CONGRESSIONAL RECORD—SENATE

June 27, 2001

THE CHALLENGE OF BIOTERRORISM

Mr. AKAKA. Mr. President, I rise to address the threat of bioterrorism to our Nation’s security.

President Bush has asked Vice President Cheney to “oversee the development of a coordinated national effort so that we may do the very best possible job of protecting our people from catastrophic harm.” He also asked Joseph R. Biden, Jr., Director of the Federal Emergency Management Agency, FEMA, to create an Office of National Preparedness to implement a national effort.

On May 9, 2001, Attorney General Ashcroft testified before a Senate Appropriations subcommittee that the Department of Justice is the lead agency and in sole command of an incident while in the crisis management phase, even if consequence management activities, such as casualty care and evacuation, are occurring at the same time. Clearly, FEMA and the Department of Justice need to work together to shoulder the burden of responding to a large scale event. What is unclear, however, is how the Department of Justice will know that its crisis management skills are needed during a bioterrorism event.

Will a growing cluster of disease be recognized as a terrorist attack? How do we differentiate between a few individuals with the flu and a flu-like epidemic perpetrated by terrorists? When will it be called a crisis? When will the FBI or Justice be called in to handle the newly declared “crisis”? In the case of a bioterrorist attack, the response will most likely be the same as if it was a naturally occurring epidemic. The key question is not “how to respond to an attack” but “are we prepared to respond to any unusual biological event?”

What would happen if a bioterrorist attack occurred today? It would not be preceded by a large explosion. Rather, over the course of a few days or a couple of weeks, people would start to get sick. They would go to hospitals, doctor’s offices, and clinics. Hopefully, a physician in one hospital would notice similarities between two or three cases and contact the local public health officials. Maybe another physician would do the same and maybe, finally, the Center for Disease Control would be notified. So, the first responders would not be a Federal agency.

Across the country, local law enforcement, fire, HAZ MAT and emergency medical personnel are doing a tremendous job preparing and training for terrorist attacks, and I commend their efforts. But, in the scenario I described, they would not be our first line of defense. Instead, the first responders for a biological event would be the physicians and nurses in our local hospitals and emergency rooms. We need to ensure that hospitals and medical professionals are prepared to deal with this threat. This is not the case today.

This past November, emergency medical specialists, health care providers, hospital administrators, and bioweapon experts met at the Second National Symposium on Medical and Public Health Response to BioTerrorism. A representative of the American Hospital Association, Dr. James Bentley, spoke about the challenges hospitals are confronting and stated that “we have driven over the past twenty years to reduce flexibility and safeguards.” Flexibility and safeguards are exactly what is needed by a hospital to go from “normal” to “surge” operations. Surge operations do not require the extreme scenario of thousands of casualties from a bioweapon. Dr. Thom Mayer, chief of the emergency department at Inova Fairfax Hospital, was quoted in the Washington Post, on April 22, 2001, stating that 20 or 30 extra patients can throw an emergency department into full crisis mode.

J.B. Ogrenstein, an emergency room physician, in a recent Washington Post op-ed, wrote about the “State of Emergency” the dedicated men and women working in our hospitals and clinics are already facing with the added worry of bioterrorism. Until a year ago, hospitals dealt with surges for only a few days or a week a year during the winter flu, cold and icy sidewalk season. Now, mini-surges occur in the spring, summer and fall due to decreasing numbers of emergency rooms, beds available in any hospital, and qualified nurses. On May 9, 2001, the Society for Academic Emergency Medicine convened a special meeting in Atlanta to discuss “The Uncharted Safety Net.” Are we ready with all the planning and funding the Federal Government has done over the past few years to address terrorism, providing sufficient help for hospitals to shoulder the burden of responding to a biological event?

As Chairman of the Subcommittee on International Security, Proliferation and Federal Services, I am concerned that we are not addressing a fundamental problem. Would a biological event be a national security law enforcement incident with public health concerns, or would it be a public health crisis with a law enforcement component? I hope that the effort led by Vice
President Cheney will address specifically this question and that the unique problems biological weapons present are being addressed by any national plan to counter terrorism. I ask unanimous consent that the text of Dr. Orenstein’s article be printed in the RECORD. 

There being no objection, the article was ordered to be printed in the RECORD, as follows:

[from the Washington Post, April 22, 2001]

STATE OF EMERGENCY
(By J. B. Orenstein)

It’s a typical bad-day crowd in my ER: Here’s a wheezing baby who developed a blue spell in front of her panicked mom. This 62-year-old gentleman came in with chest pain 36 hours ago; his worrisome EKG and equivocal lab tests should have put him inside for observation, but there’s no room in the ICU so he’s been waiting here for 24 hours. This lady, razor sharp at 89, suddenly started acting “not right,” so her granddaughter brought her in the token three hours ago, but can’t get into treatment because chest-pain guy, blue baby and 18 other patients are parked in the treatment beds we’re not allowed to admit.

Our communications nurse just told an approaching ambulance to find somewhere else to take its potentially critical passenger because we had no place to put him. Not in the ER, not in an ICU, not even in a plain old bed in a ward. The official term for what’s happening here is “saturation,” but down in the pit this is known as a bottleneck.

And it’s happening too often, in more hospitals than ours. On May 9, the society for Academic Emergency Medicine will convene a special meeting in Atlanta on “The Unraveling Safety Net.” The meeting was called in December because panic buttons were being pushed in overcrowded E/Rs across the country—Boston, St. Louis, Chicago, New York. It was a medical version of the California power crisis, with our rolling blackouts coming in 45 minutes to an hour away of “diversion.”

Up until a year or two ago, we faced this nerve-racking logjam for only a few days or weeks in winter, when flu and cold viruses turn into potentially fatal pneumonias which fall prey to respiratory and intestinal viruses, depression fills the psych wards and slippery ice keeps the orthopedists busy. But now we’re seeing mini-surgeons in the spring, summer and fall as well.

When I started at Inova Fairfax Hospital in 1991, the ER treated 55,000 patients in the course of the year. Last year the number was 70,000. This is in keeping with the national picture. In 1988, there were 81 million visits to U.S. emergency rooms, according to the National Center for Health Statistics. The number for 1998: 104.1 million. Meanwhile, over the same decade, the number of emergency departments fell from about 5,200 to 4,600—too many bodies packed into a space built ages ago for a much smaller population.

But like most of the mess is more complicated than that. One very important factor is the total number of beds available in any hospital—particularly ICU beds. State and local health officials know that the number of beds based on a long list of factors: population, estimates of disease prevalence, average lengths of stay. In the early 1990s, conventional wisdom held that managed care would reduce the occupancy rate. To a significant extent, that happened, and in the mid-90s empty beds forced a number of underused hospitals to close. In 1990, according to the American Hospital Association, there were 927,000 staffed beds in 5,384 community hospitals in America. In 1999, the last year for which there are complete numbers, 4,956 such hospitals provided just over 829,000 beds. Meanwhile, the country’s population had grown by 10 percent.

Many of those vanished beds might have been superfluous anyway, due to a sweeping explosion in medical technology and therapeutics. Ten years ago, a heart attack kept a patient in the hospital for under nine days; by 1998, these folks were out the door in six. Stroke? The average length of stay was down by a half: 10 days to five. Home nursing and therapy freed countless patients from the confines of a hospital bed. But the hospital closings were uneven. In booming suburban areas such as Northern Virginia, there have been 75 new high-tech services and customer-friendly support at mega-hospitals like Inova Fairfax. But some smaller hospitals, like Jefferson Hospital in Loudoun County, found their beds chronically empty and had to close. (The planned shutdown of D.C. General’s inpatient facility is a result of forces pushing the opposite direction, resulting in too many unused beds.)

When hospitals close, it puts more pressure on those that survive. At Inova Fairfax, occupancy average annual emergency department volume rose from 15,500 to 21,800—that’s more than 50 percent.

In all of American medicine, the only place where quantity, but not quality, guarantees Americans the right to a physician, 24-7, is the emergency room. This is because of the 1986 “anti-dumping” law, the Emergency Medical Treatment and Labor Act, or EMTALA, which was enacted to force the Health Care Finance Administration and recently upheld by the U.S. Supreme Court, EMTALA is a civil right extended to all Americans, regardless of how much they can pay or pay. But even EMTALA protection for the American Hospital Association, told a Senate committee earlier this year. And men aren’t making it up for the shortfall. A marginally experienced nurse, last did floor work more than 10 years ago, and though conditions were tough enough then, may recall that what she would do if she went back now: More and sicker patients on an exponentially higher number of meds; less time getting to know the person who is the patient, and therefore less opportunity to catch early signs of deterioration; widespread use of “health techs”—people who take vital signs and dispense pills but have no training for more meaningful interaction.

No wonder students at nursing schools dread the first few years following graduation, because before they can get to the challenging, rewarding places to work, such as ERs or ICUs, they have to get experience on inpatient wards.

It’s crowding in those ICUs that puts the wheels in motion. The pressure on the already sophisticated environment of the ICU, a patient’s heart rate or blood pressure can be fine-tuned with an shift of an IV drip. A plethora of monitors record the patient’s physiological trends to answer the question, “Is this person getting better or worse?” When a patient requires this moment-by-moment monitoring and all ICU beds are filled, the only place we can perform the same level of care—is the ER. This ties up our nurses and blocks the bed from the next guy waiting to get in.

And chances are, that next guy is in pretty bad shape. Most people who come to the ER want a home delivery of nebulous high-techs, pampered in a sophisticated environment of the ICU, a patient’s heart rate or blood pressure can be fine-tuned with an shift of an IV drip. A plethora of monitors record the patient’s physiological trends to answer the question, “Is this person getting better or worse?” When a patient requires this moment-by-moment monitoring and all ICU beds are filled, the only place we can perform the same level of care—is the ER. This ties up our nurses and blocks the bed from the next guy waiting to get in.

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OPENING STATEMENT
Mr. HELMS. Mr. President, at the close of business yesterday, Tuesday, June 26, 2001, the Federal debt stood at $5,656,750,181,308.17, five trillion, six hundred fifty-six billion, seven hundred fifty million, eighteen dollars and thirty-seven cents.

One year ago, June 26, 2000, the Federal debt stood at $5,647,619,000,000, five trillion, six hundred forty-seven billion, six hundred nineteen million.

Five years ago, June 26, 1996, the Federal debt stood at $5,118,149,000,000, three trillion, five hundred billion, nine hundred one million.

Fifteen years ago, June 26, 1986, the Federal debt stood at $2,040,983,000,000, two trillion, forty billion, nine hundred eighty-three billion.

Mr. BREAUX. Mr. President, I rise today to pay tribute to Timothy J. Rhein, who recently retired after 34 years with American President Lines, Ltd. APL is today one of the world's largest shipping and intermodal lines, and a globally recognized brand, thanks in large part to Tim Rhein's leadership.

I came to know Tim through his appearances before the Subcommittee on Merchant Marine, and I can personally attest to his commitment to merchant shipping and his leadership in the U.S. shipping industry. His rise to president and chief executive officer of APL from 1995 to 1999, and then to chairman, was marked by key decisions in a difficult business.

He was instrumental in expanding APL from primarily an Asia-America business into a truly global operation. He gained a decisive edge on his competitors by embracing information technology earlier than anyone else in his business. He knew the numbers and metrics of his business better than anyone else. He was rarely at a loss for an answer before our committee, and always worth listening to.

And he worked very hard at developing one particular line of business—the U.S. military—to the point where our government is today APL's largest customer. One of the reasons for that sixty-five million understanding of logistics, of managing supply lines, a critical skill to the military as well as to APL's multinational corporate customers.

But without doubt his toughest decision was to negotiate the sale of APL to a non-U.S. buyer, in order to protect all of APL’s stakeholders and to preserve the APL presence and brand. APL was the oldest continuously operating shipping company in America, and a premier US-flag shipping company. He stuck his neck out on that decision; put his reputation on the line, and negotiated the sale personally—and successfully.

Tim Rhein understood his business. He was a nimble and gutsy decision-maker, and we in Washington will miss his understanding and knowledge as we continue our pursuit of a policy to promote a strong U.S. flag maritime shipping presence. I hope he will continue to avail us of his knowledge and wise counsel.

Good luck in your retirement, Tim Rhein.

DEATH OF ROBERT MCKINNEY
Mr. BINGAMAN. Mr. President, earlier today I sent a letter to the oldest daily newspaper in the West, “The New Mexican” regarding the death of its publisher, Robert McKinney.

Robert McKinney was well known to the Senate. His decades of service to this country, in one capacity or another, and his remarkable career in business and publishing brought him in contact with many of us, and with colleagues who have preceded us in this body. He and Clinton Anderson, late a Senator for New Mexico, were great friends, and worked together on the San Juan-Chama water project for our State.

Five presidents called on him for service from Harry Truman through Richard Nixon. He put his prodigious skills to work at various times at the Department of the Interior, the Atomic Energy Commission, and the Department of the Treasury. Under President Kennedy, he served as our Ambassador to Switzerland.

He was a fine citizen, and a good friend who will be missed, but whose influence, I know, is “a widening ripple, down a long eternity.” The world is a better place for his having lived. I ask that my letter be printed in the RECORD.

The letter follows:

LETTER TO THE EDITOR OF “THE NEW MEXICAN”

To the Editor: With so many others, I was saddened earlier this week when word came of the death of Robert McKinney whose American life made him one of the world’s distinguished citizens. When he died in New Mexico on Sunday night, this man of the American West had forged great successes in business, journalism, international diplomacy, public service and public policy in the course of his ninety years of “life well lived” and much of it was lived in New Mexico where he was the deeply respected publisher of this newspaper.

He was a singular individual with a wide-ranging mind, vast talents, and varied interests. He brought his considerable energy to