

Local Law Enforcement Act of 2001 would add new categories to current hate crimes legislation sending a signal that violence of any kind is unacceptable in our society.

I would like to describe a terrible crime that occurred April 15, 1998 in Boise, Idaho. Mark Bangerter was brutally beaten because of his perceived sexual orientation. As a result of this attack, Mr. Bangerter was left with severe facial injuries and blindness in one eye.

I believe that government's first duty is to defend its citizens, to defend them against the harms that come out of hate. The Local Law Enforcement Enhancement Act of 2001 is now a symbol that can become substance. I believe that by passing this legislation, we can change hearts and minds as well.

#### HUNGER AND POVERTY IN AFRICA

Mr. LEVIN. Mr. President, it is my pleasure to join with Senators LEAHY and HAGEL in submitting S. Con Res. 53, which encourages the development of strategies to reduce hunger and poverty in sub-Saharan Africa.

In the year 2000, almost 200 million Africans, fully a third of the total population, went to sleep hungry and 31 million African children under the age of five were malnourished. One child out of seven dies before the age of five, and one-half of these deaths are due to malnutrition. Nearly half of sub-Saharan Africa's population, some 291 million people, live on less than \$1 a day, and almost 85 percent of the world's 41 heavily indebted poor countries are in sub-Saharan Africa.

These problems are compounded by epidemics of HIV/AIDS, tuberculosis, malaria, cholera, and other diseases now ravaging the continent. The human costs are staggering. Almost 4 million people are infected with AIDS each year, adding to the over 25 million already infected. Over 75 percent of the people worldwide who have died of AIDS lived in Africa. One million people each year, mostly children, die from malaria.

Hunger only adds to the spread of disease, rendering the poor and malnourished too weak to defend against AIDS and other infectious diseases. Even if treatment clinics are available, those suffering from hunger are unable to afford fees for care or medicine to aid them with their battle against the illness.

Despite funding shortfalls, the U.S. Agency for International Development, USAID, and other U.S. government agencies, foundations, universities, non-governmental organizations, NGOs, and private sector companies are presently implementing many innovative programs directed toward alleviating hunger and poverty in Africa.

While tremendously significant, these actions are not enough to keep poverty and hunger from growing in many African countries. Many of our experts have concluded that the United

States is not tapping into the full range of interest, ability, experience and capacity available to address this problem. The introduction of our Resolution, which addresses these issues, coincides with the conference of The Partnership to Cut Hunger in Africa, an independent effort formed by U.S. and African public and private sector institutions, international humanitarian organizations and higher educational institutions. Michigan State University continues to play a strong leadership role in this effort. The President of Michigan State University, Peter McPherson, serves as one of the Partnership's co-chairs and was instrumental in arranging conference-discussion activities in the Senate this week.

The goal of the Partnership is to formulate a vision, strategy, and action plan for renewed U.S. efforts to help African partners cut hunger dramatically by 2015. For three days this week, the Partnership's 22 distinguished policy experts and practitioners from the U.S. and 8 African countries will share their views on hunger in Africa and will open a dialogue on the role the U.S. might play in diminishing hunger and poverty in Africa. On Thursday, June 28, 2001, Partnership experts will culminate their 3-day conference with a roundtable discussion on Capitol Hill, during which time they will share their findings and action plan to effectively combat hunger and poverty in Africa. I am honored to have the opportunity to join in hosting this event.

I ask unanimous consent that the members of the Partnership to Cut Hunger in Africa and the Partnership's expert panel be printed in the RECORD. They are as follows:

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

#### PARTNERSHIP TO CUT HUNGER IN AFRICA EXPERT PANEL

From Bamako, Mali:  
Dr. Bino teme, Scientific director, Institute for Rural Economics.

Mme. Konare Nafissatou Guindo, Administrative and Financial Director, Ministry of Territorial Administration and Local Government.

Dr. Niama Nango Dembele, Coordinator, APCAM-MSU Market, Information Support Project, Visiting Assistant Professor, Michigan State University.

Dr. Mbaye Yade, Coordinator, Institute du Sahel/MSU, Food Security Support Project, Visiting Assistant Professor, Michigan State University.

From Maputo Mozambique:  
Mr. Joao Carrilho, Vice-Minister, Ministry of Agriculture and Rural Development.

Mr. Sergio Chitara, Executive Director, Confederation Of Mozambican Business Associations CTA.

From Accra, Ghana:  
Dr. Sam Asuming Brempong, Department of Agricultural Economics, Faculty of Agriculture, University of Ghana.

Dr. Kwaku Owusu Baah, Faculty of Agriculture, University of Ghana.

From Abuja, Nigeria:  
Dr. Salisu A. Ingawa, Head of Unit, Projects Coordinating Unit (PCU), Federal Ministry of Agriculture and Rural Development.

Dr. Ango Abdullahi, Special Adviser to the President on Food Security.

From Entebbe, Uganda:  
Dr. Isaac Joseph Minde, Coordinator of ECAPAPA Project, ASARECA.

Dr. Fred Opiio, International Food Policy Research Institute, Regional Office for the 2020 Network—Eastern Africa.

Dr. Peter Ngategize, Plan for Agriculture Modernization, Ministry of Finance.

Dr. J.J. Otim, Presidential Advisor on Agriculture, Office of the President.

From Addis Ababa, Ethiopia:  
Mamou Ehui, Economic Commission for Africa.

From Rwanda:  
Edson Mpyisi, Coordinator of Food Security Research Project-FSRP/MINAGRI, Ministry of Agriculture.

Others:  
Dr. Akin Adesina, Resident Representative for Southern Africa, The Rockefeller Foundation.

Serge Rwamisarabo—USAID/Rwanda,  
Francis Idachaba University of Ibadan, Nigeria,  
Kandeh Yumkella—UNIDO/Nigeria,  
Mbenga Musa, Executive Secretary of CILSS, Ouagadougou, Yamar Mbodj, Food Security Advisor, CILSS Secretariat, Ouagadougou.

#### EXECUTIVE COMMITTEE

Peter McPherson, Co-Chair, President, Michigan State University.

Alpha Oumar Konare, Co-Chair, President, Republic of Mali.

Senator Robert Dole, Co-Chair, Special Counsel, Verner, Liipfert, Bernhard, McPherson and Hand.

Lee Hamilton, Co-Chair, Director, The Woodrow Wilson International Center for Scholars.

David Beckmann, President, Bread for the World.

Mary Chambliss, Deputy Administrator, Export Credits, Foreign Agriculture Service, USDA.

Imani Countess, Outreach Director, Shared Interest.

William B. DeLauder, President, Delaware State University.

Stephen Hayes, President, Corporate Council on Africa.

Joseph Kennedy, Co-Founder, Africare.

George Rupp, President, Columbia University.

Emma Simmons, Director, Center for Economic Growth and Agricultural Development, USAID.

Edith Ssempera, Ambassador, Republic of Uganda.

Bob Stallman, President, American Farm Bureau Federation.

#### 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 Allbaugh, 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.

When 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.

Dr. J.B. Orenstein, 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 without 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 Unraveling Safety Net." Are we, 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 prepare for bioevents?

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 not overlooked 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; she's been in the triage area for three hours, but can't get into treatment because chest-pain guy, blue baby and 18 other patients are parked in the treatment beds while they wait to be admitted.

Our communications nurse just told an approaching ambulance to find someplace 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 buttock.

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 ERs 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 the form of ambulance "diversions."

Up until a year or two ago, we faced this nerve-racking logjam for only a few days or weeks in winter, when flue and cold viruses turn into potentially fatal pneumonia, babies 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-surges 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: 100.4 million. Meanwhile, over the same decade, the number of emergency departments fell from about 5,200 to just over 4,000. Their average annual patient volume rose from 15,500 to 24,800—that's more than 50 percent.

In all of American medicine, the only place that federal law 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, known as EMTALA. "[A]s enforced by the Health Care Finance Administration and recently upheld by the U.S. Supreme Court, EMTALA is a civil right extended to all U.S. residents," Wesley Fields, chairman of the American College of Emergency Physicians Safety Net Task Force, recently wrote. Crowded as we are, if you walk in the door, you'll be treated whether you can pay or not. Just get in line and take a number with everyone else.

I don't like this any more than my dissatisfied, frustrated patients do. I tell them that it's like rush hour on I-66—too many bodies packed into a space built ages ago for a much smaller population.

But like most of life, 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 agencies regulate 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-90's 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 just 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 IV 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, money poured into expanding both 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 in the opposite direction, resulting in too many unused beds.)

When hospitals close, it puts more pressure on those that survive. At Inova Fairfax, occupancy averaged a jam-packed 92 percent over the past year. Thom Mayer, chief of our emergency department, put it this way: "The inpatient population is so high so regularly that a mere 20 or 30 extra patients throws us back into full crisis mode." And that can happen during one shift in a busy emergency room.

Beyond the number of beds, just how many are available at any given time often comes down to two letters: RN. A hospitalized patient needs a doctor for just a few minutes each day, but nursing care must be available around the clock. But, like hospital beds, fully qualified nurses have been disappearing fast, too. A widely cited study from Vanderbilt University, published last year in the *Journal of the American Medical Association*, pointed to some ominous trends. A key finding: The average age of nurses is rising. The number of nurses under the age of 30 fell from 419,000 in 1983 to 246,000 in 1998; by the end of this decade, the study said, 40 percent of working nurses will be older than 50. Retirement will create an estimated shortfall of half a million nurses in the year 2020. The clear reason: A decline in the number of high school girls who go to college intent on becoming nurses. "Women, who traditionally comprise the majority of nursing personnel, are finding other career options that are less physically demanding, more emotionally rewarding and come with a higher rate of pay," Brandon Melton, representing the American Hospital Association, told a Senate subcommittee earlier this year. And men aren't making up for the shortfall.

My wife, a savvy, experienced nurse, last did floor work more than 10 years ago, and though conditions were tough enough then, she recoils at what she would face 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 worst pressure on the ER. In the highly sophisticated environment of the ICU, a patient's heart rate or blood pressure can be fine-tuned with a shift of an IV drip. A phalanx of monitors register any number of physiological trends to answer the question, "Is this person getting better or worse?" When a patient requires this moment-by-moment scrutiny and all ICU beds are filled, the only place with roughly equal capacity—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 these days have higher "acuity" than a decade ago—that is, they're sicker. There's been no easy way to quantify this change, but, like tornado victims, ER docs know what we've been big with. We spend more time trying to get a borderline patient "tuned up" enough to go home rather than be admitted to a busy, barely staffed hospital floor. We arrange home delivery of nebulizer machines for asthma patients. We check out the patient discharged yesterday after surgery who is back today, feeling weak, wondering if he's really well enough to be home. I kind of miss the good old days when a 10-hour shift

meant a string of straightforward technical procedures—like reducing a dislocated shoulder or sewing a complex laceration. These days, it seems more time is spent tracking down a patient's three or four specialists—the oncologist, the psychiatrist, the infectious disease guy—or negotiating with the intake person to authorize a bed or transfer the patient to a hospital that accepts his insurance.

Whine, whine, whine. I started writing this as a letter of apology to all the miserable, aggravated patients who wonder why they have had to wait so many hours to see me, and here I am complaining about my own problems. I'll try to get back on track, because the worst is still ahead. And the worst by far is ambulance diversion.

It happened a lot over this past winter. In Boston—hardly a hospital-deprived town—the *Globe* reported that 27 area ERs went "on diversion" for a total of 631 hours in November, 677 hours in December and more than 1,000 hours in January. And it was worse in Northern Virginia: In January, the area's 13 ERs placed themselves on diversion for more than 4,000 hours. Evenly divided, and it most assuredly was not, that would be every ER refusing ambulances for 10 hours every day. Almost half the time, back in that icy January, if you needed an ambulance to get to an ER you were SOL: severely out of luck.

The American College of Emergency Physicians is certainly concerned about the problem: Last October, an advisory panel proposed guidelines for ambulance diversion, blaming "a shortage of health care providers, lack of hospital-based resources and ongoing hospital and ED [emergency department] closures." But it's easy to get the feeling that others at the national level aren't taking it seriously. At a public health conference in November, at the beginning of the critical winter season, U.S. Surgeon General David Satcher was quoted as recommending that people be "educated" not to go the emergency room unless they really need to. Dennis O'Leary, head of the Joint Commission on Accreditation of Healthcare Organizations, a critical monitoring group, was quoted as saying: "Quite frankly, this problem waxes and wanes . . . but without anything tangibly happening it resolves itself . . . The system will somehow muddle through."

They're right: I muddle through each shift worrying about patients trapped in the waiting room or ambulances that can't discharge their passengers at our door. I mutter humble apologies to private docs outraged that the patients they sent in specifically for urgent treatment—pain control, antibiotics, whatever—cool their heels for hours on end. I go home exhausted and aggravated with myself after 10 hours of juggling alternatives so as not to put a patient into a scarce bed—telling people to try a "stronger" antibiotic, ratchet up the home respiratory treatments, take a few extra tabs of pain reliever each day, and always be sure to follow up with your own doctor tomorrow. I wonder which patients are going to be back in another ER the next day because I missed their real problems or insisted on an ineffective patch.

Doctors and nurses have a bottom line that ultimately distinguishes us from other professions: quality patient care. When we can't provide this, we have failed. Our hospital administrators and department chiefs assume that excellent patient care is a non-negotiable minimum standard. But every winter, and increasingly at other times, the crash of the system is the quite capitulation to these accumulated pressures. When forced to maneuver so many sick patients through an overwhelmed system, I just don't know if I'm doing a good job any more. As a result, I

often find myself phoning the patient the next day, checking in: "Everything okay today?"

Many of the region's hospitals have received, or are negotiating for, approval for more beds. Where more nurses will come from is another problem. Anthony Disser, the chief executive nurse at Fairfax, says the intrinsic value of nursing is already luring a certain number of burned-out software writers or disappointed entrepreneurs for a second career. Yeah, I guess we are muddling through, after all.

I look forward to that "Unraveling Safety Net" meeting in Atlanta in three weeks, where I expect to be transfixed, like the audiences at "Hannibal," by the horror stories and dire statistics of other ER docs and public health researchers. Maybe they've been coming up with some solutions. If they have, I hope they haven't been waiting till May to share them with the rest of us.

#### THE VERY BAD DEBT BOXSCORE

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, one hundred eighty-one thousand, three hundred eight dollars and seventeen 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, five trillion, one hundred eighteen billion, one hundred forty-nine million.

Ten years ago, June 26, 1991, the Federal debt stood at \$3,500,901,000,000, 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 million, which reflects a debt increase of more than \$3.5 trillion, \$3,615,767,181,308.17, three trillion, six hundred fifteen billion, seven hundred sixty-seven million, one hundred eighty-one thousand, three hundred eight dollars and seventeen cents during the past 15 years.

#### ADDITIONAL STATEMENTS

##### TIMOTHY J. RHEIN

• 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.