up a separate 501(c)(3) secular organization. Then those groups cannot proselytize with tax dollars, and they cannot discriminate in job hiring with those tax dollars.

Under those limited but important conditions, for decades faith-based groups such as Catholic Charities and Lutheran Social Services have received Federal dollars to help social work causes without obliterating the wall of separation between church and State. So the bill is simply a solution in search of a problem.

Secondly, as I mentioned, this bill not only allows discrimination against American citizens based on their religion, it subsidizes it. Let me be specific. If this bill were to become law and a church associated with Bob Jones University were to receive a Federal grant under the program, that church could use our tax dollars to put out a sign that says no Catholic need apply here for a federally funded job. Mr. Speaker, that is wrong.

In the year 2001, over 200 years after the passage of the Bill of Rights, no American citizen should have to pass someone else's religious test to qualify for a federally funded job. No American citizen, not one, should be fired from a federally funded job simply and solely because of that person's religious faith.

Next, I would point out that this bill basically is built on a foundation of a false premise, the false premise that somehow if the Federal tax dollars of this government are not going directly to our houses of worship and our synagogues and mosques, that is somehow discrimination against religion. I think Mr. Madison and Mr. Jefferson would be shocked by that suggestion of discrimination against religion. I think they would have argued that the Bill of Rights for 200 years has not discriminated against religion. The Bill of Rights has put religion on a pedestal above the long arm and reach of the Federal Government, both Federal funding and the Federal regulations that follow.

Mr. Speaker, H.R. 7 is a bad bill for our churches, our religion, our faith and our country. I urge a ''no'' vote tomorrow.

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## PASS PATIENTS' BILL OF RIGHTS FOR MEANINGFUL HMO REFORM

The SPEAKER pro tempore (Mr. FLAKE). Under the Speaker's announced policy of January 3, 2001, the gentleman from New Jersey (Mr. PALLONE) is recognized for 60 minutes as the designee of the minority leader.

Mr. PALLONE. Mr. Speaker, this evening I want to spend the time with

my colleague from North Carolina talking about the Patients' Bill of Rights. I have been to the well many times to talk about this legislation.

I know that we do have a commitment from the House Republican leadership to bring up HMO reform, hopefully at some point over the next 2 weeks. But what I wanted to stress tonight is if we are going to deal with the issue of HMO reform, we have to pass real HMO reform, and that is the Patients' Bill of Rights. It is a bipartisan bill sponsored by the gentleman from Michigan (Mr. DINGELL), who is a Democrat; the gentleman from Iowa (Mr. GANSKE) and the gentleman from Georgia (Mr. NORWOOD), who are Republicans.

This bill or a similar bill passed in the last session of Congress overwhelmingly, almost two-thirds of the Members, most Democrats, and 60-some-odd Republicans. However, once again the House Republican leadership does not support it and does not want to bring it up and is trying, even after a similar bill passed the other body, is trying to kill it effectively by coming up with what I consider a sham HMO bill and trying to get support for that sham Republican HMO bill.

I would like to speak tonight to explain not only why the real Patients' Bill of Rights should be brought to the floor immediately and passed but also why it is such an improvement, as opposed to the sham bill that I fear the Republican leadership may try to slip by.

But at this time I yield to the gentlewoman from North Carolina (Mrs. CLAYTON), who has worked long and hard, I think too many years that we have worked on this bill, and we hope it will come to the floor in the next few weeks.

Mrs. CLAYTON. Mr. Speaker, I thank the gentleman for his leadership on this issue. He has not only been working hard, but he has been persistent and insistent that we stay on course.

Mr. Speaker, what we want to bring to our colleagues' attention and therefore their awareness and appreciation, not only do we think that the American people want this but we also think that the scare tactics that we hear that are being promoted that this bill will somehow cause employers to have greater liability, therefore, increase the costs, reducing the opportunity for having insurance coverage for their employees, I think it is a scare tactic.

Indeed, the Ganske-Dingell bill does provide for accountability, but that accountability goes only for insurance companies or individuals who interfere in the provisions of health care. It does not hold small businesses responsible or accountable if they indeed are not interfering in the decision.

All this Patients' Bill of Rights does is give the patients the right to expect and to receive what they have contracted for in their health insurance. That is not too much to ask. That is expected in contract law. If you enter into an agreement, there is the expectation that one will receive the benefits for which they are paying. The reason we buy insurance is to have that assurance that, when we need it, those provisions within the insurance policy will be enacted.

That doctors would be able to make those decisions, that I would have a right in the case of an emergency to go to the nearest hospital, that I would have the right to get a second opinion or get the kind of expert medical care that I need, that I would not be proscripted in the sense to be limited to the minimum health care service by putting a gag order on the doctors.

The doctors would be free to provide the kind of leadership in health services that they and they alone are capable of doing, and that a doctor would not be held in violation of his contract if he gave several options and prescribed, perhaps, the option best for me that may be a little higher cost than the health insurance desired.

□ 2230

This is a commonsense approach, and the scare tactics that we have heard indeed is unfounded. What this bill is not, this bill is not an effort to increase greater liability on small employers and by and large small employers are held liable as well. They are paying part of the costs and these are provisions that they are paying dearly for and they expect that their employees will receive the benefits for which they are paying for.

My understanding as well is that this bill will amend, or is in the process of amending itself to conform with the Senate's bill, that the liability there would be consistent here. Only in those cases where you are self-insured or indeed you make a decision would there be any case of liability. Furthermore, the external appeal system in the bill does provide for an orderly appeal process which suggests that before there is a remedy as a lawsuit, one would be expected that they use that appeal process before they indeed resort to the legal area.

Again the consistency between States, I know the Senate bill, my Senator, Senator EDWARDS, has been working very hard with Senator MCCAIN and Senator KENNEDY to make the bill that they pass consistent with States and where States had stronger views, stronger provisions, they would indeed be the ones that would govern.

So there has been every effort to speak to issues that have been raised, and I think it is now time for the leadership of the House to bring this bill so that we can have an up or down vote. I think the American people want it, I think the votes are here, and I think it is the right thing to do.

Again, I thank the leadership of the gentleman from New Jersey (Mr. PALLONE) and others who have been working on this task force and certainly support the efforts that both the gentleman from Iowa (Mr. GANSKE) and the gentleman from Michigan (Mr. DINGELL) have brought before us. It is very similar. We were original cosponsors of the last bill and with the gentleman from Georgia (Mr. NORWOOD) who is also, I should say, a part of this. This is a good, bipartisan effort to try to give the American people a reasonable approach and a meaningful approach. So the scare tactics that we are hearing, I think, are unfounded. We need to spend as much time saying what this will do as well as what this is not. This is not an effort to put a great burden or unnecessary liability on small businesses or employers of any size if they are not involved in creating the injury or the health provision that resulted in injury or death.

I thank the gentleman for allowing me to participate.

Mr. PALLONE. I want to thank the gentlewoman for all her participation and everything that she has done to try to put this patients' bill of rights together. There are a couple of things that she mentioned that I wanted to repeat, and I think are important and need to be repeated. One is that if you think about what we are really trying to do here, there really are basically two principles: one is that we want to make sure that decisions about what kind of medical care a patient gets or an American gets is a decision that is made by the physician and the patient, not by the insurance company, not by the HMO. Too often today I get complaints from my constituents in New Jersey who say that they were denied care, they were denied a particular operation, they were denied to stay in the hospital a certain number of days, they were denied a particular procedure because the insurance company did not want to pay for it. That should not be the way it is. Decisions about what kind of care you get, medical decisions, have to be made by the physicians. That is why we have physicians. That is why decisions are made collectively by physicians and their patients.

The second thing is that if you have been denied care and you think unjustly so, you have to have some ability to redress your grievances, to appeal that. What we suggest in the patients' bill of rights, what we guarantee, is that you can go to an independent review board, outside the realm of the HMO, not appointed by the HMO, and that they will review the decision and if they feel that you were improperly denied care, then they can overturn the decision of the HMO or the insurance company. Failing that, you can go to court and ask that it be overturned or sue for damages if you have been injured and there is no real recovery from those injuries.

These are just basic rights. Most people, until they get into a situation where they have been denied care, have no idea that what I am suggesting is not already the law. They think it is the law. They think it is fairness, which is essentially all we are asking for.

The other thing that my colleague from North Carolina mentioned that I think is so important is that we as Democrats and a significant amount of Republicans as well in this Chamber, we are simply asking for an opportunity to vote on this bill. This bill was voted on in the other body. It is now over here. It should be taken up here in the House of Representatives; and we should be allowed a clean vote, not bogged down with all kinds of procedures so that we cannot vote on it, and certainly not have an alternative bill which the Republican leadership has put forward which is not protective in the same way of patients. To give us the opportunity to vote on that and say that is HMO reform and then not have the opportunity to vote on the real patients' bill of rights I think is a travesty. And I hope that that is not what the Republican leadership has in mind, although there is every reason to believe that, in fact, that is the case.

I see I was joined also by my colleague from Texas. I was hoping, and I know that he will also get into the fact that in the State of Texas, our President Bush was the Governor of Texas and while he was there, the Texas legislature passed a patients' bill of rights, very similar to the patients' bill of rights that we now seek to have voted on here.

It has been a tremendous success. It has not resulted in much litigation. People have been able to overturn denials of care on a regular basis without having to go to court. It works well, and there is absolutely no reason why the same type of legislation should not be passed on a Federal level so everyone in every State can have the same benefits that the citizens of Texas have.

I yield to the gentleman. He has also been a very active member of our health care task force.

Mr. TURNER. I thank the gentleman from New Jersey (Mr. PALLONE) for yielding. It is a pleasure to join him in this special order hour to talk about this very important issue for the people of America, the patients' bill of rights. We have been working on this bill for the last 4 years. Ever since I have been in this Congress, we have been working trying to pass a patients' bill of rights; and I think now is the time to pass a good, strong bill for the American people.

When I was a member of the Texas Senate, I was the Senate sponsor of the first patient protection bill offered anywhere in the country. It passed our legislature overwhelmingly, with very little dissent. Unfortunately in that session of the legislature, the Governor, then Governor Bush, vetoed that bill.

The legislature in the following regular session broke the bill down into four parts, passed it again, overwhelmingly, the Governor signed three of the bills and let the fourth, relating to accountability and liability of HMOs, become law without his signature. The Governor cited his concern that the legislation would run up health care costs and create unnecessary litigation.

I am pleased to report that in the years since 1997 in Texas, there have only been 17 lawsuits filed under our patient protection legislation. There have been 1,400 patients who had the right under the Texas bill to object to the findings of the review panel and go to the external appeal process, which is an independent appeal process, to have their grievance heard. In those 1,400 appeals to the external panel, 54 percent of the time the patients have prevailed, 46 percent of the time the HMOs have prevailed. As I said, the next step, going to court to exercise your legal rights, that has occurred in only 17 cases since 1997.

So in Texas, the law is working. The Norwood-Dingell-Ganske bill is modeled after the law in Texas. It creates this independent review panel. It allows a person, if they are not satisfied with the decision of the external review panel, to exercise their right to go to court to receive the treatment they are entitled to. I think the experience across this country will be much the same as it has been in Texas, with very minimal litigation. So I am very hopeful that this Congress and this President will see fit to sign the Dingell-Norwood bill which I am confident will pass. After all, it has already passed in the last session, the 106th Congress, by a solid margin in this House.

As the gentleman will recall, it went to the Senate after it passed in the House and died in the Senate. This year, we have an opposite scenario. The bill has already passed in the Senate and is now back in the House to be voted on again. I am confident that this bill will be passed, and I hope that the President will sign it when it reaches his desk.

I would like to share my thoughts on the differences in the Dingell-Norwood bill and the other version of the patient protection law that will be offered by the gentleman from Kentucky (Mr. FLETCHER), a Republican. This legislation offered by the gentleman from Kentucky does not provide the same protections for patients as the Dingell-Norwood bill does. It is deficient in several respects.

First of all, the bill does not provide a meaningful appeals process for a patient. In fact, the bill provides very specifically that if the external review panel makes a decision and the HMO follows that recommendation and that decision, then no one has the opportunity to appeal anywhere. That to me seems to be very unfair. Under the Norwood-Dingell bill by contrast, once the external review panel makes a decision, if either party is dissatisfied, they have their constitutional right to go to the courthouse and to get a judgment that they think is correct. It seems to be fundamental in this country that if you set up an administrative review procedure and you do not like the outcome that you should and do have the right under our Constitution to an open court to be able to go in to file your grievance and get a decision by a jury of your peers.

Some have even suggested that the Fletcher bill may, in fact, be unconstitutional, because it prevents a patient from going to court if they are unhappy with the decision.

We are talking here about life and death decisions. We are talking about making HMOs accountable just as every other business organization in our society is now accountable. There is not one entity, not one person, not one business in this country that is not liable in the courts of our land for their negligent acts. I have always believed if our court system says that if a doctor makes a mistake in giving you medical treatment, if they are guilty of malpractice and the law provides that a patient has a remedy if malpractice is committed, then they also should have a remedy if an HMO commits malpractice. Because under the system of managed care that is becoming so popular in this country, HMOs are, in fact, making medical decisions. I have talked to many doctors who are totally frustrated with the current system, when they have to argue for hours on the telephone with an insurance clerk trying to get the treatment for their patients approved that they think is medically necessary and the HMO and their representative are saying no, in our judgment, it is not medically necessary.

Patients are entitled to quality health care in this country. We have one of the finest health care systems in the world. And we have got to be sure we protect it. I tell my friends in the HMO industry and the insurance industry that they have an important obligation, too, and, that is, to help us create a system where all of the parties will be satisfied with the outcome, because I am a firm believer that we must protect what we know is the best health care system in the world. And with more and more health care being delivered by managed care, we have got to make it work for everybody, not just the insurance companies, but for the patients, for the health care providers, for the doctors that are making the decisions about your health care and mine.

And if we fail to make this system work for everybody, then I hasten to think that we might come to the point where somebody will say, we have got to have a new system of health care, we have got to have a system like they have in Canada, we have got to have a system like they have in Europe; and I do not think we should go in that direction.

□ 2245

So we all have a stake in making this system of managed care work, and work for all of the parties in the system, not just the insurance companies.

When we look at the Fletcher bill, we also see numerous other deficiencies.

We see a provision in that bill that would require one when they do have the opportunity, which is rare, to appeal to the courthouse, that they have to go to Federal Court.

Now, most of us understand that most litigation regarding tort liability is handled in the State court system. Most of us are familiar, when we have an automobile accident, somebody has to go to court to recover damages, they go in the courthouse in their local county, where they usually have a State District Court. They do not travel hundreds of miles away to have to go to the nearest Federal court, they go the State court. Traditionally, these kinds of matters are reserved for State courts.

The bill we passed in Texas in 1997 sets up a fair procedure for allowing the patient, if they are dissatisfied with the review process, to go into State court. The Fletcher bill will preempt that legislation. It will put these kinds of cases in Federal court. It will federalize these causes of action, take them out of the State courts where they have traditionally been.

I believe this is an important State right that must be preserved. We do not need to get into a system where these kinds of cases have to be dealt with in Federal court. Most of the lawyers in your hometown and mine are accustomed to going to State court, not to Federal court. So we remove by one step further the ability to get redress of grievance, if we require these kinds of cases to go to Federal court. So the Fletcher bill basically strikes down current State law, like we have in Texas and many other States around the country.

We also know that the Fletcher bill creates some awkward time frames for appeal, and in many respects the legislation makes it very hard for a patient to exercise their rights under the legislation. We know that the independent review process is much more tilted toward the insurance companies under the Fletcher bill than it is under the Norwood-Dingell bill.

I think that we must face the fact that if we are really for protecting patients, we need to support the Norwood-Dingell bill. Every major medical group, the American Medical Association, in my State the Texas Medical Association, hosts of patient groups, have endorsed the Norwood-Dingell bill. It is a bipartisan piece of legislation.

The gentleman from Georgia (Mr. NORWOOD), the gentleman from Iowa (Mr. GANSKE), two of the Republican leaders, a respected doctor and dentist, have been fighting for this legislation for at least 5 years. Now is the time for action. I think that we can have a good bill, we can pass this bill, and we can hope that the President will see fit to sign it.

One other issue that I wanted to mention very briefly about this legislation is the fact that were it not for an arcane Federal law, we call it ERISA, the Employment Retirement Income Security Act that regulates health plans and retirement plans that operate in more than one State, is the only reason that we are in the predicament that we are in today, having to pass legislation to be sure that patients are protected. Because after we passed our good legislation in Texas, which, as I said, has only resulted in 17 lawsuits in the last 4 years, what we found is that a court decision handed down by one of our Federal courts in a suit in which the Aetna Insurance Company was involved, overnight made a large portion of our folks in Texas exempt from the State laws that we had provided, because the court ruled that part of our State law and its coverage was preempted by this arcane Federal ERISA law.

So all we are trying to do is restore the accountability that was provided in the law in Texas and many other States for HMOs by passing a law that in essence repeals an exemption that most, thought was not even in the law until the court ruled, created by a law passed by this Congress way back in 1974.

All we are doing in this legislation really is putting the HMOs back in the same position as every other individual and every other business in this country, which, under the laws of our land, if they commit a negligent act, if they wrongfully refuse to provide health care, if they wrongfully deny medical treatment, they are ultimately accountable in the courts of this land. So no longer will we allow HMOs to be exempt, the only entity that is exempt, from being responsible for their actions.

Mr. Speaker, I hope we have a good strong vote on this bill. I hope we pass the stronger bill. I am very pleased to be able to join the gentleman from New Jersey (Mr. PALLONE) tonight in talking about this important piece of legislation.

Mr. PALLONE. Mr. Speaker, I want to thank the gentleman, first of all, for explaining how in his home State of Texas that this bill has been tremendously successful and has not brought the frivolous lawsuits that we keep hearing from the other side, and that really we have nothing to fear. It is just basically has been a success in every way.

I know sometimes when we talk about the Patients' Bill of Rights, maybe we sound a little too lawyerly and technical about how one goes about appealing a denial of care. But the bottom line is, if there is no fair way to appeal a denial of care, if you have not been able to get the operation or procedure you need, if we do not set up a procedure to reverse that, then we might as well not pass the law. So it is necessary for us to go into how we go about letting people redress their grievances, and it is also important to point out that the Republican bill, the Fletcher bill, is not going to accomplish that, certainly not in any way that I think is meaningful.

I did not want to dwell upon it too much, but I just wanted to mention a couple other examples. We have to keep in mind when we talk about these procedures to overturn a denial of care that the people that are seeking to do that are ill. Oftentimes they are very ill. They need action fast. They cannot sit around forever if the HMO denies them an operation or procedure.

So it is very easy, as I think they do in the Fletcher bill, in the Republican bill, to tweak the bill in a way so that that procedure becomes meaningless. I do not want to dwell on it too much, but this is one of the things I thought was so important, was in the Ganske-Dingell proposal, the real Patients' Bill of Rights, there is a requirement that decisions are made in accordance with the medical exigencies of the patient's case, and there is a requirement that patients have a right to appeal to an external review before the plan terminates care.

Those are not in the Fletcher bill. They do not take into account timeliness, the fact that you do not have a lot of time to appeal or to go to an external review board. There are little things like this, I am not going to get into them, but they make it very difficult. If you are in a situation where you are denied care and need the operation, that you can in a timely manner reverse that decision.

So I just mention it, because I know a lot of times we talk about all these details, Federal versus State court, whatever, but these details are very important, because people do not have a lot of options when they are sick and ill and need to immediately have access to the kind of treatment that is necessary for them.

I see my other colleague from Texas has stood up, and I would like to yield to him. I know, once again, he has been very much involved in this issue for a number of years both on our Health Care Task Force as well as on the Subcommittee on Health.

Mr. GREEN of Texas. Mr. Speaker, I would like to thank my colleague from New Jersey for hosting this Special Order tonight on the need for a meaningful Patients' Bill of Rights.

Most folks may not know that we spent 11 hours today in markup in our Committee on Energy and Commerce on energy legislation, and my colleague from New Jersey probably got tired of hearing about Texas so often, but that is what we are going to talk about tonight.

The gentleman from New Jersey (Mr. PALLONE) has been the leader for several years, and I am happy to join him in calling for immediate passage of a real Patients' Bill of Rights.

We have a real opportunity to pass a meaningful Patients' Bill of Rights this year. After 5 years of heated debate, the U.S. Senate passed a meaningful Patients' Bill of Rights with protections for both patients and employers. Opponents of this measure argue that the legislation will result in a

landslide of frivolous lawsuits against employers, but that is simply not true.

We have a Patients' Bill of Rights in Texas for more than 4 years, now since 1997. In that time, we have had only 17 lawsuits filed. That is right, only 17 lawsuits. I know if you are watching this, you heard that from my fellow Texan (Mr. TURNER) here just a few minutes ago. But, at the same time, we have had more than 1,000 patients cases where patients appealed a denied claim to an independent review organization, an IRO.

In more than half of those cases, the IRO ruled in favor of the patient. That independent review organization more than half the time ruled in favor of the patient.

I always use the example, I would like to have more than the luck of a flip of a coin when it comes to health care for myself, my family or constituents. In Texas, more than half the time the IRO found the HMO was wrong in whatever they said they would not cover for the patient.

These independent review organizations are important not only because they protect the patients, but they protect the HMOs as well. Under Texas law, the HMO that follows the recommendation of that Independent Review Organization cannot be held liable for the damages in State court. That is right, an HMO who follows that Independent Review Organization recommendation cannot be held liable. There may be some other reason that they may have had a problem, but they are not responsible for that decision that was made if they stuck with it.

If an HMO denies care and ignores the review, if the patient is injured or dies, the HMO can be held liable in State court. Thanks to that law, Texans have real enforceable laws to obtain health care that they paid for.

But in the rest of the country, we do not. In fact, even in my own district, in Houston, Texas, I have constituents who have their insurance under Federal law. Sixty percent of people in my district have their insurance under Federal law. So no matter what our legislatures do in Texas, New Jersey, or the State of Washington, it does not help us under ERISA. We have to pass a strong law here on the House floor.

Mr. PALLONE. If I could take my time back, I think that is real important, that people have to understand, even in Texas the majority of the people do not have the benefit of that Texas Patients' Bill of Rights.

Mr. GREEN of Texas. Our surveys in my own district, very urban, 60 percent of the people have group insurance under Federal law. Even though the legislature passed something 4 years ago, most people get their insurance under Federal law. That is why we have to pass something here on this floor like what the Senate passed.

This legislation contains similar protections that we have had in Texas law, including provisions for an external appeals process. More importantly, the Senate version contains additional provisions to safeguard employers against frivolous lawsuits. Employers can only be held liable if they are directly responsible for the delay or the denial of treatment. So if an employer is acting like a doctor, they are going to be treated like a doctor.

It is time that important health decisions are made by doctors and their patients, and not HMO bureaucrats, and it is time the House passed the Norwood-Dingell-Ganske Patient Protection Act.

Mr. Speaker, thank the gentleman from New Jersey. He is the Chair of our Democratic Health Task Force and we have worked with each other for many years. Hopefully, by the time we leave for our August district work period, we will have debated and passed a strong Patients' Bill of Rights on this floor.

Mr. PALLONE. I want to thank the gentleman from Texas. Again, he has been in the forefront on this issue, not only on putting together the Patients' Bill of Rights, but trying to get it passed. Frankly, I think we are just becoming a little impatient. This is a bill that passed in the last session, two years ago, overwhelmingly, almost every Democrat, about a third of the Republicans, and the only problem we have is that the Republican leadership refuses to bring it up. All we are asking for is a clean vote on the bill.

Mr. GREEN of Texas. We are asking for patients' rights and becoming impatient.

Mr. PALLONE. Exactly.

I would like to yield now to the gentleman from Washington (Mr. MCDERMOTT), who is one of very few physicians that we have in the House of Representatives. I know that he, because of his background as a physician, probably more than any of us knows about the problems that patients have with HMOs and with denial of care.

Mr. MCDERMOTT. Mr. Speaker, first of all, my hat is off to the gentleman. I was sitting over in my office doing my mail, and I saw these gentlemen out on the floor talking about this issue. I thought, I have to go over and help them and also say some things that I think might be useful I think for people trying to understand this whole issue.

□ 2300

The first one is, why do we need a national bill? Why do we not just pass it at the State level? The gentleman from Texas (Mr. GREEN) sort of alluded to the need for Federal protection because of a law called ERISA.

ERISA was a law passed many years ago to protect pensions, and it is now used by many corporations to protect their involvement in health care so that it cannot be touched by insurance commissioners in States. They say the insurance commissioner has to go away. We are covered by the Federal law called ERISA, and you cannot monkey with how we do our health care. So the managed care companies are hiding behind ERISA all over this country, and that is why we need a national law. It is not sufficient to do it just in Texas or in my own State of Washington, where we just passed a law. We have done the best we can, but we are in the same place Texas is: Only about 50 percent of the people are covered by our Patients' Bill of Rights.

The second thing that is worrisome about these other bills that we see out here, the Fletcher bill and others, is the possibility that we will have a Federal law that overrides what is done at the State level. Now, if we set a high standard in the State and in comes a Federal law with a low standard, we lose; and that is why we need to have a provision in the bill that does not allow the Federal law that we pass here to override a higher standard that we might have in a State. The State of Washington, the State of New Jersey may decide to do something more than is done by the Federal law, and they should have that right. They should be able to do that.

Now, the history of this bill is sort of interesting. The Clintons worked very hard at getting a health care bill to cover all people that could never be taken away. They failed for lots of reasons, but, certainly, in the election of 1994, the Republicans took great pleasure in saying, we saved you from government medicine, which was how they defeated the President's attempt to give everybody universal coverage. Everybody remembers the Harry and Louise ads where this couple is sitting around the dining room table saying, well, can you believe it? The government is going to come in and take over our health care.

Well, the people who said they did not want government medicine essentially said at that same point, we are going to give health care coverage to the insurance industry. Anything they want to do is fine, because that is the free enterprise system. Let them squeeze the people and let them squeeze down health care as much as possible so that they can make more money.

There is nothing wrong with a managed care company, but it is very simple what they do. They take in premiums and then they pay out as few benefits as possible so they can give all the rest in dividends to their stockholders. Now, there is nothing wrong with that, except that it means that the patients are always being squeezed.

The first obvious one that came to the Congress back in 1994 was the fact that women would come to the hospital at 8 o'clock in the morning, deliver a baby, and by 5 o'clock they were in the car on the way home before the baby had ever had a feeding or there was time to observe whether the child had jaundice, or anything. And we called it drive-by babies. We passed a bill through both Houses that said we cannot have a drive-by baby system. We have to let the doctor and the patient decide how this is going to happen.

Well, the next thing that happened was women went into the hospital to have a breast removed for cancer and, lo and behold, they go in in the morning at 8 o'clock and out at 5' clock, and they were on their way home. So we were having drive-by mastectomies in this country because, again, the insurance company was trying to squeeze down the number of days they spent in the hospital so that they could save money to give to their stockholders. The patients and the doctors were frustrated by that, so they came up here, and we passed another bill preventing that, saying that the doctor and the patient should decide it.

Well, we were going one disease at a time, the disease of the day, the disease du jour. We said, that is not going to work. We have to have a bill that gives patients and doctors the right to make medical decisions for people. It seems so obvious that the person that is receiving the treatment and the person that is giving the treatment should be the ones to decide what is appropriate.

But the insurance companies took the view that they could look over your shoulder and decide, that is too much, or they do not need this. I had the experience, because I am a physician; I am a psychiatrist. I had a patient on a ward in Seattle; and they came along and said, this patient has to be discharged. Well, this patient was suicidal. I have to make the decision about whether I am going to put a patient that is suicidal out of the hospital and send them home, risking that they may kill themselves, or fight with an insurance company. So I got on the phone. Here I am talking to some very nice woman in Omaha, Nebraska, from Seattle, and she is telling me that I have to justify to her why that patient can stay in the hospital another day.

Now, it is ridiculous. I am a psychiatrist. Surgeons go through that, pediatricians go through that, obstetricians, gynecologists, all kinds of physicians go through this all the time, fighting with insurance companies, managed care companies that are making decisions for patients that they have never seen. When the physician is standing there looking at the patient and they have to get on the phone and explain why to somebody who has never seen them, it shows us how ridiculous it is. It seems like this bill ought to go through immediately.

Mr. PALLONE. Mr. Speaker, if I could just interrupt a second, because we had a hearing a couple of years ago, I think it was one of our task force hearings, and I do not remember the details, but it directly referred to psychiatry.

The problem was that the HMO was using a standard that was not really acceptable by those who certify psychiatrists and basically saying that, for a patient who had a mental illness, they would only be entitled to, say, three visits, where maybe the standard for the psychiatric society was 15 visits. They just made it up. I mean, they just made up the number of days that they would provide. The testimony showed that they were about to be acquired by another HMO, and so they were trying to show that they were making a lot of money. They just established that standard based on the cost, that they would save money.

One of the things that is in the Dingell-Ganske bill, it says that, with regard to specialty care, that the standard has to be that which is typical for that specialty care. They use, I do not know what they call them, the diplomacy board or whatever as the standard. That is another major difference I think in terms of why the Patients' Bill of Rights is such a good bill. I do not remember all the details, but I remember specifically that.

Mr. McDERMOTT. Mr. Speaker, the gentleman is absolutely right. In every profession, every specialty in medicine, whether it is pulmonary surgery or pediatrics or obstetrics or whatever, there is a board that gives people the right to say, I am an obstetrician, I am a psychiatrist, I am a pediatrician; and those boards look at all of these particular conditions related to that specialty and make decisions about what is an appropriate standard of care.

Now, if an insurance company wants to just arbitrarily make their own standards of care in contradistinction to what the doctor has been taught, what he has agreed to as being an obstetrician, this is the way you handle these kinds of cases, and suddenly he is told by somebody who is not in the profession that they should do otherwise, you can see the conflict. I mean, it is terrible for doctors. That is why doctors hate this so much. Here you have been trained, gone to college, medical school, an internship and a residency, all this training, and here is somebody coming out of nowhere telling you you cannot do that; what you have to do is what we tell you to do.

Mr. Speaker, I think that the essence of this whole thing is bringing it back to a place where doctors and patients make the decision.

Now, the other part, and this is about deciding, what does the ordinary citizen know? The ordinary citizen is not a physician or a nurse or anybody in the health care profession. When they feel sick, when they feel pain in their chest or pain in their stomach or whatever, they go to see a physician or they go to see the emergency room in a hospital, because they are worried.

Now, it may turn out that what they thought was a heart attack is really related to eating spicy food or something else. It may turn out that it was not a heart attack. But to say that the average citizen is supposed to make that decision in their own home and diagnose themselves, put a stethoscope on their chest and say, well, it sounds all right to me, I mean, it is crazy. Everybody knows that. None of us wants to go to the emergency room in a hospital, but people go, and because it turns out it was not anything really big, why, they say we are not going to pay for it.

□ 2310

But people go, and then because it turns out it was not anything big, then they say, well, we are not going to pay for it. Those kinds of issues, sort of a reasonable person standard, what would a reasonable person do in this case, those kinds of issues, should not be turned back on the patients.

I had a hearing in Seattle with my constituents. I opened my door and said, come on in. People told me all kinds of things. For instance, thy were told by an insurance company they could not have this kind of treatment, but somebody a thousand miles away in Kansas City or Los Angeles was having that kind of treatment for exactly the same kind of circumstances. So one place is doing one thing and another place is doing another thing, and all of these differences are based simply on insurance companies' decisions about how tightly they can squeeze this issue down.

There is a story or a case that came up from Florida where a man, an elderly man about 75 years old who had prostate cancer, after he had the prostate cancer removed, then they talked about, how do you suppress the male hormones. Now, obviously there are a couple of ways to do that. One is to castrate him. That is a one-time $1500 operation. Or they can put him on medication that costs about a thousand dollars a year. So it will cost more if he lives 5 or 10 years. So they made the decision to do the castration. The man said, I do not want that.

Again, we have these kind of things. These are tough decisions. But they ought to be made between the doctor and the patient about what is best for the patient, not by an insurance company saying, ''do it the cheapest way.''

Lots of physicians are leaving medicine today. Many of my colleagues in my class have said, ''I am through with this. I cannot fight with insurance companies any more, because it has just taken all the joy, all the pleasure out of being a physician because I am always caught.''

So there was a time, and the insurance companies have changed this, but there was a point where they would say, ''You cannot even tell the patient that there is another treatment. If we only cover x, you cannot tell the patient there is y, or that there is another way to be treated. If you go over to see Dr. Johnson, he'll give you another treatment.''

Mr. PALLONE. If I could follow up on that, Mr. Speaker, that is one of the things that is also a big difference with the Fletcher bill, with the Republican bill. The Republican bill, as the gentleman knows, that the leadership wants to bring out leaves out this basic right, if you will, or basic protection that we have in the real patient bill of rights that says doctors can communicate freely with their patients without fear of retaliation by the HMO.

That guarantee, or the gag rule, is not in the Fletcher bill.

The other thing that is not in the Republican bill, it also fails to protect against HMOs when they have these financial incentives where they say to the doctor, if you do not provide a certain amount of care, or if you do not have your patients use the hospital or certain procedures and save us money, then you'll get a financial incentive, sort of a rebate of some sort, there is nothing in the Fletcher bill that guarantees that those kinds of arrangements could not continue.

We primarily tonight have been talking about the patients. Of course, this impacts the patients as well, but there are a lot of protections for physicians so they can practice freely that are in the Dingell-Ganske bill that are not in this Republican bill. Those are two important ones.

Mr. McDERMOTT. The whole financial incentive business of saying to the doctors that each month they get to make 80 referrals for consultation with outside consultants, and if they make more than 80 they will reduce the salary, and if they make less they will get more, well, that puts that initial early primary care physician in a very difficult position, because if we have a patient who has diabetes, for instance, we will say, well, I could handle diabetes. I learned about it in medical school. I am not going to refer them to a specialist in diabetes until they get into trouble.

So they are taken care of, and then when they get in trouble at that point they are sent in a mess to a specialist. That is not patient care, but that is the kind of thing that physicians are put in if they are trying to stay within these kind of limits, these financial incentives that have been put there. They are under tremendous tension about how many people they refer to specialists when they think, this is something that ultimately could be a real problem. I want to have somebody with more experience in this area to see them now.

The same is true in gynecological things or in cardiac things or in psychiatric things. Why would he refer a patient to a psychiatrist if he could just give them some pills and see how they do. They might do that once and see if it works, but at a certain point it is better to send them to somebody better trained who has more experience. For physicians who are caught in that economic vice, that is a terrible way to run the medical system, to say, I am going to hit you in your pocket if you do what you think is best for your patient.

If the patient knew what was in the doctor's mind, they would be afraid to go to him.

Mr. PALLONE. Is it not also true that in many areas, and it depends on what part of the country one is in, but there are certain parts of the country, and New Jersey is certainly one of them, where the physician is really forced to join the HMO. In other words, they have a difficult time staying independent and relying on traditional insurance, so they are in a situation where they have to sign up and take these contracts with gag rules and the financial incentives and all those things. They are not free necessarily to avoid all that.

Mr. McDERMOTT. I was flying home to Seattle. Sitting next to me was a middle-aged woman. We got to talking as we were eating dinner.

I said, What do you do? She said, I run a neurologist's office in Vienna, Virginia. I said, Really? You are the one who handles the billing and all that kind of stuff? She said, Yes. I said, Has he joined any HMOs? She laughed and said, He has signed 60 agreements with HMOs. We would have no practice if we did not sign with all these operations.

I said, Have you read all the contracts? She said, Are you kidding? How could I possibly read 60 contracts and still do business? I do not know what we have signed, because we had no choice, because all of our patients came in with insurance cards from those plans. If we were not in the plan, we would not get paid.

That is a big part of what is going on out there, why it costs more money, because you have people who are having to bill all these companies with different rules. There is no single set of rules. If the doctor makes a decision, if he has made a decision because of the way he thought one plan worked and it is not the way the other plan worked, then he is wrong, and they send it back to him and do not pay him. Of course, the patient keeps getting the bills, because they say, your doctor has not sent these in, or whatever. So there is this endless paper mill that gets caught up. Patients really should not have to worry about that.

I had some surgery and I wound up at home receiving all the bills that came from the hospital. At one point they had not paid a bill. I said, Well, this consultant came in and saw me. Why have you not paid him? They said, We have not received any confirmation that you were in the hospital. I said, where did you think I had the surgery, out in the parking lot? Because until the bills came in in the right order, they kept coming back to me.

That happens to people all over this country. Doctors spend a lot of time and money filling out forms for their patients. There is no need for that. There is no need for the insurance company to do that.

The reason they do that is the longer they hold on to the money, the more they have to give to the stockholders. If they paid their bills right away when they came in the money would be gone, but this way they can invest it and hold on to it and give the profits to their stockholders.

This patient bill of rights, in my view, in a democratic society there should not be any question about this passing. It has taken us 5 years to get it to this point, and we have passed it again, again, and again. The insurance companies have killed it either in the Senate or in the House.

It is absolutely a crime. The American people ought to demand of thier Members of Congress that they vote for the Dingell-Ganske-Norwood bill.

I have to give great credit to the gentleman from Iowa (Mr. GANSKE) and the gentleman from Georgia (Mr. NORWOOD). They are Republicans. But when one is sick, one is not a Republican or a Democrat, just a sick person. They have taken this very professionally. The gentleman from Iowa (Mr. GANSKE) is a very good surgeon, and the gentleman from Georgia also has a medical background. They have taken this and said, We do not care what our caucus said, we are going to do what is right.

In my view, that is what Members of Congress really should do, and I think all of them ought to do it. If the leadership does not bring it out here pretty quick, we are going to have to make them bring it.

□ 2320

Mr. PALLONE. I agree. And I know we are running out of time, so I guess we will finish off here; but I want to say two things.

First of all, I really appreciate the gentleman's joining me tonight, because I think a lot of the emphasis that we have talked about, not only tonight but on other occasions, has been more from the patient's point of view. And what the gentleman is pointing out is that basically the patients' bill of rights frees up the doctors to practice medicine, and that if we do not do this, in the long run we are going to lose a lot of good doctors. We already have. And, of course, that is a patient issue as well. Whatever helps the doctors certainly in these circumstances also helps the patients.

The other thing, of course, is my fear, and the reason we are here tonight is because we keep hearing that the Republican leadership, which does not want this bill and has done everything over the past 5 years to kill the bill, is trying to do that again. Basically, what they are doing is going to the 60-some odd Republicans who voted for the Patients' Bill of Rights in the last session and trying to get them to oppose that and support this Fletcher Republican bill, which does not accomplish the goal. My fear is that if they do not get enough votes to pass the Fletcher bill, the Republican leadership simply will not bring up the Patients' Bill of Rights.

So we are just going to have to keep holding their feet to the fire, so to speak. And as the gentleman says, if they will not bring it up, I guess we will have to resort to a discharge petition. But these procedural efforts are difficult. It is not easy to accomplish these things. So as the gentleman says, if we can get the American people to

wake up sort of and say, look, this is something that has to be voted on; if we can accomplish that, that is really the way to go.

But we have to continue to speak out, as we did tonight and we will continue to, until we have a freestanding vote on this bill. It is that important.

Mr. McDERMOTT. I think what people really need to understand, too, is that in a democracy there should be open debate. Both sides can make their case, and then we put it to a vote and the majority should rule. We have the majority of votes. The leadership is just using all the maneuvers of the parliamentary system to keep it locked up. But the ones they are hurting, not themselves perhaps, maybe they have not had the experience yet, but who they are hurting are the American people; and that is unconscionable, should not happen.

We have been too long on the road on this, and I congratulate the gentleman again for putting his time and effort into making this happen.

Mr. PALLONE. I thank the gentleman again.

## TRIBUTE TO VETERANS OF PACIFIC THEATRE DURING WORLD WAR II

The SPEAKER pro tempore (Mr. KERNS). Under the Speaker's announced policy of January 3, 2001, the gentleman from Guam (Mr. UNDERWOOD) is recognized for the time remaining until midnight.

Mr. UNDERWOOD. Mr. Speaker, I rise today to pay tribute to the veterans of the Pacific theatre during World War II, especially for those who participated in the battle for Guam; and I also want to take the time to honor the Chamorro people, my people, the indigenous people of Guam, for their show of courage during the 2½ years of enemy occupation, and most especially to pay homage to the many lives lost during World War II, both by men in uniform and by the civilian population in Guam, particularly the lives lost at the Fena, Tinta, and Chaguian massacres that occurred near the end of the Japanese occupation. I will be submitting a list of names for the record of those who suffered the fate of death at those massacres.

On July 21, 2001, at the end of this week, the people of Guam will be celebrating the 57th anniversary of the liberation of Guam. It is that day that commemorates the landing of the Third Marine Division on the shores of Asan and the First Marine Provisional Brigade, supported by the 77th Army Infantry, in Agat. I wish to extend a very warm Hafa Adai and sincere Si Yu'os Ma'ase' to the veterans of that conflict who liberated Guam. I would also like to honor and pay respect and remember the people of Guam and the suffering they endured for some 2½ years under the enemy occupation of the Japanese Imperial Army.

On the morning of December 8, 1941, Japanese troops bombed and invaded Guam as part of Japan's attack on U.S. forces in the Pacific, including the attack on Pearl Harbor and the Philippines, both areas also having significant U.S. forces. They all occurred on the same day, except that Guam is on the other side of the date line. This commemoration, which I do annually, and try to bring a little honor and respect for the experiences of the people of Guam, is marked by a laying of the wreath at the Tomb of the Unknowns, which honors both the American veterans and remembers the sacrifices of the people of Guam.

This is also a tribute of the necessity for peace, for it is only in the remembrance of the horrors of war that we do really truly remain vigilant in our quest for peace.

I was privileged to lay a wreath at the Tomb of the Unknowns yesterday at Arlington National Cemetery honoring the liberation of Guam; and I was assisted by the gentleman from Arizona (Mr. STUMP), the chairman of the House Committee on Armed Services and a World War II veteran himself.

My purpose this evening, in the time that I have, is to give a historical perspective to the events we are commemorating on Guam at the end of this week, and to enhance the understanding of people across the Nation of the wartime experiences of the people of Guam and the postwar legacy which has framed the relationship of my island with the United States. It is a story that is both a microcosm of the heroism of soldiers everywhere and the suffering in particular of civilians in occupied areas during World War II.

This is encapsulated in these three pictures that I brought with me today, and it is part of a lengthy display that we have had called tempon gera, the time of war. And down here we have basically the cemetery, a temporary cemetery, in which servicemen were buried right after the battle of Guam. Here we have some servicemen entertaining some children from Guam right after the liberation of Guam. And this is the most poignant picture of all. Actually, these are a couple of kids from the Cruz family. This is a young lady and a young man, and this is probably the most remembered picture of the wartime period in Guam. Their mother has made a flag. Their mother was a seamstress, and she hand made this flag; and they carried it around at the time of the liberation of Guam.

Guam has a unique story all to itself. It is an experience of dignity in the midst of political and wartime machinations of larger powers over smaller peoples as well as a story of loyalty to America and a demonstration of loyalty that has not been asked of any civilian community, I believe, during the entire 20th century.

It is important to understand that Guam was an American territory since the end of the Spanish-American War in 1898. It was invaded, as I pointed out earlier, in the early morning hours of December 8, 1941, and thus began a 32-month epic struggle of the indigenous people of Guam, the Chamorro people, to maintain their dignity and to survive during an occupation by the Japanese.

In the months leading up to the war in the Pacific, many of the planners had decided that it was not feasible to defend Guam against the possible invasion by Japanese forces in the surrounding areas. All of the areas in the Micronesian region were held by Japan, save for Guam. The rest of the islands in the central Pacific were held by the Japanese under a League of Nations mandate, the most significant Japanese installations being held in Saipan, 100 miles to the north, and the naval forces in the Truk Lagoon, some 350 miles to the south.

This decision not to build up Guam became a major controversy in the latter part of World War II as people reviewed the records of Congress. Even though an effort was made in Congress, by amendment, to try to reinforce Guam, it failed; and subsequently the people of Guam, as well as the island of Guam, was laid defenseless.

When the Japanese Imperial Forces landed on Guam in December of 1941, they basically found 153 Marines, 271 Navy personnel, 134 workers associated with the Pan-American Clipper Station, and some 20,000 civilians, Chamorro people, who at that time were not U.S. citizens but were termed U.S. nationals. All of the American military dependents had been evacuated from Guam in anticipation of the war, with the last ship having left on October 17, 1941.

Despite the fact that of course we all think of the Japanese attack on Pearl Harbor as a surprise attack because of where it took place and the suddenness of it, I think most people at the time were fully cognizant of the fact that war was eminent in some fashion in the Asian Pacific area. And proof of that is the fact that the American military dependents were evacuated from Guam. But, of course, the people of Guam were not evacuated.

□ 2330

And it was the people who were left faced to confront the cruel occupation that they did actually experience in subsequent months. The actual defense of Guam then fell to these handful of Marines and handful of sailors and actually to the Guam ancillary guard and Guam militia consisting of civilian reserve forces.

The insular force, which was a locally-manned type militia, actually were the ones who faced the Japanese. The Japanese invasion force numbering some 5,000 easily overwhelmed these men in uniform. Ironically, the only ones who really fired any shots in anger were Japanese Imperial Forces, were members of the Guam insular guard who had set up some machine gun nests in defense of the Placa de Espana and at the governor's offices.

Throughout the ordeal of the occupation, the Chamorro people maintained