Withdrawal/Redaction Sheet
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. list	re: video proposal meeting (1 page)	06/28/2000	b(6)

COLLECTION:
Clinton Presidential Records
Speechwriting
Josh Gottheimer
OA/Box Number: 19004

FOLDER TITLE:
Videos 7/10/00: AANA [American Association of Nurse Anesthetists]/IFNA [International Federation of Nurse Anasthetists]

2016-0201-S
rc2222

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
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b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

V –
AANA / IFNA

Video Proposal Meeting
Wednesday, June 28, 2000

Video for World Alzheimer's Congress **July 16**

Staff Contact: Mary Beth Cahill
Location: Washington, DC
Duration: 1 minute
Viewers: 4,000 direct care providers from nursing homes, assisted living adult day care, and the health care system
--to provide an opportunity to talk about prescription drugs, $3,000 long term tax credit, and the caregiver's initiative.

Video for Rededication of the *Magna Carta* **July 15**

Staff Contact: Beth Nolan
Location: Runnymede, United Kingdom
Duration: not specified
Viewers: 300 guests from U.S. and British Bars, American Bar Association Central and East European Law Initiative
--to congratulate the American Bar Association (ABA) Central and East European Law Initiative at an event rededicating the *Magna Carta.* Attorney General Janet Reno will deliver keynote. Justice O'Connor will also deliver remarks.

Video for the Annual Meeting of the ~~American Association of Nurses~~ Anesthetics and the International Federation of Nurse Anesthetics **July 12**

Staff Contact: Mary Beth Cahill
Location: Chicago, IL
Duration: 1-3 minutes
Viewers: Members of the American Association of Nurses Anesthetists and The International Federation of Nurse Anesthetists
--to highlight that the President's mother was a nurse anesthetist. They are key players in our efforts to pass the Patients Bill of Rights legislation.

Video for the National Association of Counties **July 13**

Staff Contact: Mickey Ibarra
Location: Mecklenburg, NC
Duration: 2-3 minutes
Viewers: 5,000 county officials
--to deliver greetings and outline the Administration's remaining legislative priorities.

Video for the Town Hall Meeting of the President's Advisory Commission on Asian Americans and Pacific Islanders **July 21**

Staff Contact: Mary Beth Cahill
Location: Los Angeles, CA
Duration: 7-8 minutes

Viewers: Participants of Town Hall Meeting
--to provide welcome message which will emphasize the importance of the White House Initiative on Asian Americans and Pacific Islanders.

Video for the Disney Institute Afterschool Alliance Symposium **July 23**
Staff Contact: Bruce Reed
Location: Orlando, FL
Duration: 3 minutes
Viewers: top representatives from the U.S. Department of Education, National education leaders, state policy makers, school officials, Business and community leaders, teachers and students
--to commend local, state and national activists for their diligent work and dedication to ensure high-quality afterschool instruction for children nationwide.

Video for the American Postal Workers Union Convention **July 24**
Staff Contact – Karen Tramontano
Location: Washington, DC
Duration: 1-2 minutes
Viewers: American Postal Workers Union Convention participants
--to honor Moe Biller, President of the American Postal Union Workers

Video for the 66th Constitutional Convention of the Building and Construction Trades Department **July 25**
Staff Contact: Karen Tramontano
Location:
Duration: 1-2 minutes
Viewers: Participants of the Convention of the Building and Construction Trades Department
--to show support of the event

Video for the GSA's 11th Annual Child Care Conference **July 27**
Staff Contact: Thurgood Marshall, Jr.
Location: New York, New York
Duration: 5-10 minutes
Viewers: 500 teachers, center directors, child care providers, facilities managers And government agency representatives.
--to give conferees an opportunity to hear the President briefly describe the Administration's child care initiatives.

Video to honor Presiding Bishop, J. Delano Ellis, II **August 7**
Staff Contact: Mary Beth Cahill
Location: Cleveland, OH
Duration: 1-2 minutes
Viewers: TBD
--to recognize 40 years of ministry by the Presiding Bishop, J. Delano Ellis

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Video for "team processing" for members of the 2000 Olympic Team **August 15**

Staff Contact: Thurgood Marshall, Jr., Mickey Ibarra
Location: Chula Vista, CA
Duration: TBD
Viewers: Olympic athletes
--to congratulate the athletes on their selection to the 2000 U.S. Olympics and Paralympic Team

(b)(6)

[001]

What are the educational requirements for CRNAs?

Applicants to nurse anesthesia educational programs are required to have:

- A Bachelor of Science in Nursing or another appropriate baccalaureate degree from an approved nursing program.
- A current license as a registered nurse.
- A minimum of one year's acute care nursing experience.

- There are more than 90 accredited nurse anesthesia educational programs nationwide.
- Nurse anesthesia education programs vary from 24 to 36 months of graduate coursework depending on the university. The program includes both classroom and clinical experiences.
- Graduates of nurse anesthesia educational programs must pass a national certification exam to become CRNAs.
- CRNAs are required to earn 40 continuing education credits every two years as one of the criteria for recertification.

What is the AANA?

- Founded in 1931,the American Association of Nurse Anesthetists is the professional association representing CRNAs nationwide.

What are some of the association's ongoing activities?

The association's ongoing activities include:

- Developing standards that ensure high quality anesthesia care to safeguard patients.
- Facilitating the nurse anesthesia education process and research.
- Seeking private and public sector funding sources for educational advancement and research.
- Providing educational opportunities and professional recognition.
- Monitoring, assessing and working with legislative and regulatory bodies to impact government initiatives.
- Promoting a professional and equitable work environment by addressing legal and ethical issues facing CRNAs.
- Facilitating effective cooperation between nurse anesthetists and other health care groups.
- Working with state nurse anesthetist associations on projects of mutual interest.
- Disseminating information about nurse anesthesia by publishing a scientific journal, newsletter and monographs.
- Conducting an annual membership survey trending the practice of anesthesia by CRNAs.

Other activities include those of the association's credentialing councils which strive to improve the quality of nurse anesthesia education and provide competent providers:

- The Council on Accreditation of Nurse Anesthesia Educational Programs accredits each program, a process which is repeated at intervals of up to six years and which provides assurances concerning the quality of educational preparation. The Council has been designated the official accrediting body for Nurse Anesthesia Educational Programs by the U.S. Department of Education.
- The Council on Certification certifies graduates of accredited nurse anesthesia educational programs who successfully complete the national certification exam.
- The Council on Recertification recertifies qualified CRNAs every two years.

The Council formulates and adopts criteria for eligibility for the recertification of CRNAs.

For more information about nurse anesthesia and the American Association of Nurse Anesthetists contact: info@aana.com

IFNA

Wednesday, June 28, 2000

American Association of Nurse Anesthetists

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About the International Federation of Nurse Anesthetists (IFNA)

The International Federation of Nurse Anesthetists (IFNA), which represents 45,000 nurse anesthetists worldwide, is a growing organization whose membership practices in both developed and developing countries.

The first International Symposium for Nurse Anesthetists convened in Lucerne, Switzerland, in June 1985. Two hundred fifty nurse anesthetists from 11 countries attended. Three years later, when the Second International Congress of Nurse Anesthetists convened in Amsterdam, The Netherlands, 511 nurse anesthetists from 16 countries attended. Before this meeting, several European associations had already discussed the possibility of developing an international organization. The concept was greeted with great enthusiasm at the Amsterdam meeting, and plans were made to continue to move ahead with the formation of an international organization.

At the first organizational meeting in September 1988, the name, International Federation of Nurse Anesthetists (IFNA), was chosen, and a decision was made to hold a World Congress every 3 years.

In June 1989, when country representatives met to review the applications for membership in the IFNA, 11 countries were admitted as charter members and the first meeting of the IFNA Board of Directors was held.

After the establishment of IFNA, 1,100 nurse anesthetists attended the Third International Congress in Oslo, Norway, and by 1994, when the Fourth World Congress convened in Paris, France, attendance had grown to over 2,600 representing 47 countries. The Fifth World Congress was held in Vienna, Austria in April 1997.

IFNAs membership has grown and is growing at a rapid pace.

In 1995, the executive office of IFNA was established at the AANA headquarters in Park Ridge, Illinois, with Ronald Caulk, CRNA, as its first executive director.

For more information please contact:

Ronald F. Caulk, CRNA
Executive Director
IFNA Executive Office
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Park Ridge, Illinois USA
Tel: (847) 692-7050 ext. 5090
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IFNA
Holderlinstrasse 17
CH-9008 St. Gallen
Switzerland
Tel: (41) 71 25 33 30
Fax: (41) 71 25 33 21

▼ Also See

Objectives
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Contacts
Nurse Anesthetists at a Glance
History of Nurse Anesthesia
Q & A about a career in Nurse Anesthesia
Accredited Nurse Anesthesia Programs
Board of Directors
State Nurse Anesthetist Associations
AANA Meetings and Activities

Information

Nurse Anesthesia ... no longer the best kept secret in health care.

Established in the late 1800's as the first clinical nursing specialty, nurse anesthesia developed in response to the growing need surgeons had for anesthetists. Certified Registered Nurse Anesthetists (CRNAs), and the American Association of Nurse Anesthetists (AANA), have played significant roles in developing the practice of anesthesia. Today, more than 27,000 CRNAs provide cost-effective, quality patient care that is essential to America's health care system.

Meeting the needs of tomorrow

- CRNAs have a proud history of meeting the challenges of changing health care trends. The recent acceleration of managed health care services will provide additional opportunities and new challenges for these advanced practice nurses. CRNAs will continue to be recognized as anesthesia specialists providing safe patient care.

How do CRNAs impact health care?

- As anesthesia specialists, CRNAs administer approximately 65% of the 26 million anesthetics given to patients in the U.S. each year. As advanced practice nurses, CRNAs can serve in a variety of capacities in their daily practice, such as clinician, educator, administrator, manager and researcher.
- CRNAs administer anesthesia for all types of surgical cases, using all anesthetic techniques and practice in every setting in which anesthesia is delivered, from university-based medical centers to free-standing surgical facilities.
- CRNA's are the sole anesthesia providers in more than 70% of rural hospitals in the United States, affording some 70 million rural Americans access to anesthesia. CRNAs provide a significant amount of the anesthesia in inner cities as well.
- CRNA's are qualified and permitted by state law or regulations to practice in every state of the nation.
- CRNA's provide safe, effective anesthesia services for millions of patients each year.

What is the role of the individual CRNA?

- Nurse anesthetists, pioneers in anesthesia, have been administering anesthesia for more than 100 years. As anesthesia specialists, CRNAs take care of patients before, during and after surgical or obstetrical procedures. The nurse anesthetist stays with you for the entire procedure, constantly monitoring every important function of your body and individually modifying your anesthetic to ensure your maximum safety and comfort.

Anesthesia safer than ever

- Statistics show that anesthesia today is safer and more effective than ever before. New technologies, extensive specialty training and high professional standards have made the administration of anesthesia one of the safest aspects of a surgical or obstetrical procedure.
- The nature of anesthesia requires the constant vigilance of the anesthesia provider. Vigilance has been the hallmark of nurse anesthesia practice since the profession's creation.

Wednesday, June 28, 2000

American Association of Nurse Anesthetists

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Nurse Anesthetists at a Glance

Nurse anesthetists have been providing anesthesia care in the United States for over 100 years. Approximately 95% of this country's nurse anesthetists are members of the American Association of Nurse Anesthetists (AANA).

Certified Registered Nurse Anesthetists (CRNAs) are anesthesia specialists who administer approximately 65% of the 26 million anesthetics given to patients each year in the United States.

CRNAs are the sole anesthesia providers in nearly 50% of all hospitals and more than 65% of rural hospitals in the United States, affording these medical facilities obstetrical, surgical, and trauma stabilization capabilities.

CRNAs provide anesthetics to patients in collaboration with surgeons, anesthesiologists, dentists, podiatrists and other qualified healthcare professionals. When anesthesia is administered by a nurse anesthetist, it is recognized as the practice of nursing; when administered by an anesthesiologist, it is recognized as the practice of medicine.

As advanced practice nurses, CRNAs practice with a high degree of autonomy and professional respect. They carry a heavy load of responsibility and are compensated accordingly; the average annual income for a CRNA in 1997 was approximately $88,000 based on the AANA Membership Survey.

CRNAs practice in every setting in which anesthesia is delivered: traditional hospital surgical suites and obstetrical delivery rooms; the offices of dentists, podiatrists, ophthalmologists, and plastic surgeons; ambulatory surgical centers; and U.S. Military, Public Health Services and Veterans Administration medical facilities.

Managed care plans recognize CRNAs for providing high-quality anesthesia care with reduced expense to patients and insurance companies. The cost-efficiency of CRNAs helps keep escalating medical costs down.

Legislation passed by Congress in 1986 made nurse anesthetists the first nursing specialty to be accorded direct reimbursement rights under the Medicare program.

A total of 42% of the nation's 27,000 CRNAs are men, versus approximately 5 percent in the nursing profession as a whole.

Education and experience required to become a CRNA includes:

- A Bachelor of Science in Nursing (BSN) or other appropriate baccalaureate degree.

- Hold a current license as a registered nurse.

- At least one year's experience in an acute care nursing setting.

- Graduate from an accredited school of nurse anesthesia educational program ranging from 24-36 months, depending upon university requirements. These programs offer a graduate degree and include clinical training in university-based or large community hospitals.

- Pass a national certification examination following graduation, and complete a continuing education and recertification program every two years thereafter.

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History of Nurse Anesthesia Practice

Nurses were the first professional group to provide anesthesia services in the United States. Established in the late 1800s, nurse anesthesia has since become recognized as the first clinical nursing specialty. The discipline of nurse anesthesia developed in response to requests of surgeons seeking a solution to the high morbidity and mortality attributed to anesthesia at that time. Surgeons saw nurses as a cadre of professionals who could give their undivided attention to patient care during surgical procedures. Serving as pioneers in anesthesia, nurse anesthetists became involved in the full range of specialty surgical procedures, as well as in the refinement of anesthesia techniques and equipment.

The earliest existing records documenting the anesthetic care of patients by nurses were those of Sister Mary Bernard, a Catholic nun who assumed her duties at St. Vincent's Hospital in Erie, Pennsylvania in 1887. The most famous nurse anesthetist of the nineteenth century, Alice Magaw, worked at St. Mary's Hospital (1889), in Rochester, Minnesota. That hospital, established by the Sisters of St. Francis and operated by Dr. William Worrell Mayo, later became internationally recognized as the Mayo Clinic. Dr. Charles Mayo conferred upon Alice Magaw the title of "mother of anesthesia," for her many achievements in the field of anesthesiology, particularly her mastery of the open-drop inhalation technique of anesthesia utilizing ether and chloroform and her subsequent publishing of her findings.

Together, Dr. Mayo and Ms. Magaw were instrumental in establishing a showcase of professional excellence in anesthesia and surgery. Hundreds of physicians and nurses from the United States and throughout the world came to observe and learn their anesthesia techniques. Alice Magaw documented the anesthesia practice outcomes at St. Mary's Hospital and reported them in various medical journals between 1899 and 1906. In 1906, one article documented more than 14,000 anesthetics without a single complication attributable to anesthesia. (Surgery, Gynecology and Obstetrics, 3:795.)

In 1909, the first formal educational programs preparing nurse anesthetists were established. In 1914, Dr. George Crile and his nurse anesthetist, Agatha Hodgins, who became the founder of the American Association of Nurse Anesthetists (AANA), went to France with the American Ambulance group to assist in planning for the establishment of hospitals that would provide for the care of the sick and wounded members of the Allied Forces. While there, Hodgins taught both physicians and nurses from England and France how to administer anesthesia.

Since World War I, nurse anesthetists have been the principal anesthesia providers in combat areas of every war in which the United States has been engaged. During the Panama action, only nurse anesthetists were sent with the fighting forces. Nurse anesthetists have been held as prisoners of war, suffered combat wounds during wartime service, and have lost their lives serving their country. The names of two CRNAs killed in the Vietnam War are engraved on the Vietnam Memorial Wall in Washington, DC. Military nurse anesthetists have been honored and decorated by the United States and foreign governments for outstanding achievements, dedication to duty, and competence in treating the seriously wounded.

Although nurse anesthesia educational programs existed prior to World War I, the war sharply increased the demand for nurse anesthetists and, consequently, the need for more educational programs. Nurse anesthetists were often appointed as directors of anesthesia services in both the public and private sectors. In academic health centers, they were frequently responsible for the education of other nurses, medical interns, and physicians. Among the notable early programs of nurse anesthesia were: Johns Hopkins Hospital in Baltimore, the University Hospital of the University of Michigan in Ann Arbor, Charity Hospital in New Orleans, Barnes Hospital in St. Louis, and Presbyterian Hospital in Chicago. In 1922, Alice Hunt, a nurse anesthetist at Peter Bent Brigham Hospital in Boston, was invited by Dr. Samuel Harvey, professor of surgery, to join the Yale Medical School faculty as an instructor of anesthesia with academic rank. She accepted that position, eventually retiring from that institution in 1948.

Founded in 1931, the AANA is the professional association representing more than 27,000 nurse anesthetists nationwide. The AANA promulgates education, and practice standards and guidelines, and affords consultation to both private and governmental entities regarding nurse anesthetists and their practice. The AANA Foundation supports the profession through award of education and research grants to students, faculty, and practicing CRNAs.

The AANA developed and implemented a certification program in 1945 and instituted mandatory recertification in 1978. It established a mechanism for accreditation of nurse anesthesia educational programs in 1952, which has been recognized by the U.S. Department of Education since 1955. In 1975, the AANA was a leader among professional organizations in the United States by forming autonomous multidisciplinary councils with public representation for performing the profession's certification, accreditation, and public interest functions. Today, the CRNA credential is well recognized as an indicator of quality and competence.

The national office of the American Association of Nurse Anesthetists is located in Park Ridge, Illinois. The Association's federal affairs office is maintained in Washington, DC.

References

Bankert, M. Watchful Care: A History of America's Nurse Anesthetists. New York: Continuum. 1989.
Thatcher VS. History of Anesthesia with Emphasis on the Nurse Specialist. Philadelphia: JB Lippincott Company. 1953.

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Wednesday, June 28, 2000

American Association of Nurse Anesthetists

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August 5-10, 2000

For more info contact:
meetings@aana.com

Also See

- August 3rd
- August 5th
- August 6th
- August 7th
- August 8th
- August 9th
- About Chicago
- Housing

6th World Congress for Nurse Anesthetists

Friday, August 4, 2000

8:00 a.m. - 5:00 p.m.

- **IFNA Council of National Representatives Business Meeting**
  at Hyatt Regency Chicago Hotel
  International Federation of Nurse Anesthetists

Lunch sponsored by: Baxter

8:00 a.m. - 5:00 p.m.

- **AANA Board of Directors Meeting**
  at Chicago Sheraton Hotel and Towers
  AANA Board of Directors

Lunch sponsored by: Baxter

Day by Day Schedule of Events & Speakers

August 5-10, 2000

For more info contact:
meetings@aana.com

Also See

August 3rd
August 4th
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About Chicago
Housing

6th World Congress for Nurse Anesthetists

Scientific Program - Saturday, August 5, 2000

★ Educators' Session

8:00 a.m. – 11:50 a.m. 4 CE credits
Everyone is invited to participate

Nations and professions are moving toward a global community. Ideal learning environments for the 21st century are explored, as is quality assurance as a process for attaining learner outcomes. Continuing education will be discussed, and an open forum is planned.

- **Creating a Learning Environment for the New Millennium**
  Karsten Boden (Switzerland)
  Sponsored by: Abbott Switzerland
- **Quality Assurance as a Process for Educational Outcomes**
  Sandra M. Ouellette (USA)
  Betty J. Horton (USA)
- **A Model of Continuing Education (CE)**
  Sandra L. Lovell (USA)
- **Faculty/Student Exchange Program**
  Karin Björkman Björkelund (Sweden)
- **Moderated Discussion**

★ Managers' Workshop – Managing the Theater (O.R.) Operations: A Global Concern?

8:00 a.m. – 11:50 a.m. 4 CE credits
Everyone is invited to participate

The management of the operating room or theater demands a fine balance between well-educated personnel, attention to the cost of materials and equipment, and delivery of the highest quality care. The dynamics associated with managing the modern anesthesia care environment will be discussed.

Moderator: *Svein Olaussen (Norway)*

- **What Is Changing in the Operating Room/Theater**
  Svein Olaussen (Norway)
- **Large Department Perspective**
  Christine S. Zambricki (USA)
- **Major Private Clinic Perspective**
  Melanie van Limborgh (UK)
- **Smaller Public Hospital Perspective**
  Marie-Pierre Vihn (France)

Sponsored by: French Union of Nurse Anesthetists

★ IFNA Country Representatives/AANAState Presidents' Luncheon

12 noon – 1:00 p.m.

This lunch provides an opportunity for IFNA country representatives and AANA

state association presidents or their delegate to discuss issues of common interest. Attendance is limited to one representative per country/state.

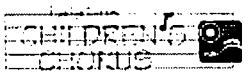
The country representatives' and state presidents' picture will be taken at 1:00 p.m.

Opening Ceremonies

1:30 p.m. – 3:30 p.m.

- Featuring:
  The music of Azusa Pacific University Choir and Orchestra Azusa, California
  – a 100 voice choir and 30 piece orchestra

  Palatine Children's Chorus – Palatine, Illinois
  – 50 voice choir ages 8-13



- **A *Musical Welcome* from the Host Country**
- **Greetings from the City of Chicago and the State of Illinois**
- **Presentation of Colors**
- **Greetings from:** – IFNA President and Executive Director
  - AANA President and Executive Director
  - Distinguished guests
- **Presentation of Awards**
  – Past Congress Planning Committee Chairmen
  – Corporate Partner Longevity Awards
- **The Grand Finale** – *We Are The World* – a musical tribute to the worldwide community of nurse anesthetists

Exhibit Hall Opening

Immediately following Opening Ceremonies

Join us for the opening of the Exhibit Hall and visit with our Corporate Partners to obtain the latest information on their products and services.

Complimentary hors d'oeuvres and soft drinks – cash bar

Exhibitor List

Exhibit Hours
Saturday 3:30 p.m. – 7:00 p.m.
Sunday 9:00 a.m. – 2:00 p.m.
Monday 9:00 a.m. – 2:00 p.m.
Tuesday 9:00 a.m. – 2:00 p.m.

August 5-10. 2000

For more info contact:
meetings@aana.com

Also See

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About Chicago
Housing

6th World Congress for Nurse Anesthetists

Scientific Program - Sunday, August 6, 2000

★ Student Breakfast

7:00 a.m. – 8:00 a.m.

- **Position statements will be presented by nominees for Student Representative to the AANA Education Committee**
- **Voting will follow the presentations**
- **Students must be registered to receive a ballot**

Sponsored by: AANA Insurance Services

★ 'Early-Bird' Symposium #1

Coffee will be served at 6:30 a.m. You must be preregistered to attend. No onsite registration.

Lecture: 7:00 a.m. – 7:50 a.m. 1 CE Credit

The focus of anesthesia in the early years of the coming millennium will differ from that which animated the last half century of the last millennium. That half century saw an enormous decrease in the morbidity and mortality associated with anesthesia. Indeed, death from anesthesia is presently a reportable event often subject to litigation. Today's focus has turned to issues of quality and money. Fast track anesthesia deals with both issues. Are these but card tricks or are they harbingers of improved care in the new millennium?

- **Card Tricks, Fast Track, and the New Millennium**
  Edmond I. Eger II (USA)

Sponsored by: Baxter

★ 'Early-Bird' Symposium #2

Coffee will be served at 6:30 a.m. You must be preregistered to attend. No onsite registration.

Lecture 7:00 a.m. – 7:50 a.m. 1 CE Credit

High-fidelity patient simulators are life-like humanoids with functional cardiovascular and respiratory systems. Simulators respond to the administration of pharmacologic

agents and interventions such as airway management, chest tube insertion, and pericardiocentesis. This session will explore current and future applications of simulation in nurse anesthesia practice, education, and research.

- **High-Fidelity Patient Simulation: A World of Opportunities**
  Alfred E. Lupien (USA)

Sponsored by: METI Medical Education Technologies, Inc.

AANA Annual Business Meeting

8:00 a.m. – 12:00 noon (Limited to AANA members)

Presiding: *Jan Stewart, CRNA, ARNP, AANA President*

Includes:

- **President's Report**
- **Executive Director's Report**
- **Committee and council reports**
- **Resolutions**
- **Bylaws amendments**
- **Other association business**
- **Election results**

Exhibit Hall Hours

9:00 a.m. – 2:00 p.m.

Session A: Research and Development: Will There Be A Next Generation?

8:00 a.m. – 11:50 a.m. 4 CE credits

Progress continues in the development of new technologies, pharmaceuticals, monitors, and methods to manage all aspects of anesthesia care. The extents to which these developments are available and utilized by countries around the world are greatly dependent on a nation's resources and the needs to its population. What the trends are in the world of research and development (R&D), how R&D affects global markets, where the impetus will lie for new developments, and how the needs of developed and lesser developed nations are addressed will be examined in this sessions.

- **Research and Development in the 21st Century: A Global Perspective**
  Steven G. Emery (USA)
- **Monitoring the Patient: Meeting Standards of Care**
  Michael D. Vickers (UK)
- **The Evolution of Data and Information Management for Anesthesia Care**
  Chester A. Phillips, III (USA)
- **Pharmaceuticals: Continuing Innovations into the 21st Century**
  Raul Trillo, MD

Sponsored by: HEWLETT PACKARD Expanding Possibilities

Afternoon Keynote Address

★ Plenary Session #1 – Globalization of Nurse Anesthetists

2:30 p.m. – 3:10 p.m. 1 CE Credit

This session will lay the groundwork for the Congress' scientific sessions. The speaker will present a worldwide perspective on health care as it relates to various economies, trade agreements, international standards, and the movement of nurse anesthetists between countries.

Judith A. Oulton, RN, Chief Executive Officer, International Council of Nurses (ICN) (Switzerland)

Sponsored by: The St Paul

★ Plenary Session #2 – The Worldwide Use of Nurses in the Administration of Anesthesia

2:50 p.m. – 3:40 p.m. 1 CE Credit

Information about the practice, education, and regulation of nurse anesthetists worldwide will be presented. Quantitative as well as qualitative data will be included. This research conducted in collaboration with the World Health Organization (WHO) provides extremely valuable information about the countries where nurse anesthetists practice, as well as findings that will ultimately have an impact on nurse anesthetists around the world.

Maura S. McAullife, CRNA, PhD (USA)
IFNA Nurse Anesthesia Researcher

★ Plenary Session #3 – Trade Agreements: Impact on the Professions

4:10 p.m. – 5:00 p.m. 1 CE Credit

Trade agreements that have an impact on anesthesia practice will be examined. Agreements such as the North American Fair Trade Agreement (NAFTA), European Union (EU), and World Trade Organization/Global Agreement Trade in Services (WTO/GATS) eventually are going to affect nurse anesthetists worldwide. Some of the salient points of trade agreements will be explored, as well as their impact on daily practice.

Marjorie Peace Lenn, RN, PhD (USA)
Executive Director, Center for Quality Assurance in International Education

★ Party With A Purpose

8:00 p.m. – 12 midnight

- **Cash Bar**
- **Rock-and-Roll Music**

Everyone is welcome!! After you have enjoyed dinner on your own, come join your colleagues for a night of dancing.

Chase House, a Chicagoland charity will be selected as the purpose of having this get-together. Following are the items that you can bring to contribute to this worthy cause. Monetary contributions will also be accepted. The items and money will be presented to the charity sometime during the Congress.

- Monetary donations --A box will be available at the door for those who wish to give a donation of cash.
- Toys and games -- For use in pre-school classrooms (age 3 to 5). For gifts, anything a child would enjoy or benefit from.
- Clothing -- For children and adults of all ages.
- Gift certificate -- Next time you are at a chain store, get a gift certificate -- McDonalds, Toys R Us, Sears, Target, K-Mart, to name a few.
- Food -- Anything non-perishable will be appreciated. Chase house distributes over 20,000 pounds of food each month.
- Household goods -- Towels, sheets, kitchen items of all kinds.

August 5-10, 2000

For more info contact:
meetings@aana.com

Also See

August 3rd
August 4th
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August 9th

About Chicago
Housing

6th World Congress for Nurse Anesthetists

Scientific Program - Monday, August 7, 2000

'Early-Bird' Symposium #3

Coffee will be served at 6:30 a.m. You must be preregistered to attend. No onsite registration.

Lecture: 7:00 a.m. – 7:50 a.m. 1 CE Credit

An in depth look at how to identify patients at increased risk for postoperative nausea and vomiting (PONV), factors that cause PONV, and development of effective methods for prophylaxis and treatment of PONV.

- **Strategies to Control Postoperative Nausea and Vomiting (PONV)**
  David H. Gleason (USA)

Sponsored by: Abbott Laboratories

'Early-Bird' Symposium #4

Coffee will be served at 6:30 a.m. You must be preregistered to attend. No onsite registration.

Lecture 7:00 a.m. – 7:50 a.m. 1 CE Credit

This presentation will provide the learner with insights in how to take our present agents into the 21st Century. Special attention will be paid to the use of anesthetics in outpatient and office-based anesthesia. The use of new technology such as Bispectral Index Monitor in regard to cost-effective delivery of our agents will also be discussed.

- **Millennium Magic: Same Great Drugs, Different Century**
  Gloria L. Spires (USA)

Sponsored by: ZENECA

Plenary Session #4: Allergies

8:00 a.m. – 9:40 a.m. 2 CE Credits

Latex allergies will be studied from a global perspective. Their origins, development, and treatment will also be examined. Methods to avoid sensitization and adverse reactions will be discussed, as well as liability and disability concerns.

- **Latex Allergies: Are You at Risk?**
- **Prevention and Management of Anaphylaxis**
  Jacqueline Jurek (France)

Sponsored by: French Union of Nurse Anesthetists

Sponsored by: MALLINCKRODT

Exhibit Hall Hours

9:00 a.m. – 2:00 p.m.

Afternoon

Session A – Current Clinical Topics

1:00 p.m. – 4:50 p.m. 4 CE Credits

Despite differences in practice locations, equipment, and training, healthcare providers share many of the same concerns. Issues ranging from infection control and intraoperative awareness to nontraditional anesthesia and allocation of healthcare resources challenge anesthetists' perseverance and skill on a daily basis. Practical information will be offered to assist providers.

- **Clinical Monitoring for the New Millennium: Utilization of the Bispectral Index**
  J. Robert Haliburton (USA)
  Kenneth C. Plitt (USA)

Sponsored by: ASPECT MEDICAL SYSTEMS

- **Emerging Infections**
  Robert J. Howard USA)
  Sponsored by: Danish Association of Nurse Anesthetists
- **Alternative Anesthesia: Are We There Yet?**
  Clarence C. Biddle (USA)

Session B – Trauma

1:00 p.m. – 4:50 p.m. 4 CE Credits

Many complexities surround caring for the trauma patient. The pathophysiology of shock and the options for fluid resuscitation will be examined, with emphasis on the anesthetic management of patients with injuries such as facial trauma and long-bone and pelvic fractures.

- **Pathophysiology of Trauma and Shock**
  David D. Rose (USA)
- **Fluid Management of Trauma and Shock**
  Sponsored by: Norwegian Association of Nurse Anesthetists
- **Airway Management of Facial Trauma**
  Georges Thao Ky (France)
  Sponsored by: Journées d'Enseignement Post-Universitaire d'anesthésie-réanimation
- **Long-Bone and Pelvic Fractures**

Caroline McAree (France)
Sponsored by: French Union of Nurse Anesthetists

★ Session C – Free Communication (Presented In French)

1:00 p.m. – 4:50 p.m. 4 CE Credits

This forum is designed to enable nurse anesthetists to present issues relevant to clinical practice, management, education, and the profession.

★ Session D – Spinal/Epidural Anesthesia (Didactic)

1:00 p.m. – 4:50 p.m. 4 CE Credits

Spinal and epidural anesthesia are well-established alternatives to general anesthesia. It is essential for those who administer and manage these cases to be knowledgeable in all areas related to this care. A discussion of topics ranging from anatomy to case management will increase understanding of this session.

- **Anatomical Review of Spinal/Epidural Anesthesia**
  Carolyn J. Nicholson (USA)
- **Local Anesthetic Pharmacology and Its Impact on Physiology**
  Pertti Pere (Finland)
  Sponsored by: Finland Association of Nurse Anesthetists
- **Patient Selection for Spinal/Epidural Anesthesia**
  Carolyn J. Nicholson (USA)
- **Technical Considerations**
  Pertti Pere (Finland)
  Sponsored by: Finland Association of Nurse Anesthetists

Sponsored by: Abbott Laboratories

★ Session E: Difficult Airway Workshop (Didactic)

1:00 p.m. – 4:50 p.m. 4 CE Credits

Airway management for the maintenance of gas exchange continues to be a fundamental responsibility of the nurse anesthetist. Recognized experts discuss the use of optic bronchoscopes, laryngoscopes, light wands, and other alternatives in a multidimensional airway management session.

- **Assessment and Preparation of the Airway for an Awake Intubation**
  W. Gray McCall (USA)
- **Utilizing the Fiberoptic Laryngoscope In the Management of the Difficult Airway in the Adult Patient**

Sponsored by: OLYMPUS

- **The Cuffed Oral Pharyngeal Airway (COPA): A New Addition to Airway Management**

Robert S. Greenberg (USA)

Sponsored by: MALLINCKRODT

- **The Evolution of the LMA in the Management of the Difficult Airway**
  Archie I. J. Brain (UK)

Sponsored by: LARYNGEAL MASK

- **Additional Devices in the Management of the Difficult Airway**
  W. Gray McCall (USA)

Sponsored by: MERCURY MEDICAL

★ Golf Tournament

1:30 p.m.

Join us for a fundraiser for the AANA Foundation and IFNA Education and Research Foundation, at a challenging 18-hole golf course. After working up an appetite, enjoy a dinner with your fellow colleagues. $175 includes green fee, cart, prizes and more. All proceeds benefit research, scholarships and development to further nurse anesthetists. To register or obtain more information call +847-692-7050, ext. 3073.

Sponsored by:

August 5-10, 2000

For more info contact:
meetings@aana.com

Also See

August 3rd
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About Chicago
Housing

6th World Congress for Nurse Anesthetists

Scientific Program - Tuesday, August 8, 2000

'Early-Bird' Symposium #5

Coffee will be served at 6:30 a.m. You must be preregistered to attend. No onsite registration.

Lecture: 7:00 a.m. – 7:50 a.m. 1 CE Credit

This symposia is designed to provide a comparison of theinhalation anesthetics of desflurane, isoflurane and sevoflurane.It will detail the cardiovascular, neurologic and respiratory effects of these agents, explain the Toxicities and side effects as well as the pharmacoeconomic issues compared to other anesthetics. The presenters will present an international perspective on the topic

- **The Benefits of Sevoflurane in Adult and Pediatric Patients**
  Thomas J. Ebert (USA)
  Isabelle Murat (France)

Sponsored by: Abbott Laboratories

'Early-Bird' Symposium #6

Coffee will be served at 6:30 a.m. You must be preregistered to attend. No onsite registration.

Lecture: 7:00 a.m. – 7:50 a.m. 1 CE Credit

Mechanical ventilators have become virtually indispensable in modern anesthesia practice. This lecture will present an historical perspective on ventilation, will identify the similarities and differences between volume mode and pressure mode ventilation, and will describe the clinical applications for these ventilation modes

- **Ventilation Modes**
  Michael P. Mitton (USA)

Sponsored by: Datex-Ohmeda

Plenary Session #5: Global Issues in Health Care

8:00 a.m. – 10:10 a.m. 3 CE Credits

The audience will interact with an international panel of experts on a variety of subjects. The challenges, barriers, and opportunities posed by all aspects of the globalization of health care as they affect the nurse anesthetist and patient care will be addressed by the panelists.

Global Issues In Health Care
John Callaway, Moderator
Host, "Chicago Tonight"
Senior Correspondent
WTTW, Channel 11, Chicago

Panelists:
Naeema Al-Gasseer (Switzerland) - Scientist for Nursing in the Cluster of Health Systems and Community Health, World Health Organization (WHO)
Lluis Bohigas (Spain) - Member, Board of Directors, International Society for Quality in Health Care
K. Tina Donahue (USA) - President, Joint Commission International Accreditation (JCIA)
Judith A. Oulton (Switzerland) - Chief Executive Officer, International Council of Nurses (ICN)
Pascal Rod (France) - President, International Federation of Nurse Anesthetists (IFNA)

★ Exhibit Hall Hours

9:00 a.m. – 2:00 p.m.

★ Plenary Session #6: Risk Management

11:00 a.m. – 12:00 p.m. 1 CE Credit

There is great diversity around the world in healthcare risk management. This session will explore malpractice claim costs and the status of healthcare quality and risk management (QRM) from a global perspective. The issues and strategies for implementing an effective QRM program will also be discussed. Viewing the challenges to anesthesia care from a QRM perspective, this session will be of great interest to our worldwide audience.

- **International Healthcare Risk Management**
  Bruce Balck (USA)

Sponsored by: The St Paul

★ Student Luncheon

12:00 p.m. – 1:45 p.m. (Students Only)

- **AANA Student Representative's farewell message**
- **Presentation of Student Writing Contest Winners**
- **Announcement of 2000 AANA Student Representative**

- **Student scholarship recognition**

Sponsored by: Baxter

Afternoon

★ Session A – Obstetrics

1:30 p.m. – 4:30 p.m. 3 CE Credits

The obstetric experience can be both joyous and complex. The potential for coagulopathy and hypertensive syndromes and the airway challenges of obstetric patients will be explored. The session will conclude with a discussion of anesthetic management for the pregnant cardiac patient.

- **Pregnancy-Induced Hypertension (PIH) and Hemolysis, Elevated Liver Enzymes, Low Platelets (HELLP) Syndrome**
  Sanjay Datta (USA)
- **Anesthesia for the Pregnant Cardiac Patient**
  Norman L. Herman (USA)
- **Failed Intubation in the Obstetric Patient: What Do I Do Now?**
  Candice Hazan (France)
  Sponsored by: French Union of Nurse Anesthetists

★ Session B – Thoracic Surgery

1:30 p.m. – 4:30 p.m. 3 CE Credits

Surgical intervention in the management of pulmonary pathology represents a challenge to the anesthesia provider. Thoracic anesthesia management will be discussed, with emphasis on some of the unique risks associated with such cases.

- **One-Lung Ventilation for Open and Laparoscopic Thoracic Procedures**
  Thierry Faucon (France)
  Sponsored by: French Union of Nurse Anesthetists
- **Thoracic Aortic Surgery: Anesthetic Management and Surgical Controversies**
  Christopher J. O'Connor (USA)
- **Current Perspectives on Cardiac Transplantation**
  Christopher J. O'Connor (USA)

★ Session C – Free Communication (Spanish/German)

1:30 p.m. – 4:30 p.m. 3 CE Credits

This forum is designed to enable nurse anesthetists to present issues relevant to clinical practice, management, education, and the profession.

★ Session D – Spinal/Epidural Anesthesia (Hands-on)

Group #1 8:00 a.m. – 12:00 p.m. 4 CE Credits

Group #2 1:30 p.m. – 4:30 p.m. 3 CE Credits

Sponsored by:

Abbott Laboratories

★ Session E – Difficult Airway Workshop (Hands-on)

Group #1 - 8:00 a.m. – 12:00 p.m. 4 CE Credits

Group #2 - 1:30 p.m. – 4:30 p.m. 3 CE Credits

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OLYMPUS

★ Session F – Quality Assurance In Health Care: An International Perspective

1:30 p.m. – 4:30 p.m. 3 CE Credits

A working definition of quality and quality assurance will be presented along with activities and mission of the Joint Commission International Accreditation.

- **Quality Assurance:ISQua Structure and Mission**
  Lluis Bohigas (Spain)
- **Joint Commission International Accreditation (JCIA)**
  K. Tina Donahue (USA)
- **The European Experience: Activities of Fundacio Avedis Donabedian AD/JCIA**
  Lluis Bohigas (Spain)
  K. Tina Donahue (USA)

★ Session G – Educators' Workshop

1:30 p.m. – 4:30 p.m. 3 CE Credits

The classroom and clinical teacher for nurse anesthetists face many challenges. Effective clinical instruction and the development of classroom teachers will be discussed, including the role of evaluation in improving education and identifying different tools for measurement.

- **Transforming Clinicians Into Teachers: Motivating and Mentoring Clinical Instructors**
  Jeanne Capron (France)
- **Effective Classroom Instruction**
  Wynne R. Waugaman (USA)
- **Assessment as a Method of Promoting Educational Excellence**
  Christine S. Zambricki (USA)

Evening Program

Nurse Anesthesia, Volunteerism, and International Health

6:30 p.m. – 8:30 p.m. 2 CE Credits

Nurse anesthesia practice around the world continues to expand its definition, scope of involvement, educational standards, and contributions to world health. As our global reach continues to extend due to rapid communication, technologies and travel, interactions between the countries of the world will also continue. This session will explore the contributions of nurse anesthetists to world health, their impact on global health and anesthesia education, and the need for continued international involvement.

- **Nurse Anesthetists and Their Impact on International Health: A Panel Discussion**

Sponsored by: The St Paul

August 5-10, 2000

For more info contact:
meetings@aana.com

Also See

August 3rd
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August 8th

About Chicago
Housing

6th World Congress for Nurse Anesthetists

Scientific Program - Wednesday, August 9, 2000

'Early-Bird' Symposium #7

Coffee will be served at 6:30 a.m. You must be preregistered to attend. No onsite registration.

Lecture: 7:00 a.m. – 7:50 a.m. 1 CE Credit

Neuromuscular blocking agents vary widely in terms of their mechanism of action, onset, duration, side effects, and metabolism. Ways in which clinical effects and economic benefits of neuromuscular blocking agents can be maximized will be explored.

- **Recent Advances in Neuromuscular Blocking Agents**
  Charles Barton (USA)

Sponsored by: Organon

'Early-Bird' Symposium #8

Coffee will be served at 6:30 a.m. You must be preregistered to attend. No onsite registration.

Lecture: 7:00 a.m. – 7:50 a.m. 1 CE Credit

Patients demand a flawless anesthetic from start to finish and expect to be returned to full function in hours. This lecture will discuss preoperative assessment and perioperative management of nausea and vomiting and patient satisfaction criteria.

- **Patient Satisfaction: Management of Postoperative Nausea and Vomiting**
  Louis M. Guzzi (USA)
  Louis E. Claybon (USA)

Sponsored by: GlaxoWellcome

Session A – Pharmacology (morning)

8:00 a.m. – 11:20 a.m. 3 CE Credits

Advances in pharmacology provide anesthetists with sophisticated options in the management of clinical dilemmas. Pharmacologic approaches to the prevention and treatment of anaphylaxis, preemptive analgesia in pain management, and aspiration prophylaxis will be presented.

- **Anesthesia Occurrences**
  Martin Lysser (Switzerland)

Sponsored by: B|Braun Medical AGSwitzerland

- **Preemptive Analgesia: Does It Work?**
  Nicole Racine (France)
  Sponsored by: French Union of Nurse Anesthetists
- **Aspiration Prophylaxis: Who Needs It and What Should They Get?**
  John J. Nagelhout (USA)

★ Session A – Pediatrics (afternoon)

1:00 p.m. – 4:00 p.m. 3 CE Credits

Care of the pediatric patient is an activity in which nurse anesthetists may be called on to participate, whether in the delivery room, the emergency room, or the operating room/theater. Current information is reviewed to enable practitioners to fully understand the physiologic and pharmacologic dynamics involved in the care of this special population.

- **Airway Emergencies in Infants and Small Children**
  Michael J. Kremer (USA)

Sponsored by: KING SYSTEMS CORPORATION

- **Managing Postoperative Pain in the Pediatric Patient**
  David J. Steward (USA)
- **Minimizing Anxiety in the Preoperative Pediatric Patient**
  Laurie J. Yates (USA)

★ Session B – Pain Management

8:00 a.m. – 4:00 p.m. 6 CE Credits

Management of the patient in pain remains an important concern for all anesthesia care providers. The physiology, pharmacology, techniques, and regimens commonly used in pain management will be examined.

- **Physiology of Pain**
  David H. Gleason (USA)
- **Opioids in the Treatment of Pain**
  Maryse Couaillet (France)
- **Adjunctive Drug Therapies**
  Margaret Faut-Callahan (USA)
- **Regional Analgesia in Pain Management**
  Lou Heindel (USA)
- **Cancer Pain Management**
  Rick Hand (USA)
- **Pain Assessment: Nonpharmacologic Interventions**
  Jürgen Osterbrink (Germany)
  Sponsored by: German Association of Nurse Anesthetists

Sponsored by: Abbott Laboratories

Session C – Free Communication (English)

8:00 a.m. – 4:00 p.m. 6 CE Credits

This forum is designed to enable nurse anesthetists to present issues relevant to clinical practice, management, education, and the profession.

Session D – Spinal/Epidural Anesthesia (Hands-on)

Group #3 - 8:00 a.m. – 11:20 a.m. 3 CE Credits

Group #4 - 1:30 p.m. – 4:30 p.m. 3 CE Credits

Sponsored by: Abbott Laboratories

Session E – Difficult Airway Workshop (Hands-on)

Group #3 - 8:00 a.m. – 11:20 a.m. 3 CE Credits

Group #4 - 1:30 p.m. – 4:30 p.m. 3 CE Credits

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Session F – Coexisting Diseases (morning)

8:00 a.m. – 11:20 a.m. 3 CE Credits

The multi-system disease process will be discussed, and its effect on anesthesia outcomes will be explored.

- **Cardiac Disease and the Patient for Noncardiac Surgery**
  Andre Marie De Wolf (USA)
- **The Patient With Cancer**
  Richard E. Haas (USA)
- **End-Stage Renal Disease**
  Andre Marie De Wolf (USA)

Session F – Hematology (afternoon)

1:00 p.m. – 4:00 p.m. 3 CE Credits

Blood remains the most important resuscitative fluid in cases of severe hemorrhage. However, such issues as coagulation disorders, homologous transfusions, and immunosuppression have a universal effect on anesthetic practice. Current information and guidelines will be explored.

- **Congenital Coagulation Disorders**

Leonard Valentino (USA)

- **Alternatives to Homologous Transfusion**
  Ralph Sautner (Germany)
- **Cell Saver**
  Paul Potter (USA)

★ Gala Banquet

Reception 6:00 p.m. – 7:00 p.m.
Banquet 7:00 p.m. – 10:00 p.m.
Dancing 10:00 p.m. – 1:00 a.m.

Semiformal/Formal Event

Highlights of the evening include:

- **Reception (Cash Bar) 6:00 p.m. – 7:00 p.m.**
- **Banquet Seating 6:30 p.m. – 7:00 p.m.**
- **Gourmet Dinner**
- **Musical Salute to the Countries**
- **Recognition of IFNA and AANA award recipients**
- ***World Congress Scrapbook***
- **Closing Ceremonies**

Sponsored by:

AANA Insurance Services

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United Anesthesia Associates, Inc.

TIG Insurance

Looking forward to Helsinki 2002

Come join us for the musical salute to the Countries and our final goodbye as we transfer the IFNA flag over to Helsinki 2002.

Sponsored by: Datex-Ohmeda

URGENT!

FAX COVER SHEET

American Association of Nurse Anesthetists
Federal Government Affairs Office
The Capitol Hill Office Building
412 First Street, S.E., Suite 12
Washington, DC 20003
Phone: (202) 484-8400
Fax: (202) 484-8408

DATE: 7/5/00 **PAGES** (including cover sheet): 3

TO: LISA STRUMWASSER
WH SPEECHWRITER 202-456-2516

FROM: FRANK PURCELL

MESSAGE:

AS REQUESTED . . .

If there are any problems with the transmission of this fax please call (202) 484-8400.

INTREPID MUSEUM FOUNDATION

INTREPID SQUARE, WEST 46TH STREET AND 12TH AVENUE • NEW YORK, N.Y. 10036 • (212) 957-7020 • FAX (212) 957-1989

Kathleen → 69370

FACSIMILE TRANSMITTAL SHEET

2 pages

DATE: JULY 5, 2000

NAME: Attn: Speechwriting

FACSIMILE: 202-456-2505

FROM: KRISTEN KELLY, VICE PRESIDENT / Charlie Gery

As discussed:

Re: Intrepid Gala this evening — Black tie dinner

Suggested speaking points for the President.

Contact #s:

Kristen Kelly 646-879-6867

Charlie Gery 202-757-8637

If this transmission is incomplete, please call 212-957-7029.

Suggested Speaking points for POTUS

- Honored to be here, but saddened that Zachary Fisher isn't with us
  - Zachary was a great patriot and a warm and generous man, Enjoyed seeing Zach, just last September when I presented him with the Presidential Medal of Freedom. Zachary was more excited to see all his friends than to receive an award, a true indication of the type of man he was. His unselfish acts of kindness showed through all his work: he built 29 Fisher Houses in 10 years to serve military families, assisted approximately 900 students of either retired or active military personnel with college scholarships and restored this great ship, all for the love of his country.

  - First time I visited the Intrepid Museum was in 1996 to receive the Intrepid Freedom Award. It was a truly great time. It was the 10th anniversary of Fleet week,and New York was in full swing to welcome the Military. Today the event has a new name – Military Salute Week because Zachary and Elizabeth were interested in supporting all 5 branches of the military. What better name to call an event that honors our heroes and celebrates serving in uniform than Military Salute Week.

  - Tonight is about continuing the legacy, continuing the vision Zach had of supporting the men and women of the military, thanking the hundreds of thousands of military personnel that are currently serving in defense of our future. We honor them, thank them and continue to pay tribute to them every day.

- recognize:

→ Tony Fisher, Chairman, IMF

→ The Board of the Intrepid Museum Foundation

→ LtGen Martin R. Steele, USMC (Ret.), Pres & CEO, IMF

→ Bill White, COO, IMF

ROUTING SLIP

DATE
FROM: Stephanie Street
Assistant to the President and Director of Presidential Scheduling

File: Accept

Comments:

SUBJECT: Video greeting for 6th World Congress for Nurse Anesthetists

Kris Balderston	—	Joe Lockhart	—
Lisa Berg	—	Sean Maloney	—
Samuel Berger	—	Capricia Marshall	—
Sidney Blumenthal	—	Thurgood Marshall Jr.	—
Chuck Brain	—	Minyon Moore	—
Charles Burson	—	Bob Nash	—
Mary Beth Cahill	✓	Beth Nolan	—
Maria Echaveste	—	John Podesta	—
Terry Edmonds	✓	Steve Ricchetti	—
George Frampton	—	Bruce Reed	—
Sarah Gegenheimer	✓	Dan Rosenthal	—
Laura Graham	✓	Rozensky/Emrich	✓
Nancy Hernreich	—	Patti Solis-Doyle	—
Mickey Ibarra	—	Gene Sperling	—
Ben Johnson	—	Carrie Street	✓
Joel Johnson	—	Karen Tramontano	—
Neal Lane	—	Loretta Ucelli	✓
Ann Lewis	—	Melanne Verveer	—
Mark Lindsay	—	Heather Riley	✓
Bruce Lindsey	—	Barbara Woolley	✓

00 JUN27 P8:34

VIDEO PROPOSAL Date: April 20, 2000

___ ACCEPT ___REGRET ___PENDING

TO: Stephanie Streett
Assistant to the President
Director of Presidential Scheduling

FROM: Mary Beth Cahill MBC
Assistant to the President
Director of Public Liaison

REQUEST: For the President to tape a greeting for the combined annual meeting of the American Association of Nurses Anesthetists and the International Federation of Nurse Anesthetists' as they form the 6th World Congress for Nurse Anesthetists from August 5-12, 2000 in Chicago, Illinois.

PURPOSE: The video will be used to highlight that the President's mother was a nurse anesthetist, they are key players in our efforts to pass the Patients Bill of Rights legislation, and have been totally supportive in expanding the role of nurses including the Nurse Anesthetists in today's society.

BACKGROUND: The American Association of Nurse anesthetists is a professional organization for approximately 95% of the nation's CRNAs, which is about 28,000 members. The AANA is the largest nurses' organizations behind the American Nurses Association. Advance practice nurses, CRNAs administer more that 65% of the 26 million anesthetics delivered in the United States each year.

The International Federation of Nurse Anesthetists charters 31 organizations, which represents 17,000 nurse anesthetists in over 120 different countries. The IFNA's primary objective is to enhance the professional development and achievements of nurse anesthetists through educational objectives that result in quality health care in communities around the world.

SOURCE OF PAYMENT: Please contact Marlene McDowell at (847) 692-7050

VIDEO NEEDED: Wednesday, July 12, 2000

DATE AIRING/ SHOWING: Saturday, August 5, 2000

DURATION:	1-3 minutes
REMARKS ATTACHED:	Provided by International Federation of Nurse Anesthetists and American Association of Nurse Anesthetists.
STAFF CONTACT:	Barbara Woolley, x62155
ORIGIN OF PROPOSAL:	Letter Attached.

...meet the world's
nurse anesthetists
august 5-10
2000

To: The White House
Office of Scheduling and Advance

From: Marlene McDowell
American Association of Nurse Anesthetists

Subject: Request for Video Greeting from President Clinton

April 11, 2000

This letter is a request for an official video greeting from President Clinton to the American Association of Nurse Anesthetists (AANA) and the International Federation of Nurse Anesthetists (IFNA).

This year, the AANA is combining its Annual Meeting with the IFNA to create the *"6th World Congress for Nurse Anesthetists."* This is the first meeting of its kind held on U.S. soil. The World Congress is expected to attract four to five thousand nurse anesthetists from France, Germany, Spain, the United States, and other countries to discuss ways to improve and maintain quality health care on a global level. This video will be used during the opening ceremonies of the weeklong gathering to officially welcome the foreign visitors to America and greet other meeting attendees.

The chosen profession of President Clinton's mother, nurse anesthetists have provided safe anesthesia care for more than 100 years. As advanced practice nurses, nurse anesthetists administer more than 65% of the 26 million anesthetics delivered in the United States each year. Additionally, nurse anesthetists practice in every setting where anesthesia is available and are the sole anesthesia providers in more than two-thirds of all rural hospitals. The AANA is the professional organization for approximately 95% of the nation's nurse anesthetists.

This meeting will be held August 5 –12, 2000 in Chicago, Ill., and we would be honored to include a video greeting from President Clinton during our opening ceremony. The specific date of the opening ceremony is Saturday, August 5, 2000.

Attached please find more information on the meeting to assist with crafting a video script. Thank you in advance for your time and attention to this matter.

If any additional information is needed, please contact me at (847) 692-7050 X-3045. Please send the video to: 222 South Prospect Avenue, Park Ridge, IL 60068-4001.

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International Federation of Nurse Anesthetists
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Background Information

International Federation of Nurse Anesthetists

The International Federation of Nurse Anesthetists (IFNA) was founded in St. Gallen, Switzerland, in 1989. Membership in the IFNA is offered to national nurse anesthesia organizations only, no individual memberships are allowed. Since 1989, IFNA has grown from 11 charter organizations to 31, which represents thousands of nurse anesthetists in over 120 different countries. The IFNAs primary objective is to enhance the professional development and achievements of nurse anesthetists through educational objectives that result in quality health care in communities around the world.

Although IFNA is a Swiss organization, its headquarters was moved to Chicago, Ill. in 1995.

American Association of Nurse Anesthetists

About the AANA

Founded in 1931 and located in Park Ridge, Ill., the AANA is the professional organization for approximately 95% of the nation's CRNAs. Advanced practice nurses, CRNAs administer more than 65% of the 26 million anesthetics delivered in the United States each year. CRNAs practice in every setting where anesthesia is available and are the sole anesthesia providers in more than two-thirds of all rural hospitals.

CHIEF OF STAFF TO THE PRESIDENT

American Association of Nurse Anesthetists
222 South Prospect Avenue, Park Ridge, IL 60068-4001 ■ Phone (847) 692-7050 ■ FAX: (847) 692-6968 ■ http://www.aana.com

Devorah R. Adler
07/09/2000 07:55:33 PM

Record Type: Record

To: Joshua S. Gottheimer/WHO/EOP@EOP

cc:
Subject: DRAFT--Nurses Video. Comments pls to Gottheimer ASAP 62554.

here you go -- minor, minor edits in bold.
---------- Forwarded by Devorah R. Adler/OPD/EOP on 07/09/2000 07:53 PM ----------

Joshua S. Gottheimer
07/09/2000 06:33:07 PM

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To: See the distribution list at the bottom of this message

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Subject: DRAFT--Nurses Video. Comments pls to Gottheimer ASAP 62554.

Draft 07/05/00 6:30pm
Gottheimer

PRESIDENT WILLIAM J. CLINTON
VIDEOTAPED REMARKS FOR AANA AND IFNA
CHICAGO, IL
July 12, 2000

I am delighted to welcome the American Association of Nurse Anesthetists and the International Federation of Nurse Anesthetists to your sixth World Congress for Nurse Anesthetists. For nearly 70 years now, the AANA has been on the frontlines of American health care, leading the fight for nurses and for better patient care. And the IFNA has brought that same level of commitment to nurse anesthetists in more than 120 different nations around the world, working for higher standards, better education, and tougher guidelines.

In clinics and in waiting rooms, in ER's and in OR's, nurses make millions of lives better each and every day. Few people work harder, sacrifice more, and care more. That's something I know first-hand, because for more than thirty years, my mother worked as a nurse anesthetist. I learned then that there is no substitute for a nurse's care – for your kind words, your unique skills and expertise. As my mother once said, "Nurse anesthetist work is all-consuming. You don't do it halfway. You're the person responsible for ... another human

being."

Our health care system is changing rapidly, and no one knows that better than nurses. No one knows better than a nurse the consequences of being without quality health care. That' s why, with your help, Vice President Gore and I have worked so hard over the last seven years to give Americans the health care they need and deserve. We enacted the single largest investment in health care for children since 1965 ... ensured that **individuals** will not lose their **health insurance**coverage when they change jobs ... and greatly increased the resources to combat HIV and treat AIDS. We've also fought to ensure parity for the treatment of mental illness.

Together we've made great progress - but there's still more for us to do. We need a strong and enforceable Patients Bill of Rights - including the right to see a specialist ... the right to go to the nearest emergency room **without fear of financial penalty** ... and the right to hold your health care plan accountable. We also need to strengthen Medicare and modernize it, with a voluntary, affordable prescription drug benefit. And we need to hold tobacco companies -- not tax payers -- accountable for the health costs of tobacco.

The unparalleled care that you give your patients makes America's health care system the best in the world. I know we can count on you to ensure our system grows even stronger in the 21st century. Thank you and enjoy your time in Chicago.

Message Sent To:

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Final 07/10/00 10am
Gottheimer

PRESIDENT WILLIAM J. CLINTON
VIDEOTAPED REMARKS FOR AANA AND IFNA
CHICAGO, IL
July 12, 2000

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Remarks on the Observance of National **Nurses** Week and an Exchange With Reporters

May 5, 1993

The President. Thank you very much, Ginny, for that wonderful statement and the introduction. And thank you, Secretary Shalala, for everything you said. I noticed a few groans in the audience when you pointed out that Dorothea Dix worked for nothing. I don't think she was suggesting that you do that, I think she was volunteering to do that, don't you think? [Laughter]

I want to say, you know, I knew **nurses** were miracle workers, having been raised by one. But I don't see how you staved off the rain today. When I first heard 100 **nurses** were going to be here I thought to myself, what else can I do? I've given up junk food. I run every day. What more do you want of me? [Laughter] I'm doing my part.

I want to say a special word of acknowledgement, too, to the **nurses** who are in this audience who work here at the White House, who care for me and my family and are available to the other people who work here. They do a wonderful job, and I'm very grateful to them. And they're here and there and around, and I thank them for their presence here.

I'd also like to pay a special word of tribute to your president, Ginny Trotter Betts, for hanging it out there with us in the election and bringing the support for the American **Nurses** Association and also for being such a forceful advocate of sweeping reforms in our health care system. Hillary and I very much appreciate the work that she and the **Nurses** Association have done. And I know that she's also an old friend of Al and Tipper Gore's, and they're grateful, too, for her contributions.

I'd also like to recognize some of the other people who are here today, including a remarkable nurse whose presence in the Congress is a symbol of your political strength, Congresswoman Eddie Bernice Johnson from Dallas and my dear friend. She's really a tribute to the practice of good health. I've known her for 20 years, and I look much older, and she looks younger than she did the first time we met.

I also want to thank all the **nurses** who have advised our Health Care Reform Task Force and brought such a valuable perspective to that effort. You've really made a difference, and we're grateful to you.

We're here today to mark the beginning of National **Nurses** Week, a time for our country to recognize the services that you and your colleagues provide 24 hours a day, 7 days a week, 365 days a year. From inner city hospitals to rural clinics, from the Red Cross to the armed services, America's **nurses** always answer the call.

Today we're reminded that our Nation's 1.8 million working **nurses** are the backbone of a health care system, the largest single group of health care providers in America, and I might add, a group that will have to do more and should do more in primary and preventive care if we're going to bring the cost of medical care down.

You know better than anyone else what is wrong with this system. You see all the people who show up at the emergency room to get the most expensive care too late because they didn't have a basic primary and preventive health care package. You see the enormous burden of paperwork squandering more and more hours of **nurses** and doctors, requiring more and more precious health care dollars to be diverted to clerical expenses instead of to investing in the health of our people. Every day you see these kinds of problems as the Nation continues to wait for action on a health care front. I'm here today on this beginning of your week to reaffirm to you my commitment that now is the time to do something about health care and to do it right.

One of the most challenging things we have to do in this city at this time is to break a mind-set that we have one problem at a time, and we'll get on it, and we'll only think about that. I believe that this country has at least three huge problems that relate one to the other. One is, there are too many people who are unemployed and too many people who are working harder with no gains in their incomes. And it's been that way for a long, long time. Two is, the cost of health care is exploding at an unacceptable rate, and yet, too few people have coverage, or their coverage is too limited. [p.568] Third is, we're absolutely being consumed by a massive national debt and a growing deficit. And these things are all related one to the other.

Now, people say to me, "Well, we just do one thing at a time." Well, look back over time where that's gotten us. People just say, "Well, we ought to just spend money and give it to people, and maybe that will work." That hasn't worked. Then for 12 years we heard the worst thing in the world is taxes; we'll just cut taxes, especially on wealthy people, and that will make everything wonderful. Well, that hasn't worked out very well either. So the guy said to me yesterday, "I know a bunch of people who got tax cuts last year, because they used to be making $40,000 a year, and now they're making $10,000. They all got a tax cut."

And what I say to you is that we don't want to just keep trying to give people things in a system that is broken. You can't give people Government money. You can't give people tax cuts if the system is broken. What we have to do is to attack all these problems at once and not keep giving people things but give them the means to take care of themselves and to create lives that are productive and good and strong for themselves and their families, their children. That's what we have to do.

That's why, yes, we have to reduce spending and increase taxes, mostly on wealthy people who got their taxes cut in the 1980's, to bring the deficit down. But we also have to invest carefully in programs that will create jobs and raise incomes, new technologies for the 21st century, and the kind of education and training that will give people work. If everybody in this country who wanted a good job had one, we wouldn't have half the problems we've got.

And then the third thing we have to do is to attack the health care crisis, because if we don't we will never get the Government deficit under control. We will never balance this budget, and more importantly, we will never provide the security that most families need and deserve in a rapidly changing and increasingly insecure world.

There are millions of Americans today who cannot change jobs, because somebody in their family has been sick. There are millions of others who have no health insurance. There are millions of others who have some health insurance but very little, because they work for small businesses who cannot afford a basic package of health care because of the insurance system that we have in this country. There are untold billions of dollars being spent that should not be spent by the people who pay the full price and more for health care because they have to pay for somebody else's health care who's not covered when it's too late and too expensive or because they're paying an unbelievable bureaucratic burden for the paperwork burdens of this system.

So I say to you, these are false choices. People cannot say to us you must choose between having a healthy country, an employed country, a country bringing its deficit down. We must do all three of those things because that's the only way we can—instead of trying to give people something that's not there to give, empower people to seize control of their destiny and bring this country back. That's what we've got to do.

There will always be defenders of the status quo. It is easy to say, "Well, let's just write somebody a check." Even easier to say, "Taxes are evil. They're out to get you."

Right now, you know as well as I do, the lobbyists are lining up strategizing about how they're going to pick this health care proposal to death. But I'll tell you something, the worst thing we could do, in my opinion, after 400-and-something people have worked their hearts out for months and months and months, is to take a dive on the health care thing, to turn away from it, to deal with the inconveniences of it.

People say, " Well, it may cost somebody else some money." Let me tell you something, all those people who don't have health insurance today, they're being paid for by everybody else who's paying the bill. What about fairness to them? Who's thinking about them? I'll tell you something else, we've been reducing defense spending quite steeply and about all we can for the last 5 years. And all the savings we hope to have in the peace dividend have been exploded away by rising health care costs and interest payments on this deficit.

So it is all related. You've got to have a job strategy. You've got to have a deficit reduction strategy. And you're got to have a health care strategy. Because if you don't have a health care strategy, the American people can't stay well, the American economy can't get well, and you cannot reduce the deficit to zero in this decade. Those things must be done together. We cannot be forced to make that false choice.

And so I ask you—you represent 1.8 million [p.569] people who know the heartache, the heartbreak, and the problems of this system, and who also know that that which is fight about our system makes it the best in the world for those who can access it. We are determined to come forward to the Congress with a plan that keeps the best of America's health care system, keeps the private provider system, keeps a lot of choice in the system, but deals with the awful problems that you know better than anybody. And I ask you to commit today not to let the special interests tell us that we can't deal with health care, not to let the special interests spook and scare the Members of Congress away from doing what is our manifest duty to the people of this country who are working hard and playing by the rules and falling further behind, and instead, to give us all a chance to do the work of a generation.

And that is really what's being given us in this time, in this Congress: the opportunity to do something that comes along once in a generation to change the whole course of America's future. By dealing with these things together, providing security and quality and control of cost in this health care system, bringing this deficit down and pursuing a long-term strategy for a high-wage, high-growth, low-unemployment economy. And they're all together. If you'll help me take that message to the Congress, this will be one of the best years the American people ever had.

Thank you very much.

Bosnia

Q. Have you heard anything from Bosnia, sir?

The President. No.

Q. How quickly are you prepared to move once you do?

The President. Well, let's wait and see what they do first.

Q. Mr. President, there is word that the parliament has agreed to the peace agreement. Mr. President, there is.-

The President. I hope they—I'm waiting for a call from Secretary Christopher right now. Let me go take the call, and I'll give you—

Q. And then what, sir?

Child Immunization

Q. Sir, what happened to your immunization program on the Hill? Why did you have to dog back on that?

The President. Well, Secretary Shalala says we're going to get a program that can immunize a lot more people. We did the best we could with the money we had. You know, a lot of these things are going to be a function of how much money we have. But I feel pretty good about it. I talked to her about it. She feels good about it. We think it's a big advance over where we are.

Thank you.

NOTE: The President spoke at 4:27 p.m. in the Rose Garden at the White House. A portion of the remarks could not be verified because the tape was incomplete.

Source: Federal Register Division. National Archives and Records Service, Public Papers of the Presidents of the United States, William J. Clinton, 1993 (Washington, D.C.: Government Printing Office, 1956-), pp.567-569

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Remarks Upon Signing the **Nurse** Training Act of 1964.

September 4, 1964

Members of the Congress. ladies and gentlemen :

The best of health for all Americans is a primary national goal for all of us. Today we are moving a long step nearer that objective. The **Nurse** Training Act of 1964 is the most significant nursing legislation in the history of our country. I believe that it will enable us to attract many more of our most qualified young people to this great and noble calling.

Nurses today are essential members of our Nation's health team. The health needs of a growing population cannot be met without their help. Blessed with the gifts of healing and with a wise and understanding heart, **nurses** perform a vital role in maintaining and strengthening America's health services and our national well-being. Yet we are critically short of the **nurses** that we need.

Far too many people today suffer needlessly, or go without the attention they require, simply because we do not have enough well-trained **nurses**. About 20 percent of positions for professional **nurses** in hospitals are today unfilled. The shortage of **nurses** has forced some hospitals to close wards and entire sections. Others have been obliged to fill vacancies with people who are poorly, or at least incompletely, trained.

By the year 1970 we will need 850,000 **nurses**. That is a startling figure, but that is 300,000 more than we have today. At their present strength, our nursing schools can graduate only 30,000 a year. Clearly [p.1037] the capacity to train additional thousands of **nurses** must be increased, if we are to improve or even maintain America's national health standards.

The **Nurse** Training Act of 1964, which we have met this morning to finally sign and complete, represents the response of an enlightened Congress to the urgent need. The act contains four principal elements. It authorizes a program of grants to build and renovate nursing schools; it establishes a program to help schools of nursing strengthen and improve their training programs and to help diploma schools of nursing meet the costs which will come with increased enrollment; it expands the existing program of advanced training of professional **nurses**; it establishes a loan program which will enable many talented but needy students to undertake the professional training for a nursing career.

All of this has very special meaning for the young women of our Nation; by removing some of the financial barriers to training it will enable many more deserving and talented young women to enter the proud profession of nursing.

A century has passed since Florence Nightingale and Clara Barton brought the art of nursing on to the world's stage. We owe a great debt of gratitude to these courageous and dedicated women, and to the many other women who have served humanity throughout our long history. Today's **nurse** must be both humanitarian and scientist. Her great compassion must be matched by much greater competence.

So the **Nurse** Training Act of 1964 is recognition of the new needs of the profession, as well as the growing needs of all of our people. We feel a very special debt to those whose legislative effort and dedication and energy and hard work made this legislation possible.

I particularly appreciate the efforts of Congressman Oren Harris, who is the author of much good legislation; and my dear friend Senator Lister Hill, who is unable to be with us this morning; Congressman Kenneth Roberts, who chaired the subcommittee which held the detailed hearings; and the other Members of the House and Senate committees that pioneered this legislation and are responsible for bringing it safely through both bodies.

You see them on the platform this morning. I am sorry that they are not outdoors people and they all like to get up in the shade, but they are here to receive what is properly theirs, a tribute for their pioneering effort in this field where we need this legislation so much.

This is truly a notable achievement toward raising the standards of health care in the United States. I predict that down through the years to come that every person here this morning will be proud that they were permitted to be a participant in this historic legislation that will do so much to keep our Nation healthy and that will permit our suffering to at least be endurable as a result of a compassionate and concerned **nurse**.

Thank you very much.

NOTE: The President spoke in midmorning in the Rose Garden at the White House. During his remarks he referred to Representative Oren Harris of Arkansas, and to Senator Lister Hill and Representative Kenneth A. Roberts of Alabama.

The **Nurse** Training Act of 1964 is Public Law 88-581 (78 Slat. 908).

Source: Federal Register Division. National Archives and Records Service, Public Papers of the Presidents of the United States, Lyndon B. Johnson, 1963-1964 (Washington, D.C.: Government Printing Office, 1956-), pp.1036-1037

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THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release June 22, 2000

REMARKS BY THE PRESIDENT
UPON DEPARTURE

The South Portico

10:00 A.M. EDT

THE PRESIDENT: Good morning. Before I leave, I would like to make a couple of comments about two questions now before Congress; first, whether to provide a voluntary prescription drug benefit to Medicare beneficiaries; and second, whether to hold tobacco companies, not taxpayers, accountable for the costs of tobacco.

Both issues require a bipartisan response. Both are important to the health of our people. Both require Congress -- for the public interest, not the special interest.

That's especially true when it comes to our seniors and their need for affordable, dependable prescription drug coverage. I have proposed that all our seniors have that option through Medicare, wherever they live, however sick they may be.

Now, Republicans in Congress say they, too, want a prescription drug benefit. They've even had pollsters, according to your reports, to teach them all kinds of new words to convince the American people they are in favor of it. But the latest plan doesn't measure up to the rhetoric.

Last night, in a completely party line vote, the House Ways and Means Committee approved a private insurance benefit that many seniors and many people with disabilities simply will not be able to afford. It's a benefit for the companies who make the drugs, not the seniors who need them most. Moreover, their bill would do nothing for the hospitals, home health care agencies and other providers who clearly need extra help to provide quality care under the Medicare program.

I hope when the full House considers this issue, it will reject this false promise and vote instead for a proposal that provides a real and meaningful Medicare prescription drug benefit on a voluntary basis, but one that is affordable and available to all seniors who need it.

If the House acts to protect the public health, it would be following the fine example it set earlier this week when it permitted the Department of Veterans' Affairs to help to fund the Justice Department's litigation against the tobacco companies. This modest investment of VA funds can help our veterans and other taxpayers recover billions of dollars in health care costs, a substantial sum that will improve health care for veterans and for all Americans.

This shows what we can accomplish when we put the public interest ahead of special interests, the public interest ahead of partisan disputes. But it's only a first step. Today, the House can move further ahead if it votes to allow the Justice Department to receive these and other funds.

Tuesday's victory for veterans and taxpayers will prove to be hollow if, today, the House reverses itself. The tobacco companies and

their powerful allies in Congress are working overtime to pass special protections to shield them from financial responsibility for the harm they've caused.

So, again, I ask Congress: Just let the American people have their day in court. The legal responsibility of the tobacco companies should be decided by judicial process, not by the political process. The health of our people is a precious resource.

Those of us in public life should be doing everything we can to work together, whether we're working to provide affordable prescription drug coverage, or to demand accountability for the health care costs of tobacco. In the days and months ahead, I will continue to work with members of both parties to achieve these goals. Thank you very much.

Q Sir, on gasoline prices, the Vice President was very direct and forthright yesterday, sir, in his accusations that there is collusion among the oil companies to inflate prices. Do you share those sentiments, and what are your thoughts on this becoming a preeminent issue in the presidential campaign?

THE PRESIDENT: Well, first of all, let's look at the problem here. This is a big problem, because there are a lot of Americans that have to drive to make a living. They have to drive distances just to make a living.

Then, you've got all these truckers out there that have to pay big fuel costs to make a living. And something that there hasn't been a lot of talk about, but if this thing can't be moderated, it's also going to have, I think, quite a burdensome impact on the airline companies, on the cost of air travel. So this is going to rifle throughout our economy.

I have said repeatedly, and I will say again: I think that it is in the best interest of the people of the United States, but also the oil-producing companies, to have oil prices somewhere in the neighborhood of $20 to $25 a barrel. That gives them the revenues they need, it keeps the incentives in our economy to continue to become more energy-efficient, and it doesn't bankrupt people that have to have fuel in substantial quantities. So this is a big problem.

Now, I have a lot of concerns about the speed with which this run-up occurred. I expected some upward pressure on prices because our economy is doing well and because the Asian economy is coming back, the European economy is coming back, so there would be a bigger global demand for oil and there would be some upward pressure.

But it doesn't explain, by a long stretch, the dramatic increase in prices. Neither does the requirement for special additives to reduce air pollution even come close to explaining the increase in the Chicago-Milwaukee area. We're talking about two or three cents a gallon for the environmental requirements, and that won't come close to explaining prices that are 50 cents a gallon higher than they are in other places.

So the proper thing to do, I think, is to have a vigorous inquiry by the Federal Trade Commission; they're going to do this. If you've noticed, there's some indication that the best evidence to support the statement the Vice President made is that two days after the call went out for the Federal Trade Commission to investigate this, there was a 16-cent-a-gallon drop in the price of the oil at the refinery level. Now, that hasn't manifested itself at the pump yet, because it takes time for this oil to be refined and to be distributed and to be sold as fuel. But I'm very concerned about it.

PRESIDENT WILLIAM J. CLINTON

AMERICAN NURSES ASSOCIATION

WASHINGTON, DC

JUNE 18, 1996

[Acknowledgments: Ginna Trotter Betts -- she is leaving after four years as national president of ANA. She was a leading voice for health care reform.]

I am honored to join you in this 100th anniversary celebration. Today, I ask all Americans to join me in saluting you for a century of service and leadership. America has the finest health care system in the world. And nurses are the heart and soul of that system.

I know the hard work and sacrifice that goes into being a good nurse. As most of you know, for more than 30 years, my mother worked as a nurse anesthetist.

I want to thank you again for honoring her memory in 1994 with a special award in her name. I have vivid memories of her getting up in the middle of the night to be at work by 7 a.m. She was serious about the life and death nature of her work. But she understood that healing is about more than medicine and technology. It is also about promoting good health and prevention. And it is about caring. That is what all of you do everyday.

What I learned from my mother and what America is learning from you are the basic values that make us strong.

We know that the mission of this country must be to offer every American an opportunity and demand that every American take responsibility -- that is the basic bargain of our democracy. And that is how we will create an America that is rooted in strong communities and strong families.

Today, I want to talk with you about how we can work together to build strong families and to guarantee that every child in this country has both quality health care and the support of responsible parents -- both mothers and fathers.

For the past three-and-a-half years, we have worked hard to give people opportunity, by giving them the tools they need to build strong families.

Working with you, we fought for the Family and Medical Leave Act to say that if you take a little time off to take care of a sick child you will not lose your job. I signed the Family Leave Law and we did it over the filibuster led by Senator Dole.

Now, this Republican Congress seems to have forgotten the first rule of health care: "First, do no harm."

I am proud that, working with you, we fought to preserve Medicaid. For three decades, we have guaranteed that poor children, pregnant women, people with disabilities and older Americans will not be denied health care simply because they can't afford it. That is the right thing to do. The Republicans in Congress are actually insisting that we repeal this guarantee. I have said that this would amount to child neglect for a whole generation. That is why I vetoed this plan last year when the Republican Congress sent it to me. And let me assure you, if they send it to me again, I will veto it again.

Working with you, we have fought to balance the budget in a way that protects Medicare and honors our duty to our parents. The Republican proposal for Medicare would undermine the hiring and training of nurses, and would close down hospital wings in cities and rural communities across America. We must reform Medicare; my plan will secure the Trust Fund for a decade. But we do not need to devastate Medicare to balance the budget.

And while we are doing no harm, why don't we do some good? We are working with you to improve access to health care for as many as 25 million Americans by fighting for the Kassebaum-Kennedy bill.

No worker in this country should have to worry that he or she will lose their health care if they lose their job or change jobs. And no one should be denied care simply because they have a pre-existing condition. I challenge Congress to send me this legislation now.

We are doing all this to give our people opportunity. But we must demand responsibility in return. You and I know that, where children are concerned, the most important building block of strong families is not government. It is parents -- mothers and fathers who love their children and take active responsibility for their care.

Parental responsibility has been the driving principle behind our efforts to end welfare as we know it. I want reform because our present system perpetuates a cycle of dependency and irresponsible behavior. Nobody wants welfare reform more than the people who are trapped in the current system. I want a system that promotes work, strengthens families, and encourages independence. That is why I have proposed time limits, work requirements, and child care and health care to help people move from welfare to work. That is real welfare reform.

This Congress sent me a bill that was tough on kids and easy on work, and I sent it back and told them to do better.

My Administration will continue to reform welfare, with or without help from Congress.

We have worked to cut red tape for 40 states by approving 63 welfare reform experiments at the local level. Just today, we approved a waiver for a welfare reform effort in New Hampshire, which combines strong work requirements with incentives to move people from welfare to work. For 3 out of 4 welfare recipients, the rules have changed.

I am proud that today, 1.3 million fewer people are on welfare than when I took office.

The food stamp rolls are down, the poverty rate is down, teen pregnancy rates are down, while work and training among welfare recipients are up and child support collections have reached a record high.

But we must do more to insist on parental responsibility. Our welfare reform proposals are about giving people opportunity and demanding responsibility in return. And I reject the idea that only the mother has to act responsibly. Every child has both a mother and a father. And for too long, we have let men off the hook. We must insist that they do their part to support the children they helped bring into this world.

How many times have you seen a frightened young girl give birth to a baby alone in the hospital, with the father of the child no where to be found? How many times has the hospital and the government been left to pay the costs, not only for the delivery but for the continuing care of that child? That is wrong. It takes two people to bring a child into this world, and it takes two people to raise that child.

That is why we have made it our mission to make sure that parents take responsibility by supporting their children. Last year, I signed an executive order that cracked down on federal employees who owe child support.

And 3 years ago I signed a law requiring states to establish hospital-based programs to determine the father of a newborn child. Based on our first reports, more than 200,000 fathers have been identified through these voluntary hospital paternity identification programs last year. That's 200,000 children whose fathers can't just up and walk away without a trace. And child support collections and paternity establishment are both up 40% since 1992.

But we have to do more. That is why earlier today, I took executive action to strengthen child support enforcement and promote parental responsibility.

First, we are putting in place a new national program to help states track parents who owe child support across state lines. Today, too many men have figured out that the way to weasel out of paying child support is to move from job to job and state to state. This must stop. Currently, twenty-five states require that when a person is hired for a job, a check is made to see if he owes child support. Under this new program, we will check that information against our national database to catch deadbeats who have crossed state lines. And I challenge every state to give us this information so that deadbeat dads have nowhere to hide.

Second, today I directed the Department of Health and Human Services to require all mothers who apply for welfare to provide the name of the father and other identifying information at the time they apply for assistance, before they can get welfare benefits. Exceptions will be made to protect a woman from the threat of domestic violence. And we will require the welfare office to contact child support authorities within two days to begin legal proceedings to hold the father responsible for support.

Our system ought to say to mothers: help us identify and locate the father, or you cannot get welfare. And it should say to fathers -- we are not going to let you walk away from your children and stick the taxpayers with the tab. The government did not bring that child into the world -- you did.

If we do all these things -- if we offer opportunity by providing health care and family leave . . . if we demand responsibility of fathers and mothers who bring children into this world -- then we can restore our social fabric and protect the American family.

You are on the front lines, every day, caring for our children and our parents.

Our nation owes it to you to give you all the help you need. For all the professionalism and compassion you pour into every hour of every day, we thank you.

Thank you and God bless you all.

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release May 25, 2000

REMARKS BY THE PRESIDENT ON PRESCRIPTION DRUGS

The Rose Garden

10:52 A.M. EDT

THE PRESIDENT: Thank you very much. Senator Daschle, Congressman Gephardt, members of the House and Senate leadership, and Secretary Shalala. Let me say how much I appreciated the meeting we had this morning and how much I support the agenda they outlined. I'd like to say a few words about it, myself. But before I do, I'd like to put it into some larger context of our overall strategy.

We just have some new evidence that our long-term strategy of fiscal discipline, investing in our people, and expanding opportunities for American markets' products around the world is working. Revised GDP figures released today confirm that our economy grew at 5.4 percent in the first quarter, and that business investment soared by 25 percent. This strategy has now given us over seven years of growth and investment, the longest economic expansion in history. We ought to stay on the path that got us here and continue to invest in our people and their future, as our leaders have outlined today.

Last month -- I want to emphasize this -- just last month, the distinguished investment firm in New York of Goldman-Sachs estimated that that turnaround from record deficits to record surpluses has kept interest rates two full percentage points lower than they would have been without this strategy. Therefore, if we turn away from it and go back to the deficits, we can expect a corresponding rise in interest rates. A two percent cut in interest rates on home mortgages, car loans, college loans, credit card bills, has been an enormous, effective tax cut to the American people and has done a great deal to strengthen our economy.

That's why we feel so strongly that we should use this moment of unprecedented prosperity to lengthen the life and modernize Medicare with a prescription drug benefit, to strengthen Social Security, to invest in key priorities, especially education, to have a tax cut we can afford and keep paying that debt down to keep those interest rates down.

Now, as you've heard already, we mostly discussed providing prescription drugs for America's seniors in that meeting. I want to thank these leaders for standing with us on this important issue. This is a show of unity and a demonstration in resolve. There is no reason that Congress cannot take the necessary steps to ensure that every older American has access to the lifesaving, life-enhancing prescription drugs they need.

Now, just a few weeks ago, Senator Daschle and Congressman Gephardt came here to announce that the Democrats were united in a single strategy to provide these prescription drugs. Today, they will be joined by leading architects and backers of the plan -- all these people behind me who have worked on the details. So we know exactly how we would do this; we know we can afford it, and we think the time to act is now. I'll just say this one more time. If we were creating Medicare

today, there is no way in the wide world we wouldn't provide prescription drugs.

Some of you were with me last Sunday afternoon when I went up to Hyde Park. Then I landed in the Poughkeepsie Airport -- there were probably 300 people there, so I had an impromptu town meeting. I went down and shook hands with everybody and just sat there and visited with them. And the only issue that was mentioned to me more than once -- spontaneously -- over and over and over again, was this prescription drug issue. It is a big issue, and it's a big hole in America's social safety net. It is totally voluntary; it is driven by the market; and we ought to do it.

We're talking more than three in five of our seniors, who are like the Lachnits Tom talked about. They may be a particularly egregious case, but over 60 percent of our seniors don't have affordable prescription drug coverage.

Now, I think that the case has been made. I don't know how in the world we can deny the fact that with the funds we have, with the evident obligations we have, with the fact that anybody who lives to be 65 in America today has a life expectancy of 82 or 83 years -- and that is only going to increase, and therefore, their need for life-enhancing and life-preserving prescription drugs will only increase -- this is the best chance we will ever have to address this. And we have to do it.

Now, the budget I presented to Congress will continue our efforts to pay off the debt in 13 years; it will make Medicare more competitive as many in this group have urged. But it will also provide this kind of voluntary prescription drug coverage.

Now, last month -- or earlier this month -- the Republican leaders in the House did put forth the plan that had the stated goal of providing affordable prescription drugs for seniors, but the policy falls far short of the promise. Suggesting a private insurance benefit that insurers, themselves, say they will not offer and no one will buy if they did offer it because it would be too expensive is an empty promise. Limiting direct financial assistance for prescription drugs to seniors below the $12,500 income will leave out over half, including the Lachnits. Their drug bills alone, if my math is right, are $16,800 a year. And that's about what their income is. They wouldn't get a nickel under the Republican plan. That's not right, and we can do better.

So we're here to say we have a full-time obligation to deal with the big opportunities and the big challenges of this country, and Congress should feel that obligation, even when they go into recess. Thee is no heavier evidence of that today than the need to provide voluntary, affordable prescription drug coverage.

Let me say there are many other priorities, and I want to just mention them. The announcement we had on New Markets a couple of days ago ought to give some impetus to raising the minimum wage, passing common-sense gun legislation, expanding health insurance for the parents of poor children, passing a strong, enforceable patients' bill of rights, and I hope that we will see more action in all these areas.

Now, today the House and Senate conferees are meeting again on the patients' bill of rights. Again, this is like the prescription drugs -- this ought not to be a bill that's held up by interest groups, it ought to be a bill that has passed in the public interest. That's our commitment, and you will see it nowhere more intensely than our efforts to get this prescription drug coverage in the closing days of this Congress.

Revised Final 05/11/00 12pm
Josh Gottheimer

PRESIDENT WILLIAM J. CLINTON
TOPPER FOR PBOR MEETING
THE WHITE HOUSE
May 11, 2000

Ack: TK

Good morning. I am joined here today by a bipartisan group of members of the House and the Senate who are working to pass a patients' bill of rights.

Last October, in an overwhelmingly bipartisan vote, the House passed a strong and enforceable patient's bill of rights. One that I would sign into law today. This legislation says plain and simple: You have the right to the nearest emergency room care. You have the right to see a specialist. And you have the right to hold your health care plan accountable if it caused you or a loved one great harm. Every American in every health plan deserves these rights. This legislation would guarantee that.

We're meeting here today to discuss the status of negotiations and the prospects for timely passage of this important legislation. I also want to offer any and all necessary assistance to help move this legislation along. It's important to remember that each day we wait, millions of Americans aren't getting the protections they need and deserve. With a diminishing number of working days left in this Congress, we simply can't afford to wait any longer. Nor can we afford to weigh down the bill with unnecessary provisions that undermine its chance of passage.

That's why we're here today: to put progress over partisanship, to put the health of Americans above the needs of special interests; and to seize this moment of unprecedented opportunity to restore trust and accountability to our health care system. The more than 190 million Americans who use managed care or other insurance plans have waited too long. I believe we can all work together to deliver to America's families the protections of a strong, enforceable patients bill of rights this year. Thank you.

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release May 11, 2000

REMARKS BY THE PRESIDENT ON PATIENTS' BILL OF RIGHTS

The Cabinet Room

2:15 P.M. EDT

THE PRESIDENT: First of all, I would like to thank this very impressive array of Senate and House members for coming, in the midst of quite a busy time up on the Hill, as we try to work out the remaining issues to get a strong patients' bill of rights passed.

I'd like to begin just by expressing my gratitude to, most recently the Senate, but also to the House, for the truly historic Africa-Caribbean Basin trade bill that passed by, I think, 77 votes in the Senate today. And this bill passed with big bipartisan majorities in both Houses. And it's an example of the kind of thing we can do if we work together. And I'm very grateful to the Congress for that, and very much looking forward to this bill.

Last October, the House passed the Norwood-Dingell bill by a big majority, but the conferees have not been able to agree on a bill which could then be taken back to the Senate and the House. So this meeting is to determine what the issues are, what the prospects are for resolving them; to make it clear to these members that I will offer anybody in the White House, starting with me, day or night, to try to help resolve this and hopefully to get a bill out.

I think it's fair to say that most of us -- maybe all of us -- really want a bill, not an issue, not a debate. We'd like to pass a bill. And so I'm looking forward to this meeting, and I want to thank you all for coming.

Q What are the prospects for approving it this year?

THE PRESIDENT: Well, you should ask us all after the meeting.

Q Mr. President, the FBI testified today there are possible intelligence officers operating as accredited reporters at the State Department. Does that concern you, sir?

THE PRESIDENT: Does it concern you? I should be asking if it concerns you. No, I don't want to make light of this. Of course, the testimony today was the first that I had heard that assertion, and obviously it has to be looked into.

I would have thought that you might have docile intelligence officers masquerading as hostile reporters.

Q Mr. President, this morning you told Diane Rehm about some predictions about what you thought George W. Bush might do if he's elected President, in terms of tax cuts, Supreme Court appointments. Do you also think that he would destroy Social Security by privatizing it, as the Vice President has charged?

THE PRESIDENT: I don't want to talk about the campaign here. I'm here trying to get something done. I'll be glad to answer -- at some appropriate time, I'll tell you what I think ought to be done on Social Security, although I'm pretty well on the record on that. But I don't think this is an appropriate thing for me to discuss right now.

Q Mr. President, do you have any concern about comments by Majority Whip Delay yesterday that he may not be doing quite as well as he had hoped getting Republican votes for the China bill?

THE PRESIDENT: No, because I've noticed he's quite effective at getting votes when the time comes -- sometimes when I like it, and sometimes when I don't. And I think he wants us to do our part, and I'm doing my best. I think in the end, especially after President Ford and President Carter and all those former administration members came, and after the, I think, very important reports in the press today about the Chinese dissidents favoring this vote, I think we'll get there. We've just got a lot of hard work the do.

Q Do you have an update on the situation in Northern Ireland, Mr. President? And do you foresee a situation where you would be able to travel over there to celebrate some success?

THE PRESIDENT: Well, we're not done yet. There's still a matter to be resolved about what exactly the new police force would be called and how it can be constituted so that both Protestants and Catholics will join the police force and be a part of the unified police force, and what the political problems this issue present to both sides are.

I think what the IRA did in agreeing to put these weapons beyond use and put them in these cachement areas and allow them to be inspected was a terrific step forward and a great credit to Gerry Adams and Michael McGuinness -- Martin McGuinness -- and everybody else who worked on it.

But we've got one last issue, and I don't think anybody ought to be celebrating until we resolve the one last issue.

THE PRESS: Thank you.

END 2:20 P.M. EDT

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release May 10, 2000

REMARKS BY THE PRESIDENT
AT CALL TO ACTION FOR
MEDICARE AND PRESCRIPTION DRUG REFORM

The Rose Garden

10:40 A.M. EDT

THE PRESIDENT: Well, good morning. Please be seated. I'm sorry you had to stand up so long, but that's the fastest one group of politicians ever walked through another group. (Laughter.) I'm delighted to see you all here. I want to thank Senator Daschle and Senator Gephardt and their colleagues -- Secretary Shalala, the Older Women's League, those who represent the aging-disability consumer, and other health advocates who are here. I want to thank Betty Dizik, who will talk in a moment to explain what this is really all about.

We are here together today to announce the support of the Democratic Caucus in the Senate and the House for legislation to provide affordable prescription drug coverage for every older American. For our seniors, prescription drugs are not a luxury, they can mean the difference between life and death; between years of anguish and years of fulfillment. At this time of historic prosperity and strength, there is absolutely no reason that we should force seniors to make a choice between their health and their food or their daily existence.

I am profoundly grateful to Congressman Gephardt and Senator Daschle and their colleagues for developing an approach that the Democrats can rally behind. In a few moments, I will ask them to share the details of the efforts we will make together. But we all know we can't achieve our efforts without bipartisan support in the Congress. That's why, just as we are trying to do with the patients' bill of rights, we want to reach across the aisle to encourage Republican support, as well.

This can, and should be, a truly bipartisan effort. But I want to make it clear first why America's seniors and people with disabilities cannot afford to wait any longer for prescription drug coverage.

Today, more than three in five older Americans lack affordable and dependable prescription drug coverage. The burden is getting worse. According to Families USA, the price of prescription drugs most often used by seniors has risen at double the rate of inflation for six years in a row now.

Two groups in particular bear a tremendous burden -- rural Americans and women. As Senator Daschle knows so well, people in rural areas are much less likely to secure prescription drug coverage. According to a study released today by the Older Women's League, almost eight out of 10 women on Medicare use prescription drugs regularly, and most of them pay for these medications out of pocket. In total, women spend 13 percent more than men do for prescription drugs, in spite of the fact that on average, their incomes are 40 percent lower.

America's seniors, men and women, deserve better. No one

should be forced to take a bus trip to Canada to get medicines made in the U.S. at a lower price. We desperately need a comprehensive plan to provide a prescription drug benefit that is optional, affordable, accessible to all, based on competition, not price controls, to boost seniors' bargaining power to get the best possible price; and one that addresses the devastating burden of catastrophic coverage.

We will have, in our budget, especially with the improved economy, the funds to deal with catastrophic coverage as well, and we absolutely should do that.

The budget I have presented to Congress will continue our efforts to pay down the debt and pay it off by 2013, will be able to provide protection against catastrophic costs, and will provide voluntary prescription drug coverage to all Americans.

Adding the voluntary prescription drug coverage to Medicare is the smart and the right thing to do. I will say this one more time: We would never think of creating Medicare today without it, and it is high time we fixed it.

Now, let me say without getting into a fight over the legislation that's been proposed, I don't think it's enough to stop at $15,000 income limit to give help on prescription drugs. Half the people who need the help fall within the income limits of $15,000 to $50,000. I don't think we should write a plan that basically is designed to please the people who are selling the drugs instead of the people who are buying the drugs.

And as long as we are trying to make the price competition system work, and give bargaining power to seniors, we ought to do this right and cover the people who need it. This is not about winning a political fight. It's about giving people a chance to fight for a good long life.

And I want to introduce now Betty Dizik, someone who know firsthand the enormous burdens of prescription drugs. She's had to make some very hard choices in order to afford the drugs that she desperately needs, and she is Exhibit A for why we are all here today.

Betty, come on up here, and tell us your story. Give her a hand. (Applause.) Thank you.

* * *

THE PRESIDENT: Thanks to Congressman Gephardt's consideration, none of you will have to spend your hard-earned money to buy prescription drugs to treat your cold that you got from being flooded out here. (Laughter.) But let me thank you, Betty, thank you, Secretary Shalala, and thank all the members of Congress. Look at our legislation. We need some Republican support. This is a good bill, it will make a big difference.

Thank you and bless you all. Get in here before you get wet. (Applause.)

END 11:00 A.M. EDT

CHIEF OF STAFF TO THE PRESIDENT

30 Weekly Comp. Pres. Doc. 1044

Public Papers of the Presidents

Public Papers of the Presidents

May 10, 1994

CITE: 30 Weekly Comp. Pres. Doc. 1044

LENGTH: 4219 words

HEADLINE: Remarks to the American **Nurses** Association Conference

BODY:

Thank you so much. Thank you for your warm welcome. And thank you, Ginna, for that award.

I arrived a few moments ago, and I re member the first time I ever heard your president speak. I knew that she had worked for Vice President Gore, and I thought it was so interesting to hear the head of a national association who was speaking without an accent. [*Laughter*]

I want to say a special word of appreciation to your first vice president, Ellen Sanders, who's participated in White House and congressional meetings on health reform, and to Diane Weaver, the president of the Association of Nurse Executives, who cosponsored this breakfast.

I am very proud to share the stage today with all the fine nurses in the executive and the legislative branches whom you have honored. And I thank you for doing that. And I thank them for their service. I also want to say a special word of thanks to all of you and to the ANA for the courage and the vision you have demonstrated by fighting for health care reform, and the right kind of health care reform, long before it was a hot issue. As you know, the position paper you put out on national health reform probably more closely parallels the recommendations that our administration has made than that of any other professional health care group in the country. And I thank you for that very much.

I want to thank you, too, for recognizing my mother, who worked for 30 years and then some as a nurse and was deeply proud of what she did. I remember when I was little boy watching her get up in the middle of the night always starting work by 7 a.m. or 7:30 a.m. in the morning, always telling me stories that indicated that there was literally nothing in the world more important to her than dealing with a person frightened, in pain, with a caring and effective manner. This award will help to expand the frontiers of nursing in the areas of women's health, something that she would have been very proud to be a part of.

My mother, as all of you now know, completed her memoirs, which became her autobiography shortly before she died. She went over about half of it and was able to do the final editing. And it was my privilege after she passed away to work with the author and just try to make sure all the facts were right. I got very stern instructions from her. She said, "Now if you have to do this do not change one word I said about you" -- [*laughter*] -- "especially the part about your manners not always being great." [*Laughter*] "And make sure you get the facts straight. Otherwise leave it alone."

But I was very pleased with the two book reviews that her book got yesterday. One by the great American author, Joyce Carol Oaks in the New York Times, and then another one here in the

Washington Post. But it tickled me, the one in the Washington Post said that if you read this book, you would understand why I perplexed people in Washington. I was actually brought up by real people, and occasionally I still acted like one. [*Laughter*] I didn't know what that -- [*laughter*] -- I'm trying to get over it, but it's hard even here.

Anyway, here's something my mother said about her work, which would apply to all of you and those whom you represent. But it meant a lot to me. It was just her words. "Nurse anesthetist work is all-consuming. You don't do it halfway. You don't daydream. You don't let your emotions wander. You're the person responsible for putting another human being into a state of unconsciousness, somewhere between life and death. For 30 years, from the minute that I would walk into the operating room and start talking to the patient and begin putting him to sleep, until I got him safely back to the recovery room, nothing in the world could have crossed my mind. I don't care what problems were on the outside. I don't care what problems I might have been having at home. I never thought of my life beyond the moment."

I remember when I was also a child, things were somewhat more informal. My mother used to take me to the hospital and let me meet the other nurses and the doctors and watch the emergency room and watch people go into the operating room. It was utterly fascinating. And the work you do has always sort of captured my imagination.

My own wife had never been in a hospital before in her entire life until our daughter was born, never been in a hospital for any kind of sickness. And learned only a few moments before the happy event that she was going to have to have a C-section. And we had gone through Lamaze, and we had done all this stuff, and I was supposed to be in the operating room. And our hospital at that time had never before let a father into the delivery room if it wasn't a natural birth. It was a big deal. So I said, "Look, I've been watching people get cut on and bleed since I was a little boy. I'll do fine." [*Laughter*] "But she had never been here before, and she may not -- you better let me come in." [*Laughter*] So they did and actually changed the policy so that if fathers had been through the Lamaze course and then the mothers eventually had to have a C-section, they got to go. So I felt -- that's my one contribution to medical advances. [*Laughter*]

But I owe all that to my mother, who was a remarkably determined woman in the face of often excruciating adversity. I think one of the reasons that the Nurses Association has been so forthright about this health care reform issue is that you see it from the grassroots up in human terms and you don't get so hung up as some people do on all the political rhetoric and the positioning and the characterizations that have, frankly, put a lot of Members of Congress at a severe disadvantage because they haven't had the chance to spend the time and make the effort to deal with this issue that you have. It is, after all, a mind-bendingly complex problem. It's 14.5 percent of our income, and for people who don't live in it every day, it can be a very difficult thing.

But I just wanted to thank you because I believe that the personal experiences you have shared, so many of you common to the ones that my own mother shared, really animated the Nurses Association to take the position that you have taken.

I want to emphasize today that what I seek, contrary to the attacks, and what you have sought, is not a Government-run health system, it's a private insurance health system that covers everybody, where the health care professionals run it and not the insurance companies. That's what we seek.

We seek private insurance that can never be taken away. It's wrong to treat seriously ill children in an emergency room who could have been treated more easily and more inexpensively if their parents had just had the coverage. With our reforms, every family will have that kind of quality insurance. We ought to reform the insurance system that today often only covers the healthiest people and even then will deny them coverage for anything they've been sick with before.

When you go to a patient's bedside, you ask, "Why does it hurt? Where does it hurt? How can I help?" You don't ask whether this is a preexisting condition you're looking at. [*Laughter*] It's a very important issue.

If you think about all this preexisting condition business, there are 81 million Americans who live in families where there's been a child with diabetes or a mother that had cancer prematurely or a father that had an early heart attack or some other problem. I see these people everywhere. This is no small number. Now, we get action lickety-split up here all the time when a million people or 2 million people are adversely affected by something if they are well organized. But these 81 million people, they're professionals and blue-collar workers; they're old folks and young folks; they're all different kinds of people; and they are by definition disorganized. There is no national association of people with preexisting conditions. [*Laughter*] You think about it; if there were, and 10 million of them showed up here, we'd have health care reform so fast you couldn't blink.

You must be their voice in an organized way. And you can be. So we ought to cover everybody with private insurance, and we ought to have insurance reforms that deal with preexisting conditions and don't discriminate people based on age. This is somewhat controversial. I know that. But I believe if we went back to health insurance the way it originally was when Blue Cross first started writing it, where everybody was put in a large group, risk was broadly spread, and people paid a fee against the day when they would be sick, it would be fairer for all Americans. And our economy would work better, our society would have a stronger sense of community, our families would function better. People would be free of a lot of the anxiety that comes --

Hillary and I have received about a million letters. And whenever I go somewhere now, they arrange for some of the letter writers to come see me. And it's just gripping to see people just over and over and over and stunning to see how they do come from all walks of life and how they have been broken by the things which have happened.

The third thing I think we should do is to preserve the Medicare program. It's interesting, the people who criticize our program say this is Government-run health care which, of course, it isn't. And if you tried to take away Medicare, which is a Government-funded health care, well, they would be up in a tree somewhere screaming about it.

But we don't want to do anything to the Medicare program, except to make it better. I do believe we should add a prescription drug benefit and phase in long-term care that is community-based or home-based for two simple reasons. One is, there are an awful lot of elderly people who aren't poor enough to be on Medicaid but aren't well off, who have significant medical bills. We know the elderly use 4 times the prescription drugs that the nonelderly do. And we know from study after study after study that a proper medication regime can keep people out of the hospital and can save money and that we now. have -- any number of elderly people every month -- I was in a grocery store in New York yesterday called Pathmark, which also operates, as many do now, a drugstore. And it was gripping; the CEO was saying, "My workers tell me that every day they watch older people come in this store and go from the drugstore, down the food aisle, and try to make up their mind what food they're going to give up to get their medicine, or whether they're going to give up their medicine to buy their food" -- gripping. So I do believe we should do that. But the Medicare program works. It has low administrative overhead. We think it should be secured.

The fourth thing we want to do is to bring greater choice to our people. I guess the thing that has made me the maddest in the relentless campaign against this plan are all those bogus ads where they say, "You're going to have to call some Government office to figure out where you go to the doctor."

There are two realities of modern life that you have to drive home to every Member of Congress, without regard to party or philosophy. Number one, Americans are rapidly losing their choices today. Already, of people who are insured at work, fewer than half have more than one choice of a health plan. That's a fact today. And they're rapidly losing their choices. Number two, medical professionals are increasingly losing their right to decide unilaterally, may have to have somebody get on the phone to an insurance company executive a long way away to ask for permission to do what anybody knows ought to be done under the circumstances.

Now, most Americans, believe it or not, don't know either one of those things, even though they may be caught up in it, and I think it's very important. Our plan is designed, number one, to increase the

choices that consumers have. We're moving to more managed care. There can be a lot of good things in it, but under our plan, every year, every person would have a choice between at least three plans, or among at least three plans but in all probability many more. And number two, under our plan, medical professionals would also be given more choices and would have to do less checking in with the insurance company in advance. Now, being treated by doctors and nurses, you know, is an American tradition. Every time I do one of these town meetings, like I did in Rhode Island last night, I talk to somebody that's just been forced to give up their doctor and just move away from the choices they made.

We believe when all Americans can choose among several health plans, many Americans, many more Americans, will choose to stay with their own providers. And many more of these plans will be organized in such a way that all providers can participate if they'll do it for the agreed-upon fee. That's what we believe will happen. And if we don't do this, if we don't have some legal action to reorganize this, you're going to have less choice by consumers, less choice by providers.

Time and again, we've also seen that the quality of care is directly related to the quality and the quantity of the nursing staff. One of the things that amazes me is how man) nurses have been laid off in recent months and been told, well, this is because health care reform is coming. I'll tell you what, one of Clinton's unbending laws of politics is, whenever somebody who's got a tough decision to make can shift the heat from themselves to you, they'll do it every time. They will do it every time. That law never varies.

Now, what is really going on? What's really going on is, a lot of these health care providers are under the gun. Right? More managed care; people bargaining tougher for prices; more and more people who are uncovered where there's uncompensated care that has to be provided; less and less ability to pass on the cost of uncompensated care to other people because they're in these managed care networks they're in: all this stuff is going to happen if we don't do anything. All of us could go on vacation for a year, and this same thing would go on. You know that. And don't let your Members fall for it.

What's going to happen is we'll continue to see these trends occur unless we find a way to give health care providers reimbursement for all the people for whom they care, at an appropriate level in an appropriate way. More than a decade of research now shows that more and better trained nurses result in shower hospital stays, better survival rates, fewer complications, whether you're dealing with low birthweight babies or older people.

You do not have to work for the Congressional Budget Office to understand that healthier patients and shorter stays means lower health care costs. Sometimes I think if you do work for the Congressional Budget Office you will never get that, but -- [*laughter*] -- we're working pretty well on the whole. This is a big deal. This choice issue and maintaining an array of qualified people doing the things for which they are best qualified is terribly important.

Finally, let me say -- and this, I guess, is, except for this whole issue of whether this is a Government program, which it isn't, is the most controversial part of it -- -our reform is based on providing guaranteed benefits at work. Now the reason for that is simple, for the people in this country that have health insurance, 9 out of 10 of them have it at work where there is some shared responsibility between the employer and the employee. For the people who don't have insurance, 8 out of 10 of them have someone in their family who is working.

It seems to me that the fairest and simplest, and if you will, the most conservative way to achieve universal coverage, to have health care security for everybody, is to ask employers and employees who aren't doing anything or barely doing anything to do more so that they can fulfill their own responsibilities and then use tax funds to cover the unemployed, uninsured people for whom you could say, "Well, there's a general responsibility just like Medicare and Medicaid" and then organize the market so that smaller businesses and self-employed people, (a) get discounts if they need it and (b) are able to buy good insurance on the same terms that those of us who are insured by Government or larger businesses can.

Now it seems to me that is a fair and simple and obvious way to do this. I think that any other way will sooner or later involve either a radical change, that is, getting rid of the whole health insurance market and substituting taxes for it, or involve people who are already paying too much for their own health care, having to pay something for people who won't do anything for themselves because they say they should be exempt.

Now I think that this is a very important issue. You know, again, we lose sight of the fact that most small businesses are making an effort to cover their employees. We have brought hundreds and hundreds of small businesses to Washington to talk to the Congress, but they are not organized. There is no association called: small businesses who cover their employees and are mad their competitors don't and mad they can't get better insurance rates -- [*laughter*] -- and wish somebody would help them. So an association that may have a lot of folks in the insurance industry, along with other small businesses, says, "Don't do this; the whole small business economy will break," says this, and there's no association on the other side. You have to be their voice.

Had a car dealer from a town of 7,000 people in Arkansas up staying with me the other night, he and his wife, long-time friends of mine. She's a college teacher. He's a car dealer. He said to me the other night -- it was funny -- he said, "You know, for 20 years I have been feeling sorry for myself because I've provided a good health plan for my employees, and none of my competitors did." So he said, "I was so happy when you proposed this just because I thought I was going to get even." [*Laughter*] And then he said, "But you know, then I remembered that in the last 20 years I put three of my competitors out of business. And I'm making more money than I ever have. And the reason is I still got the same folks working for me I had 20 years ago because I gave them health benefits."

And yesterday I went to New York and I visited this Pathmark store. They have 175 stores, 28,000 employees, the 10th biggest supermarket chain in the country. We're all told, "Oh, if you do this, the retailing business will go to pieces." These people have put new stores in inner-city areas that other chains would not touch, fine new stores. They are making money, and they have always provided comprehensive health benefits to their employees. And they are now sacking their groceries in a bag that says they favor health care benefits to all Americans, guaranteed through the workplace.

I say this to you because, as you know, there are a lot of nurses that don't have any health care coverage and a lot of nurses who are single parents who don't have health care coverage. And this is the other point I want to make that I did to all those young people working in that grocery store yesterday: Everybody now in Washington is for welfare reform, and I guess it means different things to different people. But I have basically a 3-point strategy to achieve what I think would end the welfare system as we know it: One was embodied in last year's economic plan, lower income taxes for working people who are hovering just above the poverty line with children. This year one in six American working families will be eligible for lower income taxes so they can succeed at work and can succeed as parents.

Strategy number two, give people education and training and then give them a certain amount of time to find a job. And if they don't, require them to take it. And if they can't, provide some public subsidy in the private sector or some publicly funded job so that work is preferable to welfare.

Strategy number three has got to be cover the people with health insurance. Consider this: All these people on welfare in this country who are dying to get off -- and by the way, that's most of them -- who are dying to get off, most of them have limited education. Suppose they go through a little training program and they get a job that pays a modest wage but is still more than the welfare benefits. But they go to work for an employer who does not provide for health care.

Think about this: You are a mother with two children. You give up being on welfare to take a job that pays more than the welfare check, but you lose health care coverage for your kids. What are you going to do if your kid has to go to the dentist? What are you going to do if your child is desperately ill? How are you going to feel every week, every 2 weeks or every month when you get your paycheck and you see what's taken out of it in taxes and you realize those taxes are going to pay for the health care benefits of people who decided to stay on welfare instead of going to work? You don't have to be as bright as a tree full of owls to figure out that this doesn't make a lot of sense.

[*Laughter*]

Now a lot of American nurses are in this situation today, getting up every day, slaving away, trying to take care of people who have children without insurance, caring for people who come into their office who are on public assistance who have children with insurance because of the Medicaid program. It is not fair. It is not right. It is not smart.

And you could say, "Well, all this inability to cover everybody, if this were fueling some enormous American economic expansion, because we were saving so much money on health care, maybe you could deal with that." But the truth is we're spending over 40 percent more of our income on health care than any other country in the world. Oh yes, some of it because we're more violent, and that's something we pay for. Some of it because we have better medical research and technology, and that's worth paying for. But a whole lot of it, as you well know, is because of the way we have financed health care, which has employed hundreds of thousands of people in doctors' offices, in clinics, in hospitals, and in insurance companies to read the fine print on thousands and thousands of policies to see who and what is not covered. And it has rifled inefficiencies through this system that we are all paying for.

We can fix this. We can fix it by having a law which fixes what's wrong, keeps what's right, provides health care security to everybody through a private system, increases the choices consumers have, and increases the decisions that doctors and nurses and other qualified providers make without oversight by others. We can do it.

In order to do it, we have to recognize we have to go through a fog of misinformation, a torrent of labels which aren't right, and recognize, too, that you have to lobby and stand up for, in an organized and very personal way, that great association that doesn't exist, the association of 81 million Americans and families with preexisting conditions, the association of hundreds of thousands of small businesses who ate doing the fight thing and being punished for it, the association of all the poor women in this country who are out there working their hearts out and their fingers to the bone to do right by their kids without health insurance and paying taxes for people on public assistance who have it for their children. All of those associations are disorganized.

You have devoted your lives to providing health care to all Americans. You have honored my favorite nurse today. You have given me a chance to hope that my mother and my grandmother are looking down on me thinking I was the first generation in three that didn't produce anybody that was caring for other people in health care. So they think at least I walked off with the award today. [*Laughter*] It means more to me than I can say.

But the determination that my mother showed in getting up off the pavement many times in her life is the same sort of determination you have to show for us to get health care reform this year. And remember, most of these Members of Congress want to do the right thing. But they don't know what you know; they haven't spent the time that you've spent; they haven't had the experiences you have had. You have to help them. And the people in their districts that really need their help are not in those great national associations.

You keep them in your mind and keep that example in your mind. Don't let this year go by. We can do this this year with your help and your leadership.

Thank you, and God bless you all.

NOTE: The President spoke at 9:56 a.m. in the Regency A Ballroom at the Hyatt Regency. In his remarks, he referred to Virginia Trotter Betts, president, American Nurses Association. A tape was not available for verification of the content of these remarks.

LANGUAGE: ENGLISH

LOAD-DATE: June 08, 1994

30 Weekly Comp. Pres. Doc. 1044

Source: All Sources : / . . . / : **Presidential Documents**
Terms: **headline (nurs!) and date geq (06/28/1990)** (Edit Search)
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36 Weekly Comp. Pres. Doc. 945

Public Papers of the Presidents

Public Papers of the Presidents

April 29, 2000

CITE: 36 Weekly Comp. Pres. Doc. 945

LENGTH: 706 words

HEADLINE: The President's **Radio Address**

BODY:

Good morning. Next week, when the full Congress returns from Easter recess, they'll have less than 75 working days left to make this year a year of real progress for the American people. There is no more important critical piece of unfinished business than our need to ensure that every American, young and old, has adequate, affordable health care.

Today I want to again urge the Congress to step up to this challenge by making the passage of a strong **Patients' Bill of Rights** and the provision of a voluntary **Medicare** prescription drug benefit top priorities when they return to Washington.

This critical legislation is long overdue. The more than 190 million Americans who use managed care or other insurance plans have waited too long for a strong, enforceable **Patients' Bill of Rights.** They deserve the right to see a specialist, to emergency room care, wherever and whenever they need it, and the right to hold health care plans accountable for harmful decisions.

Last year, in an overwhelmingly bipartisan vote, the House passed a strong **Patients' Bill of Rights** that provides the right protections all Americans need and deserve. It's a bill I would sign. But more than 6 months later the bill is still languishing in Congress. Despite their pledge to complete a real bill, the Republican majority has not only delayed action, it's actually considering legislation that would leave tens of millions of Americans without Federal protections.

A right that can't be enforced isn't a right at all, it's just a request. We need a strong bill that protects all Americans and all plans, not one that provides more cover for the special interests than real coverage for American patients.

Congress also has an obligation to strengthen **Medicare** and modernize it, with a voluntary, affordable prescription drug benefit. No one creating a **Medicare** program today would even think of excluding coverage for prescription drugs. Yet more than three in five older Americans still lack affordable and dependable prescription drug coverage.

Just this week we saw further evidence of the unacceptable burden the growing cost of prescription drugs places on senior Americans. According to a report by the nonprofit group, Families USA, the price of prescription drugs most often used by seniors has risen at double the rate of inflation for 6 years running, a burden that falls hardest on seniors who lack drug coverage because they simply don't receive the price discounts most insurers negotiate.

Seniors and people with disabilities living on fixed incomes simply cannot continue to cope with these kinds of price increases. That's why we must take action to help them, not next year or the year after that but this year. My budget includes a comprehensive plan to modernize **Medicare** and provide for a long overdue prescription drug benefit for all beneficiaries.

I'm pleased there's growing bipartisan support for tackling this challenge. Earlier this month Republican leaders in the House put forth an outline of a plan that offers as a stated goal access to affordable coverage for all older Americans. Unfortunately, their plan falls short of meeting the goal. It would do virtually nothing for seniors with modest middle class incomes between $ 15,000 and $ 50,000 a year. Nearly half of all **Medicare** beneficiaries who lack prescription drug coverage fall into that category.

It's not too late to give all our seniors real prescription drug coverage this year. We can work together on a plan that's affordable, dependable, and available to all older Americans.

So I say to Congress, when you come back to Washington next week, let's get back to work on a strong, enforceable **Patients' Bill of Rights;** let's get back to work on voluntary **Medicare** prescription drug benefits. The health care of Americans is too important to be sidetracked by partisan politics. The need is urgent, and the time to act is now.

Thanks for listening.

NOTE: The address was recorded at 5:58 p.m. on April 28 in the Oval Office at the White House for broadcast at 10:06 a.m. on April 29. The transcript was made available by the Office of the Press Secretary on April 28 but was embargoed for release until the broadcast.

LANGUAGE: ENGLISH

LOAD-DATE: June 2, 2000

Source: All Sources : / . . . / : **Presidential Documents**
Terms: **headline (radio address) and patient bill of rights or minimum wage or equal pay or medicare or social security and date geq (06/28/1998)** (Edit Search)

Public Papers of the Presidents

Public Papers of the Presidents

April 8, 2000

CITE: 36 Weekly Comp. Pres. Doc. 774

LENGTH: 775 words

HEADLINE: The President's **Radio Address**

BODY:
Good morning. In less than a week, Members of Congress will adjourn for spring recess, leaving behind a great deal of unfinished business. Today I'd like to speak with you about some of the pressing priorities that are languishing in Congress and the real consequence of this delay on people's lives.

First, we've waited far too long for a strong and enforceable **Patients' Bill of Rights.** Last October the House passed the bipartisan Norwood-Dingell **Patients' Bill of Rights** by an overwhelming margin. I would sign that bill tomorrow. Unfortunately, the Senate passed a much weaker bill. Now both bills have been gathering dust on a shelf for more than 5 months.

Delay may be easy for the congressional majority, but it's proving very hard on our families. According to a new analysis of physician reports, every single day the Congress sits on this legislation, thousands of patients experience serious declines in health as a direct result of bottom-line-driven managed care decisions.

At this time of great change in our health care system, patients need a guarantee that they can see a specialist and go to the nearest emergency room, a guarantee that their doctor can discuss the best treatment options, not just the cheapest, a guarantee to an internal and external appeals process, and a guarantee that they can hold a health plan accountable if it causes them great harm. They need a strong **Patients' Bill of Rights.** And they need it now.

Second, we've waited too long for an increase in the **minimum wage.** Last year we introduced legislation to give a well-deserved raise to 10 million working families by lifting the **minimum wage** by a dollar an hour. A dollar an hour -- it may not sound like much, but in the 7 months that have gone by since our legislation would have gone into effect, families have lost more than $ 600 in income. That's enough to pay for 2 months of groceries or almost a semester of community college. For these hard-pressed families, the cost of congressional delay can be measured not just by the day but literally by the hour.

Third, we've waited too long for Congress to fund our supplemental budget -- budget priorities like helping the victims of Hurricane Floyd, aiding families struggling with high energy prices, supporting our troops and our peacekeeping efforts to build stability in Kosovo, providing debt relief to the poorest nations, and combating drug traffickers in Colombia. Now, delays in this funding could jeopardize military readiness, undermine international support for Colombia's democracy and its

antidrug efforts that directly protect our people here, and leave many hurricane victims in temporary shelter for the second straight winter.

Finally, we've waited too long for commonsense gun safety legislation. Last year, with a tie-breaking vote by Vice President Gore, the Senate passed a bill that would require child safety locks for every handgun sold, ban the importation of large ammunition clips, and close the loophole that allows criminals to buy firearms at gun shows. Unfortunately, the House failed to pass similar measures. And even more disturbing, 9 months now have gone by, and the Congress has taken almost no action to complete a bill for me to sign.

Every day we wait, 89 Americans -- 12 of them young people -- are killed by gunfire. Of course, no legislation can prevent every act of gun violence or every gun accident. But when there are simple safety measures we can take, measures that will save lives. There is absolutely no excuse for sitting on our hands. Two days ago Senators from both parties voted to push congressional negotiators to produce a final gun bill by April the 20th, the anniversary of Columbine. That's the very least we can do.

With only a week to go before recess, I ask the congressional leaders to think about these daily tallies: 12 children dying from gunfire; thousands of managed care patients suffering unnecessary declines in health; millions of working families missing out on a long-overdue raise. These are just some of the everyday costs of failing to do the people's business. So let's get back on track. Let's work together to protect the health, the safety, the welfare of the American people. Let's safeguard their financial security, and in so doing, our national security. And let's do it now.

Thanks for listening.

NOTE: The address was recorded at 3:00 p.m. on April 7 in the Oval Office at the White House for broadcast at 10:06 a.m. on April 8. The transcript was made available by the Office of the Press Secretary on April 8 but was embargoed for release until the broadcast.

LANGUAGE: ENGLISH

LOAD-DATE: May 12, 2000

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release March 2, 2000

REMARKS BY THE PRESIDENT ON THE PATIENTS' BILL OF RIGHTS

Dwight D. Eisenhower Executive Office Building

11:00 A.M. EST

THE PRESIDENT: Thank you very much. Thank you and good morning. Dr. Herald, thank you for your powerful statement. I would like to thank Senator Kennedy, Senator Specter, Senator Chafee for being here; and Representative Norwood and Dingell, Representatives Berry, Morella, and DeLauro; Secretary Shalala, Secretary Herman.

I especially thank the doctors and nurses who stand with us today; the Patients' Bill of Rights Coalition, representing our nation's top health, consumer, and provider organizations.

Dr. Herald's testimony was powerful, but unfortunately, as she made it clear, not unique. For more than two years we've heard health care professionals tell us the same thing. For more than two years we've heard heart-wrenching accounts of families across our nation denied the basic patient protections they need. For more than two years we've worked for a strong, enforceable patients' bill of rights that says you have the right to the nearest emergency room care, the right to see a specialist, the right to know you can't be forced to switch doctors in the middle of a treatment, the right to hold your health care plan accountable.

Along the way, with the help of others in our administration, I've done everything I could through executive action to extend patient safeguards to some 85 million Americans who get their health care through federal plans; to provide similar patient protections to every child covered under the Children's Health Insurance Program. But no state law and no executive action can do what Congress alone has the power to do. Only federal legislation can assure all Americans and all plans get all the patient protection they need.

Thanks to the leadership of Congressman Norwood, Congressman Dingell, and the other members here, the House of Representatives passed such a bill, with the support of 275 members, including 68 members of the Republican caucus. It is a truly bipartisan bill.

Later today a conference committee will meet to take up the legislation. Many of the conferees do not reflect the will of the majority in the House or the will of the majority in the country. I told Congressman Norwood right before we came in here that I think this issue is the only issue with which I have dealt since I've been President that generated any controversy where there is, in the country, almost no difference in the level of support between Republicans, independents and Democrats.

Every major national survey shows that well over 70 percent of all Americans, without regard to their political party, support a strong, enforceable patients' bill of rights. The American people support it and they're entitled to have their elected representatives ratify it.

The Norwood-Dingell bill is the only bipartisan patient protection bill on the table. So far, it's the only bill that can make its way to my desk. I will not sign legislation, as Dr. Herald said, that is a patients' bill of rights in name only. It's not a real patients' bill of rights if it denies people the right to see a specialist, if it fails to guarantee access to the nearest emergency room care, if it denies the right to stay with a health care provider throughout a course of treatment, and if it has a weak appeals process that's tilted against the patients, if it doesn't include a strong enforcement mechanism to hold a health care plan accountable, or if it leaves more than 100 million of our fellow Americans out. We need a bill that covers all our fellow citizens, not one that provides coverage for special interests.

Again, I say, this is not a partisan issue anywhere else in the entire United States of America. And I am honored that we have had the bipartisan support we have had. This legislation has the endorsement of more than 300 health care and consumer groups across our country. So as the conference committee gets down to business, I ask them to listen to the voices of people like Dr. Herald, the people who live in the health care system, the people who know how it works, the people whose first concern is for their patients and their families and their future. It is time to reach across party lines and do this.

Let me say that if the Congress will send me a strong, enforceable patients' bill of rights today, I'll send every one of them an invitation to a signing ceremony tomorrow. Nothing would please me more than to see this issue removed from the context of partisan political debate and imbedded in the daily lives of all our citizens.

It is now my privilege to present the sponsor of the Norwood-Dingell bill, a long-time dentist, a man who has simply acted on his convictions and his experience. And I think we would all do well to listen to him. It's probably a little harder for him to come out for this bill than it was for me, and I feel particularly indebted to Congressman Charlie Norwood.

Representative Norwood.

* * *

THE PRESIDENT: Well, I just want to end on sort of a cautionary, but clarion note. Where I come from, this exercise that we have just engaged in is known as preaching to the saved. And it's very important. But this is one of those examples where the public and the people that really know how the system works are in the same place. And I believe a majority of members of Congress, if, as Congressman Norwood said so eloquently, if they're permitted, they're given a good bill to vote for, they'll vote for it. So the only way that we won't get a good bill is if this conference committee prevents the Congress from voting on a bill they would like to vote for, that is consistent with not only what the majority of the American people want, but

virtually one hundred percent of the medical professionals in the country, and a majority of the Congress.

So that's what the stakes are. I am profoundly indebted to the members who are here, to all the health care professionals who are here, to Dr. Herald who spoke so well. But I ask you to remember, the work is ahead of us. And I think we need to, all of us, each in our own way, go to work to impress upon that conference committee their profound responsibility to give the Congress and the country the bill they want to vote on, and the bill they want to live under.

Let's get to work. Thank you very much.

END 11:33 A.M. EST

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release March 2, 2000

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Dwight D. Eisenhower Executive Office Building

11:00 A.M. EST

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Representative Norwood. (Applause.)

* * *

THE PRESIDENT: Well, I just want to end on sort of a cautionary, but clarion note. Where I come from, this exercise that we have just engaged in is known as preaching to the saved. (Laughter.) And it's very important. But this is one of those examples where the public and the people that really know how the system works are in the same place. And I believe a majority of members of Congress, if, as Congressman Norwood said so eloquently, if they're permitted, they're given a good bill to vote for, they'll vote for it. So the only way that we won't get a good bill is if this conference committee prevents the Congress from voting on a bill they would like to vote for, that is consistent with not only what the majority of the American people want, but virtually one hundred percent of the medical professionals in the country, and a majority of the Congress.

So that's what the stakes are. I am profoundly indebted to the members who are here, to all the health care professionals who are here, to Dr. Herald who spoke so well. But I ask you to remember, the work is ahead of us. And I think we need to, all of us, each in our own way, go to work to impress upon that conference committee their profound responsibility to give the Congress and the country the bill they want to vote on, and the bill they want to live under.

Let's get to work. Thank you very much. (Applause.)

END 11:33 A.M. EST

...meet the world's
nurse anesthetists
august 5-10
2000

International Federation of Nurse Anesthetists
"6th World Congress for Nurse Anesthetists"

Script

HELLO TO ALL THE NURSE ANESTHETISTS GATHERED IN CHICAGO THIS AFTERNOON. ON BEHALF OF THE UNITED STATES OF AMERICA, THE WHITE HOUSE STAFF, HILLARY, AND MYSELF, I'D LIKE TO EXTEND WARM GREETINGS TO ALL THOSE IN ATTENDANCE AT THE 6TH WORLD CONGRESS FOR NURSE ANESTHETISTS.

I APPLAUD THE INTERNATIONAL FEDERATION OF NURSE ANESTHETISTS FOR ESTABLISHING THIS GLOBAL EVENT AND COMMEND THE AMERICAN ASSOCIATION OF NURSE ANESTHETISTS FOR HOSTING THIS CONGRESS.

THE CHOSEN PROFESSION OF MY MOTHER, NURSE ANESTHETISTS PLAY A VITAL ROLE IN HEALTH CARE ALL AROUND THE WORLD. WORKING IN A WIDE VARIETY OF SETTINGS, FROM HOSPITALS TO PHYSICIAN OFFICES, NURSE ANESTHETISTS PERFORM INVALUABLE SERVICES FOR PATIENTS AND THEIR FAMILIES.

THE HARD WORK, COMPASSION, AND PROFESSIONALISM THAT NURSE ANESTHETISTS HAVE PUT FORTH FOR MORE THAN 100 YEARS HAVE CONTRIBUTED IMMEASURABLY TO THE IMPROVEMENT OF COUNTLESS LIVES.

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WHETHER RESPONDING TO MEDICAL EMERGENCIES, OR PARTICIPATING IN SCHEDULED PROCEDURES, OR VOLUNTEERING YOUR SERVICES, YOU BRING HEALING AND HOPE TO THOSE IN YOUR CARE.

YOUR WORK IS ESSENTIAL TO THE EFFECTIVENESS OF A GLOBAL HEALTH CARE SYSTEM. I SALUTE THE COMMITMENT YOU HAVE SHOWN ON A DAILY BASIS, AND I AM CONFIDENT THAT YOU WILL CONTINUE IN YOUR RICH TRADITION. BEST WISHES FOR A SUCCESSFUL CONGRESS. TO MY FELLOW AMERICANS, ENJOY YOUR TIME IN CHICAGO, AND FOR THOSE WHO HAVE TRAVELED ABROAD TO BE HERE... WELCOME TO AMERICA!

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Draft 07/05/00 6:30pm
Gottheimer

PRESIDENT WILLIAM J. CLINTON
VIDEOTAPED REMARKS FOR AANA AND IFNA
CHICAGO, IL
July 12, 2000

I am delighted to welcome the American Association of Nurse Anesthetists and the International Federation of Nurse Anesthetists to your sixth World Congress for Nurse Anesthetists. For nearly 70 years now, the AANA has been on the frontlines of American health care, leading the fight for nurses and for better care for all patients. And the IFNA has brought that same level of care to nurse anesthetists in more than 120 different nations around the world, working for higher standards, better education, and tougher guidelines.

In clinics and in waiting rooms, in ER's and in OR's, nurses make millions of lives better each and every day. ~~And~~ Few people work harder, sacrifice more, and care more. That's something I know first-hand, because for more than thirty years, my mother worked as a nurse anesthetist. I learned then that there is no substitute for a nurse's care – for your kind words, your unique skills and expertise. As my mother once said, "Nurse anesthetist work is all-consuming. You don't do it halfway. You're the person responsible for ... another human being."

Our health care system is changing rapidly, and no one knows that better than nurses. No one knows better than a nurse the consequences of being without quality health care. That's why, with your help, Vice President Gore and I have worked so hard over the last seven years to give Americans the health care they need and deserve. We enacted the single largest investment in health care for children since 1965 ... ensured that patients will not lose their coverage when they change jobs ... and greatly increased the resources to combat HIV and treat AIDS. We've also fought to ensure parity for the treatment of mental illness.

Together we've made great progress – but there's still more for us to do. We need a strong and enforceable Patients Bill of Rights – including the right to see a specialist ... the right to go to the nearest emergency room ... and the right to hold your health care plan accountable. We also need to strengthen Medicare and modernize it, with a voluntary, affordable prescription drug benefit. And we need to hold tobacco companies -- not tax payers -- accountable for the health costs of tobacco.

The unparalleled care that you give your patients makes America's health care system the best in the world. I know we can count on you to ensure our system grows even stronger in the 21st century. Thank you and enjoy your time in Chicago.

PRESIDENT WILLIAM J. CLINTON
VIDEOTAPED MESSAGE
THE OPERATING ROOM NURSES OF AMERICA

Thank you for allowing me to address what is probably the hardest-working group of people in this country -- the Operating Room Nurses of America. Nurses are also the most caring people in the world -- I know, because my mother was one. And anyone who's ever spent time in a hospital has felt that compassion and its power to heal.

Our health care system is changing rapidly, and no one knows that better than nurses. No one knows better than a nurse the consequences of being without health insurance -- because you see the tragedy of uninsured children with serious illnesses arriving at the hospital too late. No one knows better than a nurse what can happen when cost-cutting interferes with medical decisions, because you have witnessed the devastating repercussions when patients are asked to leave the hospital before their doctors and nurses believe they are ready.

Whether they have traditional care or managed care, all Americans need and deserve quality care. I have called on Congress to pass a Patients' Bill of Rights to help establish vitally important protections for more Americans, like the right to emergency care wherever and whenever a medical emergency arises; the right to talk freely with doctors and nurses about all the medical options available, not only the cheapest; and the right to a specialist for specialized care. I hope that nurses will continue to speak up and speak out on this critical issue. Our nation needs your insight and wisdom.

America has the best health care system in the world -- and operating room nurses are helping to ensure that every American has the best health care in the world. From operating rooms to emergency rooms, you are helping America go stronger into the 21st century. Thank you.

Draft 8/02/99 8:30am
Josh Gottheimer

PRESIDENT WILLIAM J. CLINTON
VIDEOTAPED REMARKS FOR
NATIONAL BLACK NURSES ASSOCIATION ANNUAL NATIONAL CONFERENCE
ATLANTA, GEORGIA
August 12, 1999

Good afternoon. I am pleased to have this opportunity to join you at the Conference of the National Black Nurses Association. For more than two decades, you have been on the frontlines of American health care, leading the fight for nurses and for better care for all patients.

In clinics and waiting rooms, in ER's and OR's across America, nurses make millions of lives better each and every day. I know, because my mother was a nurse. When I was a boy, she used to bring me to the hospital to meet the other nurses and watch them on their rounds. I learned then that there is no substitute for a nurse's care – for your kind words, or your unique skills and expertise.

Since I became President, we have worked hard together and made great progress. We enacted the single largest investment in health care for children since 1965 ... ensured that patients will not lose their coverage when they change jobs ... and greatly increased the resources to combat and treat HIV and AIDS. We have also fought to ensure parity for the treatment of mental illness.

But there is more we must do. America needs a strong and enforceable Patients' Bill of Rights, including the right to see a specialist ... to emergency care whenever and wherever a medical emergency arises ... and to coverage for all Americans in HMOs. We must strengthen and modernize the Medicare program and provide all beneficiaries with the option of affordable prescription drugs. We must also continue to improve mental health treatment, strengthen prevention, and support research. I hope you will continue to speak out on these critical issues.

The unparalleled care that you give your patients makes America's health care system unmatched in the world. As we enter the 21st Century, I know we can count on you to ensure that our system is even stronger, and that all Americans have the health care they deserve.

Thank you and have a great conference.

32 Weekly Comp. Pres. Doc. 1067

Public Papers of the Presidents

Public Papers of the Presidents

June 18, 1996

CITE: 32 Weekly Comp. Pres. Doc. 1067

LENGTH: 2998 words

HEADLINE: Remarks to the American **Nurses** Association

BODY:

Thank you so much. You've made me feel welcome today. You've got my day off to a great start. And you have been a wonderful, wonderful friend and supporter of this administration in all the things we've tried to do to improve the health and welfare of the American people.

I want to begin by saying a special word of thanks to your president, Ginna Trotter Betts, for her 4 wonderful years as president of the American Nurses Association. [*Applause*] Thank you. I'll never forget the first time we met and talked about this. Al Gore said, you know, the president of the American Nurses Association is from Tennessee. He's shameless about things like that. [*Laughter*] And then we met, and I thought it was especially wonderful because she did not speak with an accent. [*Laughter*]

I want every American today to join with me in saluting your leadership on this 100th anniversary celebration. Our country has the finest health care system in the world, and nurses are the heart of that system.

As Ginna said, because of my dear mother, I know the hard work and the sacrifice that goes into your work. I want to thank you again for honoring my mother in 1994 with a special award in her name and for everything that you do. I learned from her, and America learns from nurses every day, the basic values that make this a great country. We know that the mission of our country should be to offer opportunity to every American, to demand in turn that every American take responsibility for making the most of that opportunity. That's the basic bargain of this democracy.

We know, too, that all of us have an obligation to see that we treat all responsible Americans with respect and with tolerance, to build a community out of all of our diversity. Today I ask for your prayers for the people who go to church in those churches that have been burned in the last year and a half and for your support for their right to worship and live.

I also want to thank you for the support you've given us in our attempt to change the course of affairs here in America and to deal with the real issues that affect the lives of real people. I sometimes wonder when people like you, who work and live every day all across America in the heartland and get up and try to make something good happen every day, when you come to Washington, it must be like visiting a foreign country from time to time. [*Laughter*] I think it would do more good if the people who work and write here in Washington had to go out and visit you more often. I think it would change their attitude about what really matters in life.

We've been at this business of trying to create opportunity and increase responsibilit), and strengthen our national community for 3 1/2 years now. There was a lot to be done 3 1/2 years ago. We had to get our economic house ill order. We had to reduce this terrible deficit and do it in a way that continued to invest in our people and their future. And when we passed that economic plan in 1993, there are those who said, "Well, this is a terrible thing. It will plunge the economy into recession. It's the worst thing in the world." It was a bitterly partisan fight; we prevailed by the narrowest of margins. Well, 3 1/2 years later we now can see whether they were right or we were right.

In 3% years, our economy has produced 9.7 million new jobs, 3.7 million new homeowners, 3 years of record increases in the number of small businesses, and the lowest combined rate of inflation and unemployment in 28 years. I believe we were right.

In 1994, we asked the Congress to take a serious approach to the crime problem, to get beyond rhetoric and partisan division and tough talk and to do something smart as well as tough on crime. We put 100,000 police on the streets, passed the Brady bill, passed the assault weapon ban, passed the Violence Against Women Act. There was a lot of bitter partisan rancor about it all, but we've now had a chance to see whether it works.

We are halfway through, almost, putting tile police on the street. Almost 60,000 people with criminal records have been denied the right to buy handguns under the Brady bill, which is a health issue, by the way, and an emergency room issue. We're enforcing the Violence Against Women Act, the "three strikes and you're out" act. We see that the assault weapon ban has worked to ban assault weapons but not take any sporting weapons away from the hunters and other sportsmen who were told that they were going to lose their weapons. We can see it now. We have had 3 years of declining crime in a row. We were right, and they were wrong. We did the right thing to pass the crime bill in 1994.

We have had 3 years now to evaluate the work of expanding Head Start and making college loans more affordable and passing the national service program. And we know that the more people we educate in America, the stronger our country will be and tile more people will be able to find good jobs and find other good jobs if they lose the ones they have.

And we know enough now to say that we ought to do more. We ought to give families a tax deduction for the cost of college education. And we ought to make 2 years of education free after high school, through tax credits for every American to go to community college.

Today, I want to talk with you about two other issues, about how we can reward opportunities -- increase opporttmities and reward responsibility and build a stronger conntry by improving health care and by strengthening the requirements that parents be responsible in the support of their children.

For 3 1/2 years, we have worked on these things as well. And even though we did not prevail in doing everything we've tried to do, I want you to know that I will never forget as long as I live the way the American nurses worked with the First Lady to try to give health care to all Americans. She is grateful for it, and so am I. [*Applause*] Thank you.

I thank you for standing with us when this administration became the first in American history to take on the tough issue of tobacco and the marketing of tobacco to young people. But we know -- we know -- notwithstanding some political voices who say this is no big deal and some people can deal with it and some can't, we know it is illegal to sell cigarettes to children in every State in the country. But every clay 3,000 underage Americans start to smoke, and 1,000 of them will have their lives ended prematurely because of it. That is something we know.

If we want to improve health care in America, why don't all those people who say that's what they want to do stand up and be counted and do what we need to do to restrict the advertising and marketing and sales of tobacco products to young people in this country? That's what we ought to do.

Let's not forget what has been done. As Ginna said, we did pass the Family and Medical Leave Act to say if you take a little time off to care for a sick child or a sick parent, you won't lose your job. It's amazing to me there are still some of the people who voted against the family and medical leave law defending their vote and saying they did the right thing to oppose it. Well, I think it was right to pass it, and a lot of American families think so, too. I never go into a big crowd of families very rarely that somebody doesn't come up to me and say, "I took advantage of the family and medical leave law."

The other day we had, in the White House, 50 families from 50 States who are participating in the Children's Miracle Television Network with all the chilclren's hospitals in the country, these desperately ill children and their hard-working parents, almost all of them middle class people. And two families came up to me on the way out of the room and said, "I do not know what I would have done if tile family and medical leave law had not been passed. I kept my job and took care of my child."

There's also some things that we have stopped from happening that you deserve a lot of credit for. I sometimes think that the majority in this Congress has forgotten the first rule of health care: first, do no harm. We have fought to slow the rate of inflation in Medicaid while preserving its fundamental guarantees. For three decades, the United States has guaranteed that poor children and pregnant women, people with disabilities, and older Americans will not be denied health care simply because they cannot afford it. That is the right thing to do.

The majority in Congress is actually insistmg that we repeal this guarantee. I have said and I believe this would amount to child neglect for a whole generation. That's why I vetoed that plan last year. If they send it to me again, I will veto it again.

Working with you, we have fought to balance the budget ill a way that protects Medicare and honors our duty to our parents. Let me remind you that we have cut the deficit by more than half. We added time to the Medicare Trust Fund, and we're attacked by the now congressional majority for doing it.

But their proposal for Medicare would undermine our ability to hire and train nurses, would close down more hospital wings in cities and rural communities. Of course, we have to slow the rate of inflation in Medicare. My plan will secure the Medicare Trust Fund for a decade without imposing unduly high premiums on low-income seniors and without wrecking the delivery system. That is, after all, what we have to preserve if we want people to have good health care in the first place.

And while we're doing no harm, why don't we do a little good? [*Laughter*] We are working with you to improve health care access to as many as 25 million Americans by fighting for the Kassebaum-Kennedy health care bill. No worker should have to worry about losing health care if he or she loses a job. And no one should be denied health care simply because they or someone in their family has a preexisting condition.

I am working hard with the Congress, and I do want to say that I am encouraged that there are people in both parties who support the Kassebaum-Kennedy bill. In its purest form, it passed the Senate 100 to 0. All we have to do now is to get together and pass the bill, pass a good bill. I believe we can do it. I am working with tile leadership in both parties to do it. But I want you to leave this town only after you have given a clear signal to Congress: Pass this bill now. [*Applause*] Thank you.

And while we're at it, one other thing we could do that would really help millions of working families is to raise the minimum wage now. And I hope we will do that. I am doing everything I can to increase opportunity for the American people, but as I said, we all know that the basic bargain in America is opportunity in return for responsibility.

We also know that where our children are concerned, the most important of America's building blocks is not a strong Government but a strong family. It is parents who must love their children and take responsibility for them. That has been the driving principle behind my efforts to reform welfare as we know it. I believe the present system perpetuates a cycle of dependency and irresponsible behavior. But I also know, having spent time in welfare offices as a Governor, that nobody wants to reform this system more than the people who are trapped in it. I want a system that promotes work, strengthens

families, and encourages independence. That's why I have proposed time limits and work requirements but also child care and health care to help people move from welfare to work.

The majority in Congress often criticizes me for vetoing a bill they called welfare reform. Well, I did. I did it because it was too tough on kids and too light on work. I asked them to do better. And if they'll do better, I'll be happy to sign welfare reform legislation. Meanwhile, we will continue to reform welfare with or without congressional action.

We have worked to cut redtape for 40 of the 50 States by approving 63 welfare reform experiments. Just today, we approved a waiver for a welfare reform effort in New Hampshire which combines strong work requirements with incentives to move people from welfare to work. I have received an intriguing proposal from Wisconsin which has tough time limits but actually gives assurances -- assurances -- of a job and health care and child care to people on welfare. And I expect to approve that request soon.

What you need to know, all of you, is that for three out of four Americans on welfare, the rules have already changed. Seventy-five percent of the families in this country on welfare are already under welfare reform experiments approved by our administration and devised at the State and local level. That is one big reason that today there are 1.3 million fewer people on welfare than the day I took the oath of office as President of the United States.

The food stamp rolls are also down. The poverty rate is down. Teen pregnancy rates have leveled off and are actually dropping some. Work and training among welfare recipients are up. Child support collections have reached a record high. But we must do more to insist on more parental responsibility. Our proposals are about giving people more opportunity and demanding more responsibility. And I reject the idea that when it comes to welfare it is only the mother who has to act responsibly. That is a false statement.

For too long we have let the men off the hook. We must insist that they do their part to support the children that they help to bring into this world. I wonder how many times nurses in this audience have seen a frightened young girl give birth to a baby alone in a hospital with the father nowhere to be seen. How many times has the hospital and the Government been left to pay the cost not only for the delivery but for the continuing care of the child? Well, two people are required to bring a child into this world, and two should help to raise the child.

Last year, I signed an Executive order that cracked down on the requirements for Federal employees to pay their child support. Three years ago, I signed a law requiring States to establish hospital-based programs to determine the father of a newborn child. Based on our first reports, more than 200,000 fathers have been identified through these voluntary hospital paternity identification programs. That's 200,000 children whose fathers can't just up and walk away. And child support collections and paternity establishments have increased by 40 percent since 1992. I am proud of that, and you should be as well.

But we have to do more. That's why, earlier today, I took executive action to strengthen child support enforcement and promote parental responsibility. First, we're putting in place a new national program to help States track parents who owe child support across State lines. Today too many parents get out of paying child support by moving from job to job, from State to State. This must stop.

Currently, 25 of our States require that when a person is hired for a job a check be made to see if he owes child support. Under this new program, we will check that information against our national database to catch deadbeats who have crossed State lines. I want every State in the country, the other 25, to give us this information so that these people who do not pay their child support have nowhere to hide.

Today I also directed the Department of Health and Human Services to require mothers who apply for welfare to provide the name of the father and other identifying information when they apply for assistance and before they get the benefits. Of course, there must be good-cause exceptions, such as those required to protect mothers from the dangers of violence against women. And we will require

the welfare office to contact child support authorities within 2 days, once we get this information, to begin legal proceedings to hold fathers responsible for support.

This is important. Our system should say to mothers: If you want our help, help us to identify and locate the father so he can be held accountable as well. And it should say to fathers: We're not going to let you just walk away from your children and stick the taxpayers with the tab. The Government did not bring the child into the world; you did. Our people will help to take responsibility for those children, but you have to do your part as well. We have to make responsibility a way of life, not an option, when it comes to raising children in the United States.

So let me say again to you, I thank you for the giving, nurturing work you do. We would not have a health care system without you. America wouldn't be what it is without you. I thank you for demonstrating responsibility at work and, for most of you, at home as well throughout your lifetime. I ask for your continued support as we try to not only protect but to advance the cause of health care in this country. We must not rest until we have made health care accessible and affordable to every single American citizen. But we must also say to every American citizen, you ought to be as responsible in your life every day, as the nurses of America are in their lives.

This country works with opportunity and responsibility; we cannot have one without the other. And if we're going to build an America that will be the world's leading source of peace and freedom and prosperity in the 21st century, if we're going to keep the American dream alive for all of us, we have to have both those things. You embody it ill your life. We're trying to embody it in the policies we advocate. And I ask for your continued support. You've made me very happy, personally, here today, but you make me very proud to be President of an America with people like you. Let's keep fighting to make it better.

Thank you, and God bless you all.

NOTE: The President spoke at 12 noon at the Washington Convention Center.

LANGUAGE: ENGLISH

LOAD-DATE: July 18, 1996

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Final 09/07/99 9am
Joel Johnson/ Paul Glastris

PRESIDENT WILLIAM J. CLINTON
VIDEOTAPED REMARS FOR AFL-CIO'S
"WORKING FAMILY CONVOCATION" CONVENTION
LOS ANGELES, CA
October 9, 1999

It's a pleasure for me to welcome you to the AFL-CIO's Community Convocation in Los Angeles. By joining together, you embody the bedrock values of the American labor movement, and of America itself – opportunity for all, responsibility from all, and a community of all.

One of Labor's most enduring values is the commitment of union workers not just to each other; but to something larger. Not just to strengthening union families, but making every family stronger. Not just struggling for workplace rights, but for civil rights at home, and human rights abroad. Not merely securing fair wages for union members, but ensuring a decent minimum wage for others. Not just defending hard-won health and retirement benefits for union families, but fighting just as hard for the health and welfare of those who aren't as fortunate.

That is why your values -- and your voices – are so critical at this critical moment. After six and a half years of working together, we have turned our nation around and created the longest peacetime expansion in our history. The lowest unemployment rate in 29 years. Wages rising for all income levels. And sky high federal deficits transformed into record-high surpluses.

I believe we must use this moment to secure our long-term prosperity – by paying off the debt for the first time since 1835, to keep interest rates low; by bringing new investment to areas still untouched by our recovery; and by raising the federal minimum wage. We must meet the challenges of the aging of America by saving Social Security, and strengthening and modernizing Medicare with prescription drug. We must give health care patients the fundamental rights they deserve. And we must meet the challenges of educating the largest, most diverse generation of children in history the children of the Baby Boom, with more and better prepared teachers, smaller class sizes, modernized schools connected to the Internet, and proven strategies for turning around schools that aren't working. And when we have met these fundamental obligations, we can still have significant tax cuts for working Americans.

But, the majority in Congress has other ideas. They have passed a bloated tax plan that would put at risk everything we have worked for together. It would not strengthen Social Security or Medicare. And it would jeopardize our future by forcing crippling cuts in health care, in and education, and other vital priorities.

I need your voices to be heard in this debate now.

A century ago, the men and women of labor worked for—and sometimes bled and died for—a more prosperous and secure life for children, the elderly, and working families. Now, it is our generation's turn to make our voices heard.

Thank you for coming together in Los Angeles. Thank you for the support you've shown in the past. Thank you for caring about the America we are building for the future.

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release February 9, 2000

REMARKS BY THE PRESIDENT
ON PATIENTS' BILL OF RIGHTS
UPON DEPARTURE

The South Lawn

8:46 A.M. EST

THE PRESIDENT: Good morning. Before I leave, I'd like to say a few words about the Patients' Bill of Rights legislation. A House and Senate conference will take it up beginning tomorrow. My message is simple and straightforward. Congress should seize this moment of opportunity to do what is right for the health of American family. To seize this moment to stand with doctors, nurses, and patients, to restore trust and accountability in our health care system.

Last Fall the House of Representatives passed by a large margin a strong, enforceable Patients' Bill of Rights. The legislation, sponsored by Congressman Norwood and Dingell, says you have the right to the nearest emergency room care. The right to see a specialist. It says you have the right to know you can't be forced to switch doctors in the middle of treatment. The right to hold your health care plan accountable if it causes you or a loved one great harm. And it covers all Americans in all health plans.

Now this bill is in the hands of House and Senate conferees. It reflects the beliefs and represents the needs of the overwhelming majority of the American people without regard to party. It has the endorsement of over 300 health care and consumer groups. It has the votes of 275 members of the House of Representatives, including 68 Republicans. Although I remain concerned that the conferees on the bill do not share the majority's view, I believe nevertheless they have a clear responsibility to ratify these fundamental rights. To put politics aside and pass a strong, enforceable Patients' Bill of Rights.

Americans who are battling illnesses shouldn't have to battle insurance companies for the coverage they need. Passing a real Patients' Bill of Rights for all Americans in all health plans is a crucial step toward meeting our goal in the 21st Century of assuring quality, affordable health care to all our citizens. I ask the House and Senate conferees to take the next vital step.

Thank you.

Q Mr. President, what are you doing about the daily bombing of Lebanon?

THE PRESIDENT: Well, let me say, we are doing our best to get the peace process back on track. I think it is clear that the bombing is a reaction to the deaths, in two separate instances, of Israeli soldiers. What we need to do is to stop the violence and start the peace process again. We're doing our best to get it started. And we're working very, very hard on it.

Q Mr. President, are you monitoring the situation with the hackers who have been disrupting some of the main web sites around the country the past few days? Are you monitoring that situation? Is there anything that Washington could possibly do about this?

35 Weekly Comp. Pres. Doc. Pg. 1958

Public Papers of the Presidents

Public Papers of the Presidents

October 7, 1999

CITE: 35 Weekly Comp. Pres. Doc. Pg. 1958

LENGTH: 1000 words

HEADLINE: Remarks on House Action on **Patients' Bill of Rights** Legislation and an Exchange With Reporters in New York City

BODY:

The President. This afternoon the House of Representatives took an important and encouraging step in the effort to give the American people a real **Patients' Bill of Rights.** After rejecting watered-down legislation by substantial votes, the House voted by a large margin to approve a strong bipartisan **Patients' Bill of Rights,** sponsored by Congressmen Norwood and Dingell.

The passage of this bill represents a major victory for every family and every health plan. It says you have the right to the nearest emergency room care and the right to see a specialist. It says you have the right to know you can't be forced to switch doctors in the middle of a cancer treatment or a period of pregnancy. And it says you have the right to hold your health care plan accountable if it causes you or a loved one grave harm.

It shows that America is no longer willing to allow unfeeling practices of some health plans to add to the pain of injury or disease. It proves that America is committed to putting patients first.

But let me be clear: We still have a lot of work to do before this bill becomes the law of the land. When the House and the Senate negotiators meet, we must be sure the bill is paid for, and when they meet in conference, the Republican leaders must resist the urge to weaken the patient protections guaranteed in the Norwood-Dingell bill, and they must not undo behind closed doors what has been done in the public. They must also resist the urge to load up the final legislation with poison pill provisions that they know I can't sign.

But today, let's just congratulate the Members of both parties in the House of Representatives for making a responsible choice in the face of significant pressure to do otherwise.

I especially thank Congressman Norwood and Congressman Dingell for their leadership and for their dogged determination. We have shown once again that, when we work together across party lines, we can use this moment of prosperity to meet the greatest needs of the American people.

Thank you very much.

Q. Sir, what do you think made the difference? Yesterday you were almost conceding defeat.

The President. I think a lot of work was done by a lot of people, but I think in the end, most people just went up there and voted for what they thought was right. Now, you know, there's kind of an

Press Journal (Vero Beach, FL)

June 14, 2000, Wednesday

SECTION: Indian River County; Pg. A9

LENGTH: 127 words

HEADLINE: NEW **ANESTHESIA** RULE HAS SOME UP IN ARMS

BODY:

Certified registered nurse anesthetists have been providing high-quality anesthesia care to all Americans, young and old for more than a hundred years.

The "new study" quoted by medical doctor anesthesiologists does not truly look at anesthesia-related problems. Under Florida statutes that presently control anesthesia practice, the Health Care Finance Administration ruling would have no effect on the way anesthesia is administered. Nothing will change. The new ruling applies to reimbursement, in other words, dollars.

This is what has the medical doctor anesthesiologists up in arms. The new rule simply allows individual states to decide for themselves.

Robert Albeck

Certified registered

nurse anesthetist

Boca Raton

LOAD-DATE: June 14, 2000

The Houston Chronicle

View Related Topics

June 12, 2000, Monday 3 STAR EDITION

SECTION: A; Pg. 18

LENGTH: 333 words

HEADLINE: ANESTHESIA;
Removing supervision likely to increase death rate

SOURCE: Staff

BODY:

The Health Care Financing Administration will be making a terrible mistake if it removes the federal requirement in Medicare- and Medicaid-approved hospitals that physicians supervise nurse anesthetists during surgical procedures.

For the past 35 years the law regarding Medicare has required that nurse anesthetists be supervised by anesthesiologists or surgeons. Supervision meant safety.

If HCFA removes this supervisory requirement, death rates of senior citizens undergoing surgery are likely to increase, along with related recovery complications.

A recent study at the University of Pennsylvania involving more than 65,000 Medicare patients in 219 hospitals found a 28 percent higher death rate and a 21 percent higher failure-to-rescue rate when an anesthesiologist was not involved in supervising the nurse anesthetist.

Nurse anesthetists do a good job, but they are not doctors. They complete a 24-month to 30-month training program after nursing school. But nurse anesthetists do not have the training or the medical insight of surgeons or anesthesiologists, who have finished college, four years of medical school and four years of residency.

Less than two decades ago, deaths during anesthesia in the United States amounted to 1 in 10,000. Today it has been reduced to 1 in 250,000 procedures.

HCFA's proposed rule change is opposed by most national medical societies, including the American Society of Anesthesiologists, The American Medical Association, the American College of Surgeons and state medical societies in all 50 states.

The HCFA should not rush to change the rule on supervision. Bipartisan bills have been introduced in the U.S. House and Senate to require HCFA to conduct a study of mortality rates and medical outcomes before changing the supervisory requirement.

Before making the change, the government must be sure that nurse anesthetists can perform as safely without supervision as they do under the supervision. Patients lives are at stake.

Albuquerque Journal

May 11, 2000, Thursday

SECTION: Pg. 1

LENGTH: 746 words

HEADLINE: Anesthesia change upsets some doctors

BYLINE: Gayle Geis O'Dowd Journal Staff Writer

BODY:

Medicare rule would remove supervision

A proposed change in Medicare rules that would allow nurse anesthetists to operate more independently has doctors in that business suggesting it might lessen patient safety.

The federal agency that oversees Medicare later this summer may allow certified registered nurses to administer anesthesia to patients over 65 without the direct supervision of a doctor.

The change would raise the authority of nurse anesthetists to that of physician anesthesiologists who work "collaboratively" with surgeons in an operating room. Instead of following direction from a surgeon or anesthesiologist, nurse anesthetists would be in a position to advocate different forms of anesthesia care.

Physician anesthesiologists say they have no idea why the Health Care Financing Administration wants to remove physician involvement or why the agency wants to do it without studying safety concerns, said Randall Maydew, a doctor at Anesthesia Specialists of Albuquerque, which doesn't use nurse anesthetists.

"We have been trying for the last two years to ask them (the federal agency) for an outcome study," he said.

What nurse anesthetists learn in nursing school pales in comparison with what a doctor learns in medical school, said Jane Fitch, an anesthesiologist in Texas, who also was a nurse anesthetist.

Gerald Sanford, a board member of the New Mexico Association of Nurse Anesthetists, said worries over safety are unfounded.

And if nurse anesthetists are allowed to work independently, they would be more in line with other advanced-practice nurses, such as family and pediatric nurse practitioners, he said.

Chris Peacock, spokesman for the Health Care Financing Administration, said the agency is aware of safety concerns by anesthesiologists, but the agency feels it is protecting patient care by deferring to states on this issue.

He said about 20,000 comments have been made to the agency arguing all sides of the issue including safety and that states will have the final say.

The change, if made, still would defer to New Mexico law, which requires that nurse anesthetists work under the direction of physicians.

But nurse anesthetists in New Mexico plan to ask the state Legislature in January 2001 to allow them to practice without direct physician supervision, Sanford said.

Fitch said the federal agency's plan to turn the decision over to the states would create a patchwork of state requirements.

"I don't want to have to worry about what state my parents are in if they need care," Fitch said.

The change won't save the federal government or Medicare beneficiaries any money, Maydew said, because payments are about the same for anesthesiologists and for nurse anesthetists working under a surgeon.

The difference will be in where the money goes. If the nurse anesthetist is directed by an anesthesiologist, the payment is split between the two, said Lynda Venters, executive vice president of Anesthesia Associates of New Mexico.

If nurse anesthetists worked without direct supervision, they would get the entire payment, she said.

The federal agency, which proposed the change in December 1997, believes there has been significant time for public comment and studies on this, Peacock said.

Some seniors have voiced their concern, too, Maydew said. Four out of five Medicare beneficiaries polled oppose eliminating physician supervision, according to the American Society of Anesthesiologists.

Anesthesiologists want Congress to require the Health and Human Services Department to study outcome rates to determine the safety of Medicare patients under the care of nurse anesthetists. Bills were introduced in the Senate and House of Representatives in early 1999 but remain in committees.

"We feel very confident that science will show that anesthesiologists are needed," said Douglas Brown, an anesthesiologist in Maydew's group.

Sanford said he doesn't know of any study that has shown a significant difference in patient safety.

Most Albuquerque hospitals use nurse anesthetists as long as they are directed by an anesthesiologist. Officials for University, Presbyterian and Lovelace hospitals said they don't plan to change their policies at this point.

St. Joseph Healthcare doesn't use nurse anesthetists because of its contract with Maydew's group. Any change would be decided with that partner, said Ellen Interlandi, associate vice president of clinical services.

LANGUAGE: ENGLISH

LOAD-DATE: May 11, 2000

British Medical Journal

April 8, 2000

SECTION: No. 7240, Vol. 320; Pg. 959 ; ISSN: 0959-8146

IAC-ACC-NO: 62193666

LENGTH: 688 words

HEADLINE: Unsupervised **nurses** may soon give **anaesthetics** in United States; News; Statistical Data Included; Brief Article

BYLINE: Josefson, Deborah

BODY:

Nurse anaesthetists in the United States may soon be able to give anaesthetics to some patients without the supervision of a doctor.

After deliberating for more than two years, the Health Care Financing Administration, which provides health insurance to an estimated 74 million Americans through the Medicare, Medicaid, and State Children's Health Insurance Program, has announced that it will remove the requirement that all nurse anaesthetists who provide anaesthesia to Medicare patients must be supervised by a physician.

Until now, when anaesthesia was administered to patients with Medicare, nurse anaesthetists had to be supervised by physicians in order for hospitals and ambulatory surgery centres to be reimbursed for the non-anaesthesia portion of the care.

This rule has been in effect since 1966 when the Medicare programme was established. The agency first proposed changing the rule in December 1997. Under the proposal, individual states will have the authority to decide whether nurse anaesthetists should be supervised or not.

The announcement was met with alarm by anaesthesiologists (physicians or dentists who specialise in anaesthesiology), who fear that a lack of supervision by physicians will compromise the quality of care, however, it was supported by nurse anaesthetists, who contend that certified nurse anaesthetists deliver safe, high quality anaesthesia on a par with that of anaesthesiologists but at lower cost.

Certified registered nurse anaesthetists are advanced practice nurses with graduate level education. According to the American Association of Nurse Anesthetists, they deliver about 65% of the 26 million episodes of anaesthesia in the United States and most of the anaesthesia in rural areas.

Over the past two years, the association has lobbied the agency for the passage of the rule, emphasising that advances in monitoring equipment, pharmaceuticals, and anaesthesia education have greatly improved safety. For instance, 20 years ago, there was I death for every 10000 people who had anaesthesia, while today the death rate is 1 in 240 000.

Dr Ronald Mackenzie, president of the American Society of Anesthesiologists, agreed that the safety of anaesthesia has improved greatly but pointed out that this level of safety was achieved only with the involvement of anaesthesiologists. He criticised the agency's, decision and indicated that a recent but as yet unpublished study involving 65 000 Medicare patients in 219 hospitals in Pennsylvania had found that there was a 28% higher death rate among patients receiving anaesthesia care from unsupervised certified registered nurse anaesthetists.

The association and other doctors are lobbying Congress to pass a bill, the Safe Seniors Assurance Study Act of 1999, which will reverse the agency's decision. It has also called for a national study comparing the safety outcomes of the two groups but because of the scarcity of complications overall the undertaking was deemed to be too costly by the Centers for Disease Control in 1990.

Moreover, in 1994 a study by the Minnesota Department of Health found that there were no studies, either national or specific to Minnesota, that conclusively found a difference in outcomes of patient care when anaesthesia was delivered by either of the two types of providers.

The Health Care Financing Administration claims that its proposal will not affect the quality of care but only defer the scope of practice to states. Dr Mackenzie, however, argues that since Medicare is a national programme, national standards should apply.

"This is about people, not government. It is about patients' rights, not states' rights: the right of Medicare beneficiaries in every state to the best available medical care during anaesthesia.

"If the [Health Care Financing Administration's] proposal is approved, Medicare patients would be subjected to potentially 50 different levels of anaesthesia care in this country not only [according to] where they live but where they may travel [to] as well," Dr Mackenzie said.

Deborah Josefson San Francisco

LANGUAGE: ENGLISH

IAC-CREATE-DATE: May 22, 2000

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March 18, 2000

SECTION: No. 7237, Vol. 320; Pg. 785 ; ISSN: 0959-8146

IAC-ACC-NO: 61522848

LENGTH: 3679 words

HEADLINE: Anaesthesiology as a model for patient safety in health care; Education and Debate; Statistical Data Included

BYLINE: Gaba, David M

BODY:

Although anaesthesiologists make up only about 5% of physicians in the United States, anaesthesiology is acknowledged as the leading medical specialty in addressing issues of patient safety.[1] Why is this so?

Firstly, as anaesthesia care became more complex and technological and expanded to include intensive care it attracted a higher calibre of staff. Clinicians working in anaesthesiology tend to be risk averse and interested in patient safety because anaesthesia can be dangerous but has no therapeutic benefit of its own. Anaesthesiology also attracted individuals with backgrounds in engineering to work either as clinicians or biomedical engineers involved in operating room activities. They and others found models for safety in anaesthesia in other hazardous technological pursuits, including aviation.[2 3]

Secondly, in the 1970s and '80s the cost of malpractice insurance for anaesthesiologists in the United States soared and was at risk of becoming unavailable. The malpractice crisis galvanised the profession at all levels, including grass roots clinicians, to address seriously issues of patient safety. Thirdly, and perhaps most crucially, strong leaders emerged who were willing to admit that patient safety was imperfect and that, like any other medical problem, patient safety could be studied and interventions planned to achieve better outcomes.

Accomplishments in patient safety in anaesthesiology

Anaesthesia: safer than ever

It is widely believed that anaesthesia is much safer today (at least for healthy patients) than it was 25 or 50 years ago, although the extent of and reasons for the improvement are still open to debate. Traditional epidemiological studies of the incidence of adverse events related to anaesthesia have been conducted periodically from the 1950s onwards.[4-6] Many of these studies were limited in scope, had methodological constraints, and cannot be compared with each other because of differing techniques. An important outcome has been the emergence of non-traditional investigative techniques that aim not to find the true incidence of adverse events but to highlight underlying characteristics of mishaps and to suggest improvements in patient care.

Such techniques have included the "critical incident" technique adapted by Cooper from aviation.[2 7]; the analysis of closed malpractice claims[8]; and the Australian incident monitoring study (AIMS).[9-12] These approaches analyse only a small proportion of the events that occur but attempt to glean the maximum amount of useful information from the data.

Technological solutions

Once the range of patient safety problems in anaesthesiology had been defined, several strategies have been used to improve safety. One is to apply technological solutions to clinical problems. Anaesthesiologists have become expert at realtime monitoring of patients (both electronically and via physical examination). In the industrialised world electrocardiography, pulse oximetry, and capnography (analysis of carbon dioxide in exhaled gas) have become standards and are thought to have contributed substantially to safety. No study to date, however, has had sufficient power to prove an outcome benefit from the use of these technologies.[13] Another technological strategy is the use of "engineered safety devices" that physically prevent errors from being made. There are many of these in anaesthesiology, but a classic example is the system of gas connectors that prevent a gas hose or cylinder from being installed at the wrong site.[14]

New technologies have also been developed for managing the patient's airway, resulting in a plethora of useful devices. In particular, the adoption of fibreoptic laryngoscopy has revolutionised the management of patients with known anatomical difficulties in endotracheal intubation, and the laryngeal mask airway has secured important niches in both routine and emergency airway management.

Standards and guidelines

A second strategy adopted by anaesthesiologists in the United States in the 1980s was the promulgation of "practice parameters" (standards and guidelines) developed to provide guidance or direction for the diagnosis, management, and treatment of specific clinical problems.[15] The first set of standards for basic monitoring was developed by the Harvard hospitals,[16] and similar ones were later adopted by the American Society of Anaesthesiologists. These standards included such basic requirements as the continuous presence of a qualified anaesthetist, the use of electrocardiographic monitoring, and assessment of ventilation. The standards have since been updated to require pulse oximetry for patients during anaesthesia of all types and during post-anaesthesia recovery, as well as the use of capnography during general anaesthesia.

The monitoring standards, though voluntary, are thought to have been effective in ensuring that these basic practices are followed and represent a de facto standard of care. They have also been matched by similar standards in other countries. Other standards from the society with important implications for patient safety have dealt with the management of the difficult airway, sedation and analgesia by non-anaesthesiologists, and office based anaesthesia.

Human factors and the systems approach to patient safety

Anaesthesiologists have also been leaders in applying techniques and lessons from human factors engineering and the systems approach to safety. Analysis of anaesthesiologists' tasks dates back nearly 30 years[17] and has grown in sophistication.[18] Investigators have analysed the decision making processes in anaesthesiology with various methods, including direct observation,[19] review of videotapes of real cases,[20] assessing the descriptions of cases presented at morbidity and mortality meetings, and the use of patient simulators.[21] Much of the work has been conducted by academic anaesthesiologists who adopted the techniques of the human factors field. This "inside out" approach--in which the practitioners are also the researchers--has been powerful both for generating knowledge and for generating a cadre of safety

experts. These "insiders" have also succeeded in generating interest among a number of well known "outside" human factors researchers--most of whom develop close links with anaesthesiologist collaborators.

Anaesthesiologists have been leaders in looking at safety from the standpoint of systems as well as individuals. In 1987 the work of Charles Perrow on systems issues in accidents was applied to anaesthesiology,[3 22] and, soon after, the work of James Reason on the latent error model systems accidents was incorporated.[23 24] In 1990 the Anaesthesia Patient Safety Foundation and the US Food and Drug Administration sponsored a groundbreaking expert workshop on human error in anaesthesiology. This brought together experts in human performance, human error, and organisational safety and experts on error and safety in anaesthesiology. Currently, anaesthesiologists are also involved in considering the theory of high reliability organisations (see article by Reason, p 768) as a model for performing highly hazardous activities with very low failure rates.

Applications of patient simulation

Anaesthesiologists have been pioneers in developing and applying patient simulators for research and training (see box and figure). Helmreich's article (p 781) deals with some of the simulation based, teamwork oriented training in more detail.

[Figure ILLUSTRATION OMITTED]

Patient safety in anaesthesiology--a glass only half full

Anaesthesiologists are justly proud of how their profession has acknowledged and begun to tackle tough issues in patient safety. The glass of patient safety in anaesthesiology, however, although fuller than in other healthcare fields, is still only half full:

* The overall reduction in negative outcomes that are related to anaesthesia may not be as great as the purported drop in mortality resulting from anaesthesia alone for healthy patients having routine surgery. Errors, mistakes, and system failures continue to plague anaesthesiology as well as the other healthcare fields

* Death or brain damage still occurs from hypoxaemia after oesophageal intubation or from other easily detectable and correctable events, even when modern monitoring technologies are in place

* The most basic standards are not followed uniformly--reliable anecdotes persist of anaesthetised, paralysed, and ventilated patients being left without an anaesthetist in the room, even in reputable hospitals

* Advanced simulation training is available only to a tiny minority of anaesthetists, and no certification requirement exists for continuing skills training or performance assessment

* Clinicians still practise when fatigue, illness, or stress prevent them from performing optimally

* Even modern equipment remains beset by human error; knowledge levels and training of clinicians about equipment remain suboptimal.

* It is therefore important to recognise that the various safety advances that have been made in anaesthesiology are an important model for the rest of health care, but they remain a work in progress and

will require long term commitment to achieve their full promise.

Institutionalisation of safety

In the long term the most important contribution of anaesthesiology to patient safety may be the institutionalisation and legitimisation of patient safety as a topic of professional concern. The formation in 1985 of the Anesthesia Patient Safety Foundation was a landmark. Unlike other professional trade organisations, such as the American Society of Anesthesiologists, the foundation can bring together many constituencies in health care that may well disagree over economic or political issues but which all agree on the goal of patient safety.

The foundation has several prominent activities. Its quarterly newsletter is mailed to every anaesthesiologist and nurse anaesthetist in the United States. The newsletter is currently the pre-eminent publication in the world on anaesthesia and patient safety and is thought to have the widest circulation of any publication in anaesthesiology. The foundation also runs a programme of research grants, which has funded many important projects that would probably never have been funded by a "traditional" agency. In the first 13 years of the programme, for an investment of about $ 1.5m (937 500 [pounds sterling]), 159 publications resulted directly or indirectly from such funding. Among the important topics of investigation have been patient simulation, human factors or human performance, outcome assessment, and the formation of carbon monoxide in the anaesthesia breathing circuit.

Yet the most influential outcome of the grants programme may be not the knowledge gained but the new cadre of investigators and scholars it has fostered by creating a source of funds and an intellectual home for individuals devoting their careers to patient safety. A similar story can be told for the Australian Patient Safety Foundation, whose relative influence has far exceeded the size of the Australian population.

Recently, the American foundation has taken a stand on several policy issues based on the principle of establishing a burden of proof regarding practices or policies that seem to deviate from existing norms. The foundation believes that in all cases the default policy should be the one that at face value seems to yield maximum patient safety (a "fail safe" approach). If clear and convincing data are presented showing that an alternative policy is equally safe, it can be adopted. In the absence of such data the apparently safer policy should prevail. The foundation has recently advocated, for example, that a single standard of safety for surgical and anaesthetic procedures should exist, whether these take place in a hospital, an outpatients unit, or a physician's office. The default assumption is that achieving this unified standard will require functionally equivalent organisational features including equipment, staff, emergency backup, and accreditation in each of the practice settings. The burden of proof to provide convincing data to overturn this assumption rests with those who believe that the physician's office can be a safe site for anaesthesia and surgery without these features.

It is no wonder that when the American Medical Association decided to create a National Patient Safety Foundation it did so in open imitation of the methods and success of the Anesthesia Patient Safety Foundation.[34] If the national foundation and other similar organisations throughout the world can replicate the cadre forming aspects of the anaesthetists' foundation (as well as its roles in education and research), patient safety in all areas of health care will probably make great leaps forward. None the less, this will only be achieved with hard work--the price of patient safety is eternal vigilance.

Summary points

Anaesthesiology is acknowledged as the leading medical specialty in addressing patient safety

Anaesthesia is safer than ever owing to many different types of solutions to safety problems

Solution strategies have included incorporating new technologies, standards, and guidelines, and addressing problems relating to human factors and systems issues

The multidisciplinary Anesthesia Safety Foundation was a key vehicle for promoting patient safety

A crucial step was institutionalising patient safety as a topic of professional concern

Although anaesthesiology has made important strides in improving patient safety, there is still a long way to go

Simulation for research and training

Anaesthesiologists pioneered the development of computer screen and mannequin based interactive patient simulators and also have created most of the training plans for their use.[25-33] Use of patient simulators has become widespread in anaesthesiology and has expanded into other areas.

Advantages of simulation for research, training, and performance assessment

* No risk to patients

* Many scenarios can be presented, including uncommon but critical situations in which a rapid response is needed

* Participants can see the results of their decisions and actions; errors can be allowed to occur and reach their conclusion (in real life a more capable clinician would have to intervene)

* Identical scenarios can be presented to different clinicians or teams

* The underlying causes of the situation are known

* With mannequin based simulators clinicians can use actual medical equipment, exposing limitations in the human-machine interface

* With full re-creations of actual clinical environments complete interpersonal interactions with other clinical staff can be explored and training on teamwork, leadership, and communication provided

* Intensive and intrusive recording of the simulation session is feasible, including audiotaping, videotaping, and even physiological monitoring of participants (such as electrocardiography or electroencephalography); there are no issues of patient confidentiality--the recordings can be preserved for research, performance assessment, or accreditation

Applications and target groups

* Education of students (high school and professional school in physiology, pharmacology, or physical assessment)

* Training for allied health professions

* Training of clinical students in routine procedures and specialty specific medical issues

* Training of junior doctors (residents) in routine procedures and in critical events

* Training of healthcare staff in crisis management

* Preprocurement assessment of clinical equipment

* Staff training in the use of clinical equipment

* Performance assessment of all grades of medical stall

* Research on decision making by clinicians on human-machine interactions and on factors that affect performance (such as fatigue)

The author is also professor of anaesthesia at Stanford University School of Medicine, Stanford, California.

Competing interests: The author is the secretary of the Anesthesia Patient Safety Foundation. He also licensed simulation technology to CAE-Link in 1992, for which he received a licence and royalties on the sale of patient simulators. He is also, periodically, a paid consultant to MedSim, the company that now owns the rights to the licensed simulation technology.

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"Difficulty, my brethren, is the **nurse** of greatness-a harsh nurse, who roughly rocks her foster-children into strength and athletic proportion."

- William Cullen Bryant (1794-1878)
- American poet, editor

"Faith in tomorrow, instead of Christ, is Satan's **nurse** for man's perdition."

- George Barrell Cheever (1807-90)
- Writer, author

"He who angers you conquers you."

- Sister Elizabeth Kenny (1880?-1952)
- Australian **nurse**, developed simple treatment for paralysis by poliomyelitis

"It's better to be a lion for a day than a sheep all your life."

- Sister Elizabeth Kenny (1880?-1952)
- Australian **nurse**, developed simple treatment for paralysis by poliomyelitis

"Live you life while you have it. Life is a splendid gift - there is nothing small about it."

- Florence Nightingale (1820-1910)
- English **nurse**, founder of modern nursing

"Volumes are now being written and spoken about the effect of the mind on the body -- I wish more was thought of the effect of the body on the mind."

- Florence Nightingale (1820-1910)
- English **nurse**, founder of modern nursing

"Solitude is the best **nurse** of wisdom."

- Laurence Sterne (1713-68)
- British writer, "Tristram Shandy"

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Displaying quotes **21** through **30** of **34** found matching **health** .
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"He who has **health** has hope; and he who has hope has everything."

- Arabian Proverb

"He who has **health** has hope; and he who has hope, has everything."

- Arabian Proverb

"We are usually the best men when in the worst **health**."

- English Proverb

"A man too busy to take care of his **health** is like a mechanic too busy to take care of his tools."

- Spanish Proverb

"Good friends are good for your **health**."

- Dr. Irwin Sarason
- psychologist, Univ. of Washington

"Use your **health**, even to the point of wearing it out. That is what it is for. Spend all you have before you die; and do not outlive yourself."

- George Bernard Shaw (1856-1950)
- Irish-born British playwright, founder "Fabian Society", Nobel

"Women with body image or eating disorders are not a special category, just more extreme in their response to a culture that emphasizes thinness and impossible standards of appearance for women instead of individuality and **health**."

- Gloria Steinem (b. 1934)
- American feminist, writer, founding editor "Ms." magazine

"Handguns are a public-**health** problem."

- Josh Sugarmann

"What is called genius is the abundance of life and **health**."

- Henry David Thoreau (1817-62)
- American writer, author, naturalist, "Civil Disobedience", "Walden"

"The great political tugs of the past 35 years have concerned the distribution of the golden eggs. In the 1980's and 1990's we must focus on the **health** of the goose."

- Paul Tsongas

Show Previous **11** through **20** Show Next **31** through **34**

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Friday, June 30, 2000

Health Care Quotes

Finally, a strong American cannot neglect the aspirations of its citizens—the welfare of the needy, the health care of the elderly, the education of the young. For we are not developing the nation's wealth for its own sake. Wealth is the means—and people are the ends. All out material riches will avail us little if we do not use them to expand the opportunities of our people.

-John F. Kennedy January 11, 1962

A nation's strength lies in the well being of its people.

-John F. Kennedy, 1961, *In reference to Social Security*

Millions of our citizens do not now have a full measure of opportunity to achieve and to enjoy good health. Millions do not now have protection or security against the economic effects of sickness. And the time has now arrived for action to help them attain that opportunity.

-Harry Truman

[This is] a cornerstone in structure which is being built but it is by no means complete.

-Franklin D. Roosevelt, 1935 *Remarks while Signing the Social Security Act.*

There is another tradition that we share today. It calls upon us never to be indifferent towards despair. It commands us never to turn away form helplessness. It directs us never to ignore or to spurn those who suffer untended in a land that is bursting with abundance.

-Lyndon B. Johnson, July 30 1965, *Remarks with President Truman at the Signing in Independence of the Medicare Bill.* In reference to the tradition of leadership from FDR, Truman, and Kennedy on the issue of health care.

Thou shalt open thine hand wide unto thy brother, to thy poor, to thy needy, in thy land.

-Deuteronomy 15:11

There are those, alone in suffering, who will now hear the sound of some approaching footsteps coming to help. There are those fearing the terrible darkness of despairing and poverty—despite their long years of labor and expectation—who will now look up to see the light of hope and realization

-Lyndon B. Johnson, July 30, 1965, *Remarks with President Truman at the Signing in Independence of the Medicate Bill.*

With health, everything is a source of pleasure; without it, nothing else, whatever it may be, is enjoyable...Health is by far the most important element in human happiness.

-Arthur Schopenhauer (1788-1860) "The Wisdom of Life", 1951